

**New Patient Form Inner Light Wellness, Inc.
Margaret Celli L.Ac., NCCAOM**

Name _____ Date _____
Address _____
Phone _____
(Home) _____ (Work) _____ (Cell) _____
Occupation _____ Employer _____
Date of Birth _____ Age _____ E-Mail _____
Emergency Contact Name/Phone _____ Relationship to you _____
Medications/Vitamins _____

Physician _____ Referred by _____
Primary reason for visit _____

When did symptoms first appear? _____ Are they worsening? _____
What makes it better? _____
What makes it worse? _____
Other health concerns _____
Previous injuries (describe and date) _____

Surgery/Hospitalizations (describe and date) _____

Have you ever had acupuncture? _____ Are you receiving other therapies? _____
Describe _____

MEDICAL HISTORY:

Your history:

____ Heart disease	____ Blood clots	____ Spinal Problems
____ Bleeding disorder	____ Diabetes	____ Osteoporosis
____ Low Blood Pressure	____ High Blood Pressure	____ Stroke
____ Hepatitis	____ Alcoholism/Drug addiction	____ Cancer
____ HIV/AIDS	____ Allergies	____ Asthma
____ Appendicitis	____ Depression	____ Pneumonia
____ Serious Fever	____ Seizures	____ Chicken Pox
____ Kidney Disease	____ Thyroid Disorder	____ Measles
____ High Cholesterol	____ Liver Disease	____ Lyme

Other: _____

Have you ever fainted? _____ Yes _____ No

SIGNATURE _____ DATE _____

Family History:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies |

Other: _____

Current life stressors _____

WOMEN:

Describe your typical menstruation (*if you are menopausal, describe your previous menstrual cycles*) _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Age menses began | <input type="checkbox"/> Clots | <input type="checkbox"/> Color of menses |
| <input type="checkbox"/> Length of cycle | <input type="checkbox"/> Cramping | <input type="checkbox"/> Length of flow |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Vaginal odor | <input type="checkbox"/> Vaginal Dryness |
| <input type="checkbox"/> #Pregnancies | <input type="checkbox"/> #Births | <input type="checkbox"/> #Miscarriages |
| <input type="checkbox"/> Fibroids/Cysts | <input type="checkbox"/> Yeast infections | <input type="checkbox"/> #Abortions |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Genital warts |
| <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Low libido | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Oral contraceptives | <input type="checkbox"/> HRT | <input type="checkbox"/> Breast lumps/tenderness |
| <input type="checkbox"/> Recent change in menses (describe) _____ | | |

Any other menstrual issues? _____

MEN:

- | | |
|--|--|
| <input type="checkbox"/> Difficulty starting urination | <input type="checkbox"/> Stopping and starting urination |
| <input type="checkbox"/> Urinary dribbling | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Difficult to attain/maintain erection |
| <input type="checkbox"/> Genital pain | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Genital rash | <input type="checkbox"/> Genital herpes |
| <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> Genital warts |

DIET:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Low Appetite | <input type="checkbox"/> Heavy Appetite | <input type="checkbox"/> Coffee/Tea |
| <input type="checkbox"/> Meat | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Thirsty | <input type="checkbox"/> Prefer Hot Beverages | <input type="checkbox"/> Prefer Cold Beverages |
| <input type="checkbox"/> Crave Sweets | <input type="checkbox"/> Crave Salt | |

List the foods you eat:

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SIGNATURE _____ DATE _____

For the following symptoms, please indicate your experience as follows:

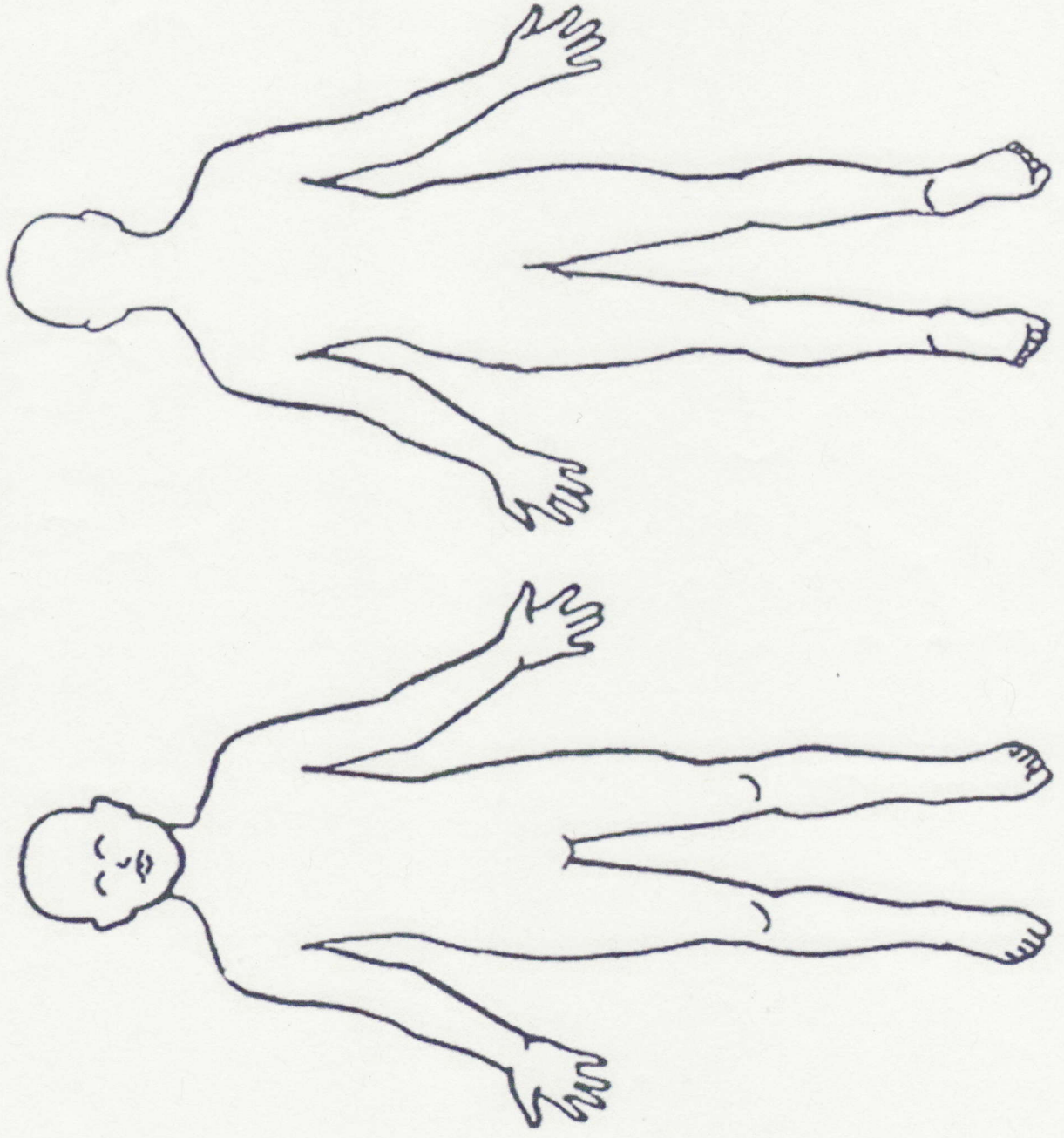
1=occasionally

2=frequently

<input type="checkbox"/> Feeling of Heat in Chest	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Stress
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Headaches
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Difficult to Pass Urine	<input type="checkbox"/> Sighing
<input type="checkbox"/> Heart Palpitation	<input type="checkbox"/> Inability to Hold Urine	<input type="checkbox"/> Depression
<input type="checkbox"/> Tight Chest	<input type="checkbox"/> Dark/Pale Urine	<input type="checkbox"/> Lump in Throat
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Anger/Irritation
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Nighttime Urination	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Difficult to Fall Asleep	<input type="checkbox"/> Urgent Urination	<input type="checkbox"/> Dry Eyes
<input type="checkbox"/> Difficult to Stay Asleep	<input type="checkbox"/> Lack of Sex Drive	<input type="checkbox"/> Red/Itchy Eyes
<input type="checkbox"/> Dream Disturbed Sleep	<input type="checkbox"/> Premature Gray	<input type="checkbox"/> Poor Night Vision
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Spots/Floaters
<input type="checkbox"/> Agitation	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Ridged Nails
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Numb/Tingling
<input type="checkbox"/> Easily Startled	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Rib Pain
<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Night Sweating	<input type="checkbox"/> Spasms/Tics
<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Ear Ringing (Low)	<input type="checkbox"/> Ear Ringing(Hi)
<input type="checkbox"/> Ulcers Mouth/Tongue	<input type="checkbox"/> Swollen Legs/Feet	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Cold/Swollen Hands	<input type="checkbox"/> Cold Feet	<input type="checkbox"/> TMJ-Grinding
		<input type="checkbox"/> Breast Pain
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Glasses
<input type="checkbox"/> Allergy	<input type="checkbox"/> Indigestion	<u>Bowel Movements:</u>
<input type="checkbox"/> Sinus Problem	<input type="checkbox"/> Heartburn	Frequency_____
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Bleeding Gums	Color_____
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Abdominal Pain	Texture_____
<input type="checkbox"/> Dry Throat/Mouth	<input type="checkbox"/> Constipation	(loose or formed)
<input type="checkbox"/> Loss of Voice	<input type="checkbox"/> Diarrhea/Loose Stool	
<input type="checkbox"/> Dry Cough	<input type="checkbox"/> Mucus/Blood in Stool	<u>Pain?</u>
<input type="checkbox"/> Wet Cough	<input type="checkbox"/> Bad Breath	Location_____
<input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Dizzy if Stand Too Fast	Describe_____
<input type="checkbox"/> Bronchitis/Pneumonia	<input type="checkbox"/> Nausea	_____
<input type="checkbox"/> Goiter/Fatty Tumors	<input type="checkbox"/> Belching/Bloating	<u>Headache?</u>
<input type="checkbox"/> Easily Sweat	<input type="checkbox"/> Weak Muscles	Describe_____
<input type="checkbox"/> Absence of Sweat	<input type="checkbox"/> Acid Regurgitation	_____
<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Thirst Excess/Little	<u>Pain Scale 1-10</u>
<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Easy Bruising	Pain_____
<input type="checkbox"/> Itching	<input type="checkbox"/> Feel Heavy	Headache_____
<input type="checkbox"/> Cysts	<input type="checkbox"/> Varicose Veins	Does it interfere with
	<input type="checkbox"/> Hemorrhoids	daily activity?_____

SIGNATURE_____DATE_____

Using the colored pen, please shade in areas of pain or tension.
Please include areas of radiating pain.



PRACTITIONER CONSENT & FINANCIAL POLICY

Patient Name: _____ Date: _____

(PRINT)

Consent to Medical Treatment by Margaret Celli and/or Staff

Margaret Celli, L.Ac. is owner and full-time acupuncturist at Inner Light Wellness. Inner Light Wellness is staffed by part time practitioners when Margaret is not in attendance. You may choose to work with one or all staff practitioners and are always notified of the practitioner in attendance prior to scheduling your appointment. Regardless of your choice of practitioners, we must receive consent to treat. *Your consent is necessary for liability purposes only and does not imply that you must work with all practitioners at Inner Light Wellness.*

"I voluntarily consent to receive Acupuncture from Margaret Celli, L.Ac., and/or one of her staff associates who are licensed acupuncturists in the state of Pennsylvania and members of the NCCAOM National Certification Commission of Acupuncture and Oriental Medicine. I understand the acupuncturists' training at Inner Light Wellness is in acupuncture and Chinese medicine and that they are not, nor do they claim to be, medical doctors. I acknowledge that no guarantee has been made to me as to the results of any examination or treatment by the practitioners."

Initials _____

Financial Policy/Insurance

Full payment is due at the time of service for office visits. **We do not accept credit cards.** Payment may be made using cash or check. Credit card exceptions will be made for those using a Health Savings Account (HSA) who have been issued a card associated with the account. If you have a checkbook associated with your HSA, please bring a check.

We are not a participating provider with any insurance carrier. However, if your insurance carrier does cover acupuncture, we will provide receipt of payment for you to forward to your insurance company so that you may be reimbursed. We do not bill insurance directly. **Please inform the receptionist at the beginning of your appointment that you require a receipt so that your receipt is ready at the end of your visit.**

Initials _____

Cancellation Policy

This office requests 24-hour notification of cancellation of an appointment. If no notice of appointment cancellation is provided, it is our policy to charge the missed visit at the normal office visit rate. **We recognize that emergencies and extenuating circumstances arise. Cancellation charges are considered on an individual basis.**

Initials _____

I have read and understand each of the sections contained above. I understand that by signing this document, I am agreeing to and providing the authorization/consent contained in each of the above sections where my initials or those of my representative are located. I have had the opportunity to ask questions regarding each of these sections and all such questions have been answered to my satisfaction.

_____ Signature of Patient or Representative _____ Date

_____ (Relationship to Patient if Representative)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO
OBTAIN, USE, AND DISCLOSE HEALTH INFORMATION

Notice of Privacy Practices

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. Prior to signing this acknowledgement and consent, I have had the opportunity to review the Notice of Privacy Practices posted on the Inner Light Wellness website and available for viewing at the office. Copies of Notice of Privacy available upon request.

I understand that my health record serves as:

- A basis for planning my care and treatment.
- A means of communication among other healthcare professionals who may contribute to my care.
- A source of information for applying my diagnosis to insurance billing.
- A means by which a third-party payer can verify that services billed were actually provided.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Request for restrictions

This organization may release information relating to your office appointments via telephone calls, answering machine messages, text messages, or electronic mail. This organization may also communicate general information to you about the practice of acupuncture via newsletter using e-mail information you provided. Email communication may occur as necessary to notify you of policy changes or office updates that pertain to patient care.

Please specify below any request to restrict the use, dissemination, or method of communication of your medical information as provided in the Notice of Privacy Practices, including notification to your primary care provider that you are receiving treatment at Inner Light Wellness Acupuncture.

I hereby acknowledge that I have received and understand the Notice of Privacy Practices, consent to the use and disclosure of information as described therein, and release Margaret Celli, L. Ac. and her employees from any legal responsibility or liability in connection with the disclosure of the information.

Signature of Patient or Representative **Print Name** **Date**