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:

____Heart disease	____Blood clots	____Cancer
____Diabetes	____High Blood Pressure	____Osteoporosis
____Stroke	____Alcoholism	____Allergies

Other:_____

Current life stressors_____

WOMEN:

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

_____

____Age menses began	____Clots	____Color of menses
____Length of cycle	____Cramping	____Length of flow
____Vaginal discharge	____Vaginal odor	____Vaginal Dryness
____#Pregnancies	____#Births	____#Miscarriages
____Fibroids/Cysts	____Yeast infections	____#Abortions
____Bladder infections	____Genital herpes	____Genital warts
____Painful intercourse	____Low libido	____Sexual dysfunction
____Oral contraceptives	____HRT	____Breast lumps/tenderness

____Recent change in menses (describe)_____

_____

Any other menstrual issues?_____

MEN:

____Difficulty starting urination	____Stopping and starting urination
____Urinary dribbling	____Urgent urination
____Premature ejaculation	____Difficult to attain/maintain erection
____Genital pain	____Low libido
____Genital rash	____Genital herpes
____Enlarged prostate	____Genital warts

DIET:

____Low Appetite	____Heavy Appetite	____Coffee/Tea
____Meat	____Vegetarian	____Vegan
____Thirsty	____Prefer Hot Beverages	____Prefer Cold Beverages
____Crave Sweets	____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

____Feeling of Heat in Chest
____Shortness of Breath
____Chest Pain
____Heart Palpitation
____Tight Chest
____Irregular Heartbeat
____Heart Attack
____Difficult to Fall Asleep
____Difficult to Stay Asleep
____Dream Disturbed Sleep
____Anxiety
____Agitation
____Restlessness
____Easily Startled
____Poor Memory
____Speech Difficulty
____Ulcers Mouth/Tongue
____Cold/Swollen Hands

____Asthma
____Allergy
____Sinus Problem
____Nosebleeds
____Sore Throat
____Dry Throat/Mouth
____Loss of Voice
____Dry Cough
____Wet Cough
____Coughing Blood
____Bronchitis/Pneumonia
____Goiter/Fatty Tumors
____Easily Sweat
____Absence of Sweat
____Dry Skin
____Skin Rash
____Itching
____Cysts

____Frequent Urination
____Painful Urination
____Difficult to Pass Urine
____Inability to Hold Urine
____Dark/Pale Urine
____Blood in Urine
____Nighttime Urination
____Urgent Urination
____Lack of Sex Drive
____Premature Gray
____Low Back Pain
____Knee Pain
____Kidney Stones
____Hearing Loss
____Night Sweating
____Ear Ringing (Low)
____Swollen Legs/Feet
____Cold Feet

____Fatigue
____Indigestion
____Heartburn
____Bleeding Gums
____Abdominal Pain
____Constipation
____Diarrhea/Loose Stool
____Mucus/Blood in Stool
____Bad Breath
____Dizzy if Stand Too Fast
____Nausea
____Belching/Bloating
____Weak Muscles
____Acid Regurgitation
____Thirst Excess/Little
____Easy Bruising
____Feel Heavy
____Varicose Veins
____Hemorrhoids

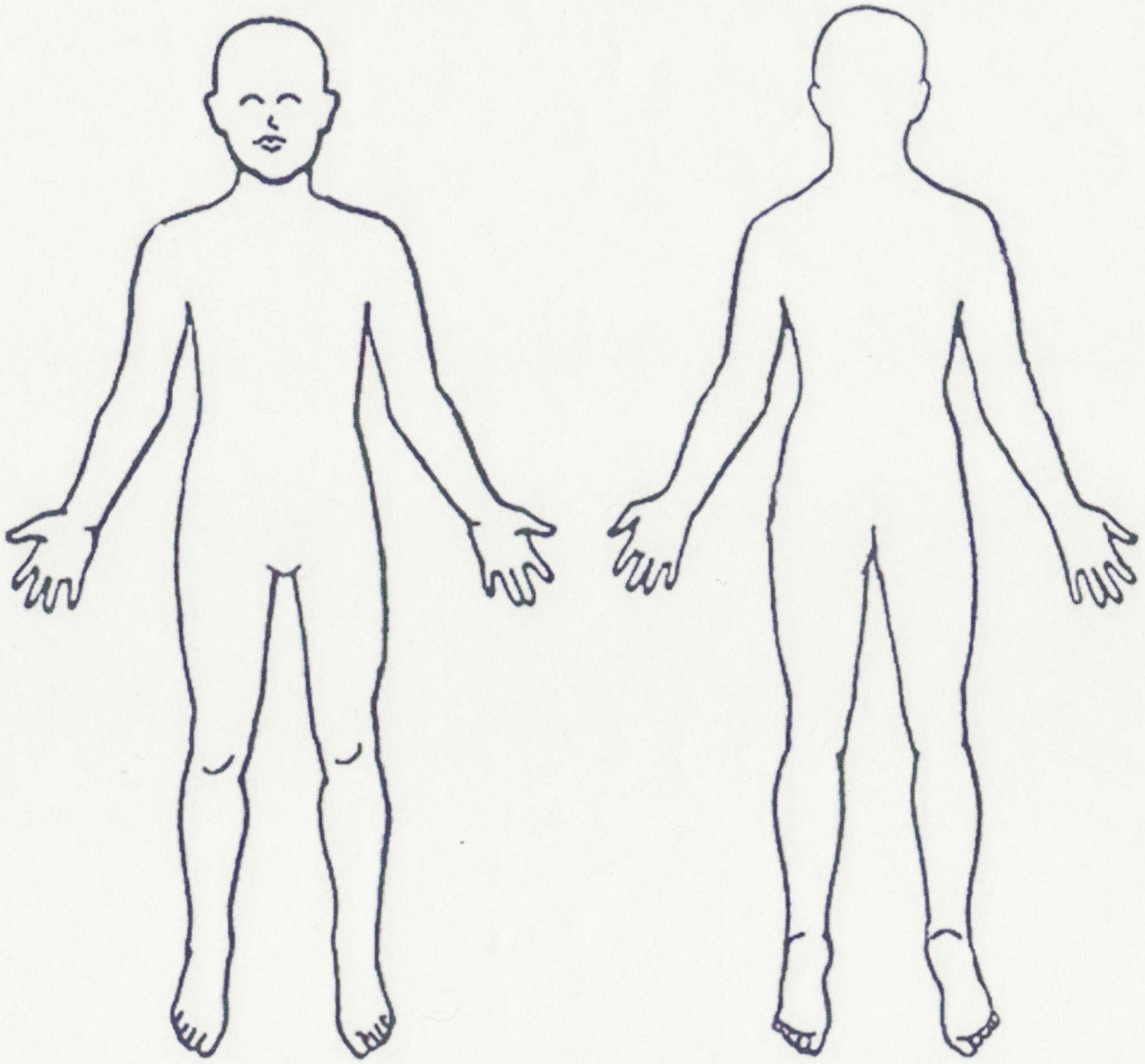
____Stress
____Headaches
____Sighing
____Depression
____Lump in Throat
____Anger/Irritation
____Light Sensitivity
____Dry Eyes
____Red/Itchy Eyes
___Poor Night Vision
____Spots/Floaters
____Ridged Nails
____Numb/Tingling
____Rib Pain
____Spasms/Tics
____Ear Ringing(Hi)
____Dizziness
____TMJ-Grinding
____ Breast Pain
____Glasses

<u>Bowel Movements:</u>
Frequency_____
Color_____
Texture_____
(loose or formed)

<u>Pain?</u>
Location _____
Describe_____
_____
<u>Headache?</u>_____
Describe_____
_____
<u>Pain Scale 1-10</u>
Pain_____
Headache_____
Does it interfere with daily activity?_____

SIGNATURE_____DATE_____

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



Inner Light Wellness Acupuncture | 797 E. Lancaster Avenue Suite 11 | Downingtown, PA 19335

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)

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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**