Hayden Acupuncture
& Wellness Center
6239 E. Brown Rd. #118
Mesa, AZ 85205
480-832-2250

PATIENT INFORMATION

Name: (last, first, initial)		
Street Address:		
City, State, Zip:		
Mobile Phone:	**Home Phone:**	**Work Phone:**
Email:	**Date of Birth:**	**Sex: ☐ Male ☐ Female**
Employers Name:	**Occupation:**	
Spouse / Partner:	**Phone:**	
Emergency Contact Name:	**Phone:**	
Phone # & Address where it is okay to contact you – *if different from above:*		
Responsible Party Information: ☐ Self/Same as above	**Relationship to Patient:**	
Name: (last, first, initial)		
How Did You Hear About Us?:		

*I authorize you to release information regarding my care and treatment to the following:

_____

*You may speak to on the phone or in person regarding my care and treatment to the following:

_____

I certify that the information provided is true and accurate. I assign any payable benefits to be paid directly to Hayden Acupuncture & Wellness Center and authorize them to submit a claim on my behalf and release any information required to obtain payment for my care and treatment.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE.

_____ _____ _____

Signature **(Relationship to Patient)** **Date**

Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities (check all that apply):

☐ Work	☐ Standing	☐ Sexually	☐ Other
☐ Sleep	☐ Emotionally	☐ Recreation	_____
☐ Walking	☐ Relationships	☐ Bending	_____
☐ Sitting	☐ Social Life	☐ Stretching	_____
			_____

What have you done about this? _____

Have you had Acupuncture before? Y/N

Are there any other therapies which you are involved in? Y/N

With whom and what therapy? _____

Are you interested in:

☐ Pain Relief	☐ Healy	☐ Energy Balancing	☐ Other
☐ Stress Reduction	☐ Laser Therapy	☐ Maintenance Care	_____
☐ Chinese Herbs	☐ Asian Bodywork	☐ Preventative Care	_____
☐ Nutritional Information	☐ Cupping	☐ Performance Care	_____
			_____

What are your health goals? _____

List exercise and sport activities you have been or are currently involved in:

_____

_____

Female Concerns

Date of last period: _____ ~OR~ Date of Menopause: _____

Age period started: _____ Is / Were your cycles regular? Y/N Is / Were your cycles painful? Y/N

Have you ever been pregnant? Y/N Number of times: _____ Number of live births: _____

Birth control? Y/N How long? _____ ❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

Date of last Pap and breast exam: _____ Results normal? Y/N

Male Concerns

Date of last prostate check: _____ Urinary problems: _____

Erection difficulties: Y/N Type and for how long: _____

Signs/Symptoms

Please check all that apply:

- ❍ Abdominal pain or distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump or pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands or feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness / vertigo
- ❍ Dry throat or mouth
- ❍ Diarrhea
- ❍ Earaches
- ❍ Eye pain or strain
- ❍ Excessive phlegm
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas / belching
- ❍ Goiter
- ❍ Grinding teeth
- ❍ Hay fever
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccups
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal cramps
- ❍ Irritability
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Knee pain
- ❍ Laxative use
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps, pain
- ❍ Nasal congestion
- ❍ Neck / shoulder pain
- ❍ Night sweats
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Premature graying
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth / gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss / gain
- ❍ Wheezing

Please indicate if you have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Asthma
- ❍ COPD / Emphysema
- ❍ Valley fever
- ❍ Heart attack
- ❍ High blood pressure
- ❍ Low blood pressure
- ❍ Heart disease
- ❍ CHF
- ❍ High cholesterol
- ❍ Stroke / TIA
- ❍ Mental illness
- ❍ Mental breakdown
- ❍ Depression
- ❍ Anxiety / panic
- ❍ Fibromyalgia
- ❍ Migraines
- ❍ Multiple Sclerosis
- ❍ Seizures / Epilepsy
- ❍ Bells Palsy
- ❍ Neuropathy
- ❍ Lyme disease
- ❍ Shingles
- ❍ Lupus
- ❍ Diabetes
- ❍ Hypo / Hyperthyroid
- ❍ Kidney disease
- ❍ Chronic UTI's
- ❍ Cystitis
- ❍ Enlarged prostate
- ❍ GERD
- ❍ Ulcers
- ❍ IBS
- ❍ Crohn's disease
- ❍ Hepatitis
- ❍ HIV / Aids
- ❍ STD's
- ❍ Gout
- ❍ Plantar fasciitis
- ❍ Arthritis
- ❍ Other auto-immune diseases

_____

_____

- ❍ Cancer

_____

_____

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____

Do you have a low point? Y/N When? _____

What are your indulgences?

_____

_____

What are your hobbies or recreational activities?

_____

_____

Medical History

Do you have a primary care or family Doctor? YES / NO If Yes, whom?

Please list all meds, including over the counter meds and supplements that you are taking or have recently been taking:

Medication	For What Condition	Dose	Times/Day	Date Stopped

Please list any food, environmental, or medication allergies you may have:

Please list all the inpatient or outpatient operations and procedures you have had:

Date:	Procedure:
Date:	Procedure:
Date:	Procedure:
Date:	Procedure:
Date:	Procedure:
Date:	Procedure:

List any significant traumas. When did they occur? (auto accident, falls, emotional trauma, sexual, etc.)

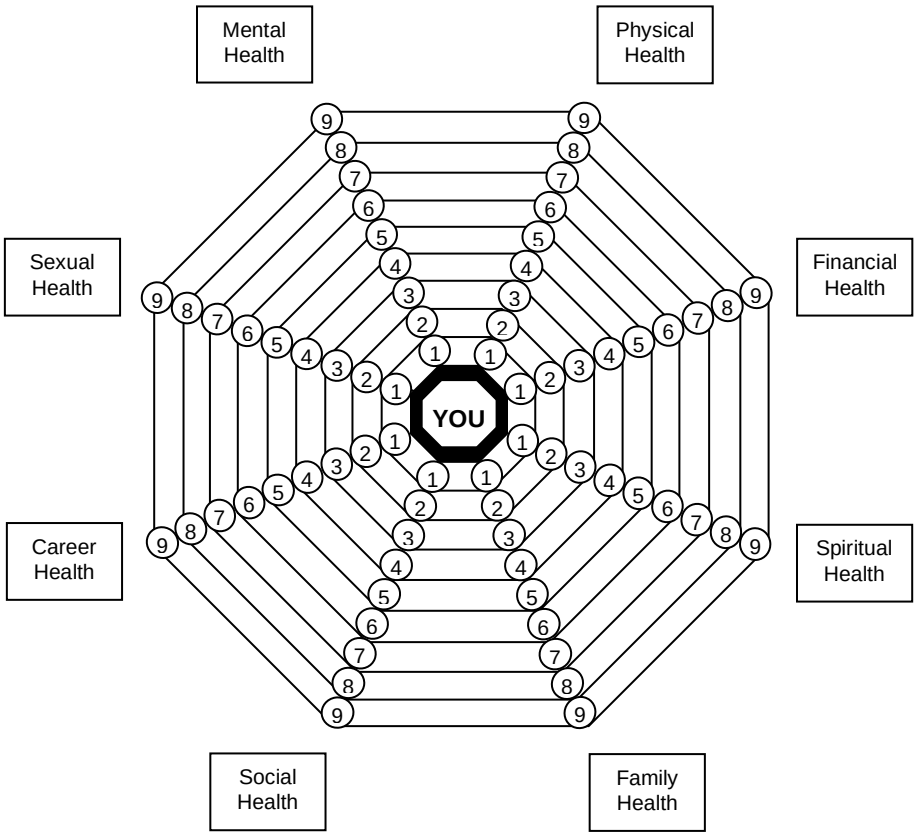
Do you/or did you smoke or use tobacco products? YES / NO	How much?	
Have you quit? YES / NO	When?	
Do you use alcohol? YES / NO	What type?	How often?

IF YOU NEED MORE ROOM TO WRITE, PLEASE USE THE BACK OF THIS PAGE

Web of Wellness

Our health and overall personal wellness are a combination of many factors. Each individual aspect of our lives can either contribute to our health and well-being, or create stress, disease or illness.
Using the diagram to the right, and starting at the center, choose your level of satisfaction in each area.

For example:
If you are extremely satisfied with your career, shade in the #9 circle in the career line.
1 = Not happy
9 = Extremely happy



Pain

Pain intensity levels (please indicate below which best describes)
No pain Moderate pain Severe pain Extreme pain

Sleeping
No problem Mildly disturbed Greatly disturbed Cannot sleep

Work – Capacity you are able to work at
100% 75% 50% 25% Unable to work

Frequency of pain
25% of time 50% of time 75% of time 100% of time

Travel
No problem on long trips Moderate pain on trips Severe pain

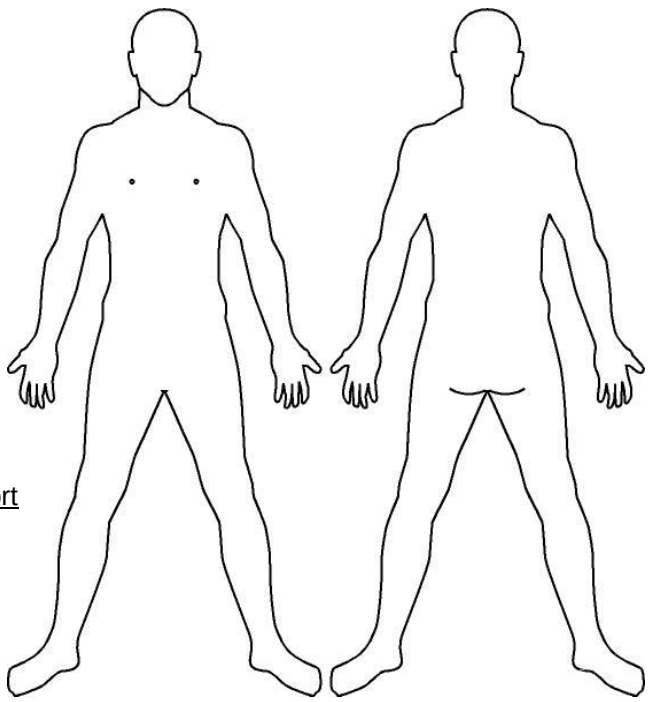
Sitting
No pain sitting Some pain while sitting Cannot sit without pain

Recreation
No problem Mild discomfort Moderate discomfort Severe discomfort

Walking
Can walk any distance Pain in less than 30 minutes Cannot walk

Body Chart

Please indicate areas of pain, tension, tightness, or discomfort on the body chart with 'Xs'.



Cancellation and Late Policy

We all hate to hurry up and wait, that is why here at Hayden Acupuncture & Wellness Center we will do everything in our power to ensure that you are seen at your scheduled appointment time. Emergencies could possibly arise which would require our immediate attention, and we appreciate your patience during these times. Remember, the emergency could be yours at some point.

This being said, our policy here at the Center on being late is this: you have a scheduled time slot and you will receive your treatment during that time. Because you are late your time slot has not changed. This is to ensure that the patient after you is seen at their scheduled time and doesn't have to wait. If there is time available after your scheduled appointment and you would like to add to your treatment time, there is a charge (billed in increments of 15 minutes). So please keep in mind traffic and other events and plan accordingly to give yourself plenty of time to get here calmly and safely.

Our policy on cancellations is a minimum 24 hour courtesy notification phone call (NOT a text or email), from the patient or patient representative. Keep in mind that we are closed on Sunday and a call on that day to cancel a Monday appointment will not count. *Failure to give a 24 hour notice will result in a No Show/Late Cancellation fee up to the cost of your session that will be billed to you or applied to your next appointment fee. Multiple No Show/Late Cancellations WILL result in prepayment for any future scheduled appointments.*
***Please note that you cannot cancel your appointment from Schedulicity.**

Acknowledgement of Receipt of Privacy Practices Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hayden Acupuncture & Wellness Center's "Notice of Privacy Practices;" revision date 11/23/2022.
As required by the Privacy Regulations, the staff of Hayden Acupuncture & Wellness Center have explained the "Notice of Privacy Practices" to my satisfaction.
As required by the Privacy Regulations, I am aware that Hayden Acupuncture & Wellness Center has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

_____ _____
Signature Date

_____
Print Name