Today's Date: ____/ ____/ _____

PATIENT & HEALTH INFORMATION

WELCOME: The doctors and staff welcome you and want to provide you with the best care possible. We will conduct a thorough history and physical examination to decide if we can assist you with your care. If we do not believe that your condition will respond to our treatments, we will refer you to the appropriate healthcare provider. If you are a candidate for our treatments, a customized plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following questions to the best of your ability. Be as descriptive as possible and check all descriptors that apply. If you have questions, please ask a staff member for assistance or clarification.

First Name: _____
Middle Name: _____
Last Name: _____
Birth Date: ___/ ___/ ___ Gender: _____
Address: _____
_____
City: _____
State: _____ Zip Code: _____

Primary Phone: _____
☐Work ☐Cell ☐Home
Secondary Phone: _____
☐Work ☐Cell ☐Home

Email: _____

Employment Status: _____
Business Name: _____
Business Phone number: _____
Business Address: _____
_____
City: _____ State: ___ Zip Code: _____

Occupation/ Title: _____
Type of Work: _____
Is it OK to contact you at work? ☐Yes ☐No

Who referred you? _____

EMERGENCY CONTACT INFORMATION

First Name: _____
Last Name: _____
Phone Number: _____
Relationship: _____

Address: _____
_____
City: _____
State: _____ Zip Code: _____

Tobacco Use ☐ Never Smoker ☐ Former Smoker ☐ Current Smoker Type and Amount/Day
Chew Tobacco ☐ No ☐ Yes Caffeine Use ☐ No ☐ Yes Frequency/Type
Alcohol Use ☐ No ☐ Yes Frequency
Street Drugs ☐ No ☐ Yes Type Exercise ☐ No ☐ Yes (Type/Freq)
Do You Play Sports? ☐ No ☐ Yes: What Sport Position
What Level Of Sport? ☐ Highschool ☐College ☐ Other

WHAT IS THE REASON FOR YOUR VISIT?

_____

_____

_____

_____

When did your symptoms appear? _____

Is this condition getting? ☐Better ☐Worse ☐No Change

Please check the types of pain that apply to you: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting ☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other _____

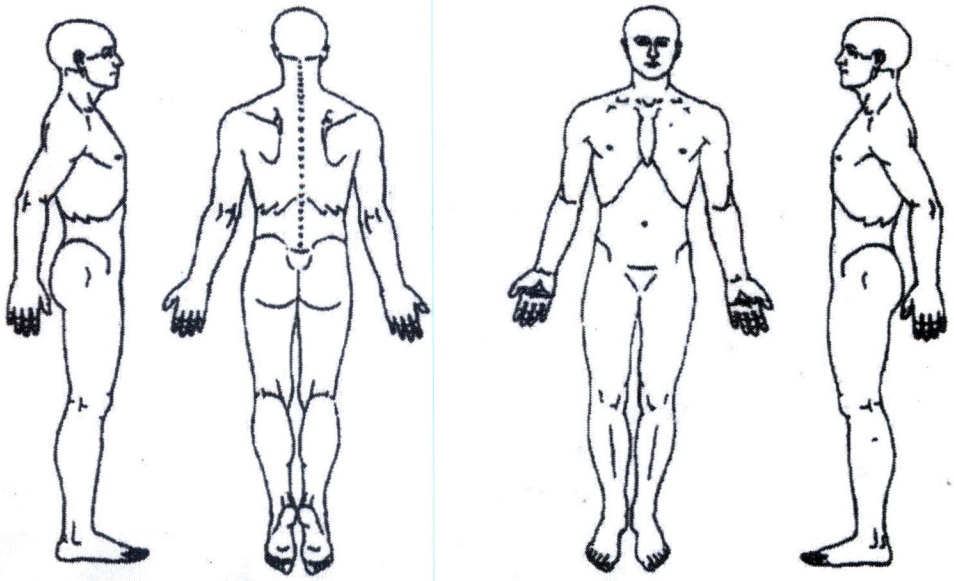
Is the pain: ☐Consistent ☐Come and go

Does it interfere with you? ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other _____

Please check the following movements or activities that are painful for you to perform:

☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐Other _____

Circle the area(s) of complaint(s) and grade the intensity of pain in each area using 0–10 scale, with 10 being the highest level of pain.



Is the condition due to an accident? ☐ Yes ☐ No

If yes, what type of accident ☐ Auto ☐ Work ☐ Home ☐ Other_____

ACCEPTANCE AS A PATIENT

I understand and agree that South West Health Professional Center (SWH) has the right to (1) accept or refuse me as a patient at any time before treatment begins, (2) terminate my care as a patient if in the course of treatment, I choose to not follow the treatment plan for my condition, or (3) be referred out to another health provider as the doctors deem medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of gathering information so that the doctors can determine whether to accept me as a patient.

HEALTH HISTORY

This section will identify key factors and indicators about your history that may impact or contribute to your current health condition. Please give us information on those that apply to you.

- Please list any medications or nutritional supplements that you are currently taking
- Please list doctors or providers that you have seen for this condition or for any conditions that you may be currently treating with and the type of treatments provided
- Surgeries (Please list all surgical procedures that you have had in the past)
- Childhood Illnesses (Please list any illnesses that you have had as a child)
- Adult Illnesses (Please list any illnesses that you have had as an adult)
- Family History (Please list any genetic illnesses in your family)
- Injuries (Please list any significant injuries, falls, trauma, or accidents that you have had in the past)
- Non-Drug Allergies and how you react to those substances

Do you have, or have you ever had any of the following health problems? (Check all that apply)

- ☐ Allergies
- ☐ Asthma
- ☐ Trouble Breathing
- ☐ Tiredness/Fatigue
- ☐ Frequent Colds/Flus
- ☐ Sinus Infections
- ☐ Headaches/ Migraine
- ☐ Concussion
- ☐ Dizziness
- ☐ Fainting
- ☐ Difficulty Concentrating
- ☐ Memory Loss/Forgetful
- ☐ Vision/Eye Problems
- ☐ Hearing Problems
- ☐ Ear Problems
- ☐ Thyroid Problems
- ☐ High / Low Blood Pressure
- ☐ Heart Problems
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Cancer
- ☐ Poor Diet
- ☐ Nausea
- ☐ Stomach Problems
- ☐ Digestion Problems
- ☐ Ulcers
- ☐ Liver/Gall Bladder Problems
- ☐ Diarrhea
- ☐ Constipation
- ☐ Pain with stools
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Incontinence
- ☐ Bed Wetting
- ☐ Prostate Problems
- ☐ Impotence (ED)
- ☐ Menstrual Problems (PMS)
- ☐ Anxiety
- ☐ Depression
- ☐ Emotional Disorders
- ☐ Irritability
- ☐ Mood Disorders
- ☐ Nervousness
- ☐ Stress
- ☐ Excessive Sweating
- ☐ Achiness / General Pain
- ☐ Sports Injuries
- ☐ Auto Accidents
- ☐ Other Accidents/Falls
- ☐ Work Injuries
- ☐ Unable to Work
- ☐ Painful Joints
- ☐ Fractured Bones
- ☐ Sore Muscles
- ☐ Shoulder Pain/Stiffness
- ☐ Elbow Pain/Stiffness
- ☐ Wrist/Hand Pain or Stiffness
- ☐ Hip Pain or Stiffness
- ☐ Knee Pain or Stiffness
- ☐ Ankle/Foot Pain or Stiffness
- ☐ Neck Pain/Stiffness
- ☐ Numbness/Tingling Arm(s)
- ☐ Upper Back Pain or Stiffness
- ☐ Mid Back Pain or Stiffness
- ☐ Low Back Pain or Stiffness
- ☐ Pain shooting down leg(s)
- ☐ Trouble Walking
- ☐ Pain w/coughing
- ☐ Pain w/sneezing

INFORMED CONSENT DOCUMENT

PATIENT NAME: _____

Read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

One of the treatments that we may employ at South West Health Professional Center is spinal and or extremity manipulative therapy. Other treatments include, acupuncture with or without electric stimulation, instrument assisted soft tissue techniques, Shockwave Therapy, myofascial release, sports taping techniques, spinal decompression, massage therapy, ice and moist heat, cupping, gua-sha, strength and conditioning exercises,Chinese herbal supplements and nutritional counseling.

Risks:

Chiropractic and acupuncture care are generally safe methods of treatment for certain conditions. As with any healthcare procedure, there are certain complications which may arise during sports chiropractic manipulative therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

Acupuncture may have some side effects including bruising, numbness, dizziness, and fainting. Unusual risks of acupuncture include infection and organ puncture. This facility utilizes sterile, disposable needles and maintains a clean and safe environment with a 0.0% incidence rate for both unusual risks. Petechiae (clusters of small red or purple spots) are an expected response to cupping and gua-sha.

We will make every reasonable effort during the examination to screen for contraindications to manipulative therapy and acupuncture to ensure that you are a candidate for treatment; however, if you have a condition that would otherwise not come to our attention, it is your responsibility to inform us.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the taking of your history and during examination and imaging. Strokes have been the subject of tremendous disagreement. The incidences of strokes are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options.
Other treatment options for your condition may include:
- Self-administered, over-the-counter (OTC) analgesics and rest
- Medical care and prescription drugs such as NSAIDS, muscle relaxants and pain killers
- Hospitalization
- Surgery

If you chose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated.
Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE THEN, SIGN BELOW.

I have read or have had read to me the above explanation of the sports chiropractic adjustment, acupuncture and related treatment. I have discussed it with my attending sports chiropractor and acupuncturist and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: _____

Patient's Name (print): _____

Patient's Signature: _____

Doctor's Name (print): _____

Doctor's Signature: _____

Signature of Parent or Guardian (if a minor):_____

The purpose of this agreement is to provide acupuncture care within the scope of the financial agreement as outlined below. Any adjustments to the rates must be agreed to, and signed by both the patient (or legal guardian) and Amy LeSage, L.Ac.

I hereby request and consent to the charges outlined below effective today. I understand by signing this agreement I am responsible for the amounts agreed upon at the time of service and my insurance will not be billed by Amy LeSage, L.Ac. Any adjustments to the rates must be agreed upon and signed by both the patient (or legal guardian) and Amy LeSage, L.Ac. Additionally, I understand and agree that I am responsible for any service(s) or supply(ies) not outlined in this agreement, which will be discussed prior to service.

Acupuncture Therapy Rates

Initial consultation and acupuncture treatment- 75 minutes: $175
Follow up acupuncture treatment- 60 minutes: $150
Cancellation Fee: no show or cancellation within 24 hours or scheduled appointment: $100
(each treatment involves assessment and may involve the use of electro-acupuncture, cupping and manual therapy)

The initial consultation will include a full assessment, treatment, prognosis, and treatment plan.

* I have read the above agreement and intend this form to cover the entire course of treatment for my present condition, and for any future condition (s), for which I seek treatment by Amy LeSage, L.Ac.

☐ By checking this, you are eSigning this form.

☐ Signature of Guardian if patients is under the age of 18.
By checking this, you are eSigning this form.

* Today's Date _____