SARAH HOFFNUNG, C.AC. Juno Wellness, LLC

PERSONAL INFORMATION

Patient Name:	Last	First	Middle
Address:			Zip Code
Telephone:	Home	Cell	Work
Email:		Fax:	
Date of Birth:		Age	Gender
Emergency Contact:		Tel:	Relationship
Referred By:			
Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other_____			

EMPLOYMENT INFORMATION

Employment Status: [ ] Full time [ ] Part time [ ] Retired [ ] Unemployed [ ] Student	
Occupation:	Employer Name:

PRIMARY HEALTHCARE PROVIDER

Primary Physician:	Tel:
Physician Address:	Date of Last Visit:

INSURANCE/SUPER-BILL INFORMATION

Insurance Company:	Policy Holder's Name:
Policy Name (if applicable):	Employer Name (if applicable):
Policy Number:	
Insurance Company Tel:	Insurance Company Fax:

ILLNESS AND TREATMENT INFORMATION

Have you had acupuncture before? No [ ] Yes [ ] If yes, when and for what reason?
Are you presently being treated for a medical condition? No [ ] Yes [ ] please describe
What are your goals for your health? What health issues do you want to address?
What other medical or treatment therapies are you currently receiving?
Other health concerns & Information I should know about you:

FAMILY HISTORY INFORMATION

	Self	Mother	Father	Sister	Brother	Child
Allergies						
Blood Disorders/Anemia						
Diabetes						
Cancer/Tumors						
Heart Disease						
High Blood Pressure						
Kidney or Bladder Disorder						
Stomach or Intestinal Disorder						
Endocrine or Thyroid Disorder						
Tuberculosis						
Seizures						
Stroke						
Depression/Mental Illness						
HIV, Hepatitis, HPV						
Drug/Alcohol Abuse						

MAJOR HOSPITALIZATIONS

Year	Operation or Illness	Hospital Name	City, State
Year	Operation or Illness	Hospital Name	City, State
Year	Operation or Illness	Hospital Name	City, State

MEDICINE: LIST CURRENT MEDICATIONS

[ ] Aspirin	[ ] Ibuprofen	[ ] Acetaminophen (Tylenol)
[ ] Oral Contraceptives	[ ] Laxatives	[ ] Fiber Supplements
[ ] Sleeping Pills	[ ] Tranquilizers	[ ] Cold Tablets
[ ] Diet Pills	[ ] Antacid	[ ] Hay Fever Tablets
[ ] Blood Pressure	[ ] Blood Thinning	[ ] Insulin, Diabetic Meds.
[ ] Vitamins:		
[ ] Herbs:		
[ ] Other:		

DRUG ALLERGIES: PLEASE LIST

ENVIRONMENT AND DIET ALLERGIES: PLEASE LIST

EXERCISE

Do you exercise regularly? No [ ] Yes [ ] What type?
How often and for how long?

HABITS

Coffee	No	Yes	Cups per Day / Week	Age started	Age Quit
Tobacco	No	Yes	Cigs per Day / Week		
Alcohol	No	Yes	Drinks per Day / Week		
Marijuana	No	Yes	Use per Day / Week		
Other	No	Yes	Use per Day / Week		

_____ Date:_____

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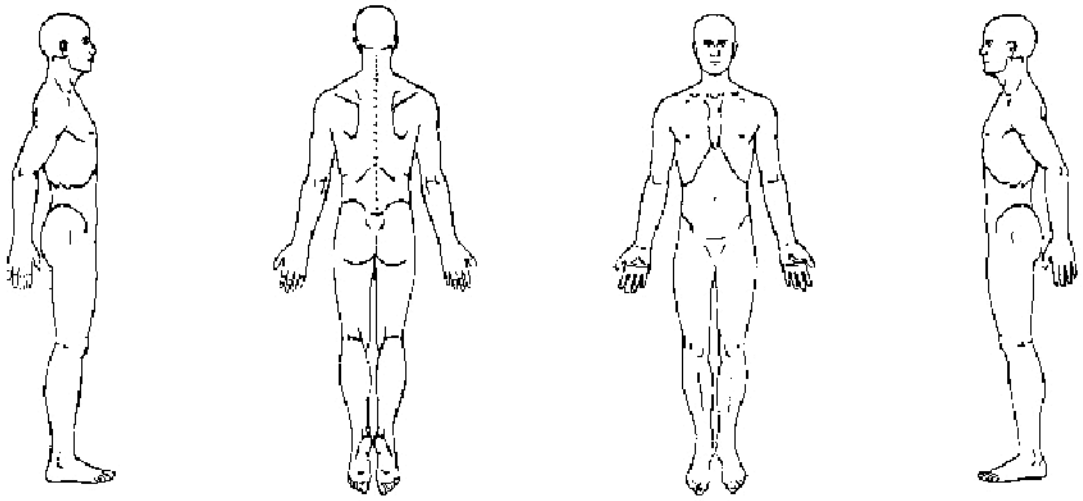
MUSCULO-SKELETAL: PLEASE MARK AN X TO INDICATE AREAS WHERE YOU FEEL PAIN, SWELLING OR DISCOMFORT. DESCRIBE WHAT YOU FEEL OR OBSERVE IN YOUR OWN WORDS. WRITE ANYWHERE IN THIS AREA. BE SURE TO INCLUDE ANY CHRONIC PAIN.



FEMALE HEALTH HISTORY: CHECK ALL THAT APPLY

Are you currently pregnant? No [ ] Yes [ ] How many weeks?_____

Birth Control: Oral Contraceptive [ ] Diaphragm [ ] Vaginal Ring [ ] IUD [ ] Other_____

Number of: Total Pregnancies [ ] Living [ ] Ectopic [ ] Miscarriages [ ] Induced abortions [ ]

Past	Present	Condition	Past	Present	Condition
[ ]	[ ]	Frequent Urinary Tract Infections	[ ]	[ ]	Irregular Menstrual Periods
[ ]	[ ]	Frequent Vaginal Infections	[ ]	[ ]	Painful Menstrual Periods
[ ]	[ ]	Pain/Itching of the Genitalia	[ ]	[ ]	Premenstrual Syndrome
[ ]	[ ]	Leukorrhea/Vaginal Discharge	[ ]	[ ]	Abnormal Bleeding
[ ]	[ ]	Pelvic Inflammatory Disease	[ ]	[ ]	Menopausal Syndrome
[ ]	[ ]	Abnormal Pap Smear	[ ]	[ ]	Breast Lumps
[ ]	[ ]	Fibroids/Cysts	[ ]	[ ]	Other:

MALE HEALTH HISTORY: CHECK ALL THAT APPLY

Past	Present	Condition	Past	Present	Condition
[ ]	[ ]	Pain/Itching Genitalia	[ ]	[ ]	Erectile Dysfunction
[ ]	[ ]	Genital Lesions/ Discharge	[ ]	[ ]	Weak Urinary Stream
[ ]	[ ]	Impotence	[ ]	[ ]	Lumps in Testicles
[ ]	[ ]	Other:			

HEALTH HISTORY: CHECK ALL THAT APPLY

General

Past	Present	Condition
[ ]	[ ]	Fatigue
[ ]	[ ]	Sweats Easily
[ ]	[ ]	Night Sweats
[ ]	[ ]	Chills
[ ]	[ ]	Fever
[ ]	[ ]	Insomnia
[ ]	[ ]	Localized Weakness
[ ]	[ ]	Poor Coordination
[ ]	[ ]	Poor Appetite
[ ]	[ ]	Excessive Appetite
[ ]	[ ]	Change in Appetite
[ ]	[ ]	Strong Thirst

Skin & Hair

Past	Present	Condition
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Lumps

Head & Neck

Past	Present	Condition
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Headaches/Migraines
[ ]	[ ]	Head Feels Heavy
[ ]	[ ]	TMJ/Jaw Tension
[ ]	[ ]	Other_____

Nose, Throat, Mouth

Past	Present	Condition
[ ]	[ ]	Nose Bleeds
[ ]	[ ]	Sinus Infections
[ ]	[ ]	Hay Fever or Allergies
[ ]	[ ]	Recurring Sore Throats
[ ]	[ ]	Other_____

Ears

Past	Present	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased Hearing

Eyes

Past	Present	Condition
[ ]	[ ]	Blurred Vision
[ ]	[ ]	Poor Night Vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses/Contacts
[ ]	[ ]	Dryness
[ ]	[ ]	Other_____

Cardiovascular _

Past	Present	Condition
[ ]	[ ]	High Blood Pressure
[ ]	[ ]	Low Blood Pressure
[ ]	[ ]	Blood Clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Fainting
[ ]	[ ]	Chest Pain
[ ]	[ ]	Irregular Heart Beat
[ ]	[ ]	Cold Hands/Feet
[ ]	[ ]	Other_____

Respiratory

Past	Present	Condition
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent Colds
[ ]	[ ]	COPD
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Other_____

Genito-urinary

Past	Present	Condition
[ ]	[ ]	Kidney Stones
[ ]	[ ]	Painful Urination
[ ]	[ ]	Frequent Urination
[ ]	[ ]	Blood in Urine
[ ]	[ ]	Urgency to Urinate
[ ]	[ ]	Incontinence/Dribbling
[ ]	[ ]	Other_____

Gastro-intestinal

Past	Present	Condition
[ ]	[ ]	Nausea/vomit
[ ]	[ ]	Poor Appetite
[ ]	[ ]	Excessive Appetite
[ ]	[ ]	Diarrhea
[ ]	[ ]	Constipation
[ ]	[ ]	Bloating
[ ]	[ ]	Indigestion/Acid Regurg
[ ]	[ ]	Bad Breath
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Rectal Pain
[ ]	[ ]	Gallbladder Disorder
[ ]	[ ]	Other_____

Neurological

Past	Present	Condition
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/Tingling
[ ]	[ ]	Paralysis
[ ]	[ ]	Other_____

Psychological

Past	Present	Condition
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety/Stress
[ ]	[ ]	Irritability/Anger
[ ]	[ ]	Nervousness
[ ]	[ ]	Treated for Emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other_____

Infectious

Past	Present	Condition
[ ]	[ ]	HIV
[ ]	[ ]	Hepatitis
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital Warts/HP
[ ]	[ ]	Herpes
[ ]	[ ]	Other_____

Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at Juno Wellness, LLC. I understand that Acupuncturists practicing in the state of Wisconsin are not considered to be primary care providers. The practitioners at Juno Wellness, LLC advise you to consult your primary care provider in addition to Acupuncture & Oriental medicine treatment.

Acupuncture: I understand that acupuncture is performed by the insertion of single use, sterile needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture is typically a safe method of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain, infection or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid specific points and herbs that are contraindicated in pregnancy. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Chinese Herbs & Nutritional Supplements: I understand that Chinese medicinal herbs and nutritional supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic or your primary care provider.

Acupressure / Tui-Na Massage: I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Special Situations: Please inform us if you have any allergies, severe bleeding disorders, diabetes, lymphedema, infectious disease-such as HIV / AIDS, hepatitis, tuberculosis, or if you are wearing a pacemaker or other electronic medical device.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgement during the course of treatment which the acupuncturist thinks is best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care or diagnosis, and that I should look to my primary care practitioner (i.e. M.D.) for those services and for routine check-ups.

I request and consent to the performance of acupuncture, Oriental Medicine procedures and nutritional supplementation/ recommendations. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the risks and benefits of acupuncture and other treatments. I have had an opportunity to ask questions and understand that if at any time I have any questions about this information, I should ask my acupuncturist. I, hereby release Juno Wellness, LLC from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Signature: _____ Date: _____ / _____ / _____

Printed Name: _____

Informed Patient Authorization

Patient Name:		Date of Birth: / /
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Occupation:	Employer:	

Informed Consent:

The benefits and risks of receiving Acupuncture, Oriental Medicine and nutritional supplemention therapies have been explained to me. Although rare, certain side effects may result from Acupuncture, herbal medicine and nutritional supplementation. I understand a licensed acupuncturist will be performing these treatments. I understand Juno Wellness, LLC may record medical and other information concerning my treatments in electronic or other physical form. Such information may be released by the clinic for the purposes outlined on this form. I understand that portions of my medical records may be disclosed to qualified non-clinician personnel for the purpose of conducting scientific or statistical research, management or financial audits without my consent. I understand that no guarantees have been made to me as a result of treatment or medical examination at Juno Wellness, LLC.

Records Release Authorization:

- I authorize the use of this form for all of my insurance submissions
- I authorize release of information to all of my insurance companies
- I permit a copy of this authorization to be used in place of an original
- I direct my previous, and current, health care providers to release medical records to this clinic
- I understand that I am fully responsible for my bill
- I authorize payment directly to Juno Wellness, LLC
- I authorize my clinician to act as my agent to obtain payment from my insurance company
- This authorization is not intended to allow the release of records regarding my treatments for services requiring a restricted release under State and Federal Law
- I understand a $50 cancellation fee will be charged if I cancel with less than 24 hours notice.
  I authorize use of the results of my treatment in statistical reports with my identity remaining confidential.

Notice of Privacy Practices:

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I have seen or received a copy of the Juno Wellness, LLC notice of privacy paperwork. I understand the paperwork defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal privacy rights.

_____ Date: _____ / _____ / _____
Patient's Signature

_____ Date: _____ / _____ / _____
Witness Signature

Consent to Treat a Minor Child:

I authorize the licensed clinicians at Foundations Acupuncture, LLC to administer Acupuncture and Oriental Medicine care as deemed necessary to my _____(relationship).

_____ _____ Date: _____ / _____ / _____
Child's Name Adult Signature