Appointment Date:

General Information

Name ______________________ Date ______________

Address ______________________ City ____________ State ________ Zip ________

Married Single Partner Divorced Widowed Date of Birth ____________ SS# ____________

Work Phone ______________ Home Phone ______________ Mobile Phone ______________

Email ______________________ Occupation ______________________

Emergency Contact ______________________ Referred By ______________________

Family Physician ______________________ Contact # ______________

Have you had Acupuncture or Oriental medicine before? Yes No

Are your presently under a doctor's care? Yes No Who and for what? ______________________

Are there any other therapies which you are involved in? Who and for what? ______________________

Insurance Information

Insurance Company ______________________ Contact # ______________________

ID # ______________ Co-pay $ ________ Visit # ________ Referral Yes No Covered % ______________

Date called ________ Contact Name ______________________ Deductable amount ______________

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?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other ______________

What have you done about this? ______________________

____

Are you interested in:

- ☐ Pain Relief
- ☐ Preventative Care
- ☐ Oriental Nutrition
- ☐ Performance Care
- ☐ Holistic Health
- ☐ Meridian Yoga
- ☐ Maintenance Care
- ☐ Stress Relief
- ☐ Herbal Therapy
- ☐ Other ______________

What are your health goals? ______________________

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List any past or future surgeries. ____________________

____

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

____

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

____

Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ 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

Female Concerns

Date of last menstruation ____________ Is your cycle regular? Yes No Is your cycle painful? Yes No

Have you ever been pregnant? Yes No Birth control? Yes No How long? ____________

❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

Medical History

Do you have any allergies? Yes No If so, to what? ____________________

Do you take medication? Yes No If so what types and how often ____________________

Do you take supplements? Yes No If so what types and how often ____________________

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

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

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Do you sleep well? Yes No   Do you dream? Yes No

Do you have a high point during the day? Yes No When? ________ Do you have a low point during the day? Yes No When? ________

What are your indulgences? ________________________________

What are your hobbies/pleasures? ________________________________

Web of Wellness

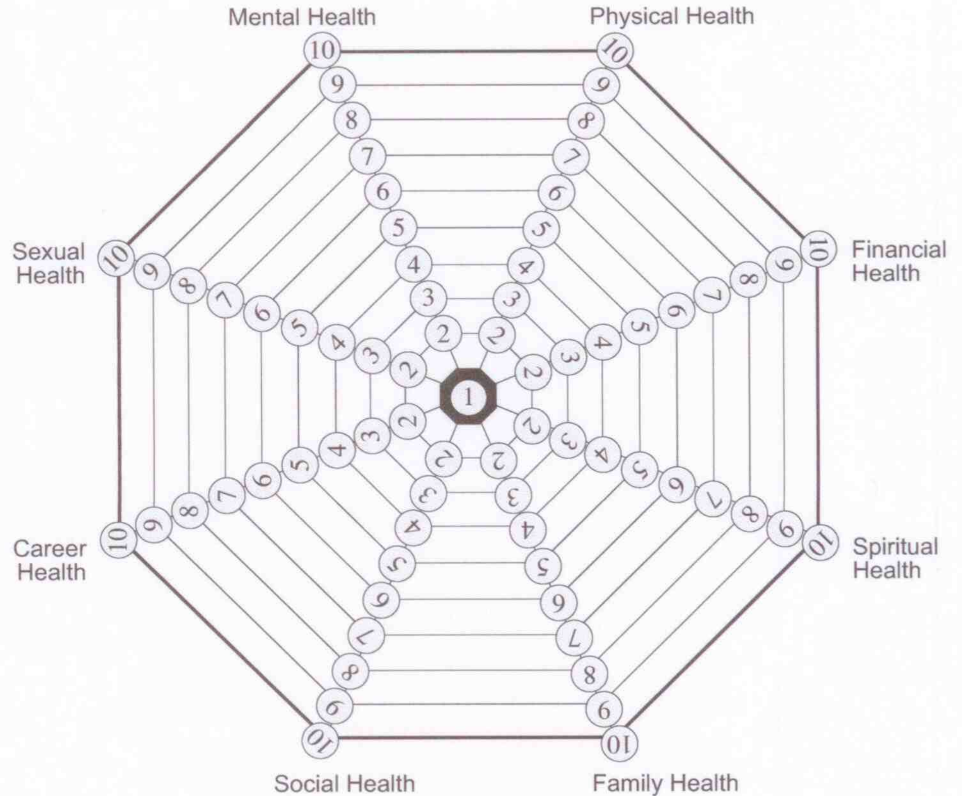
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain | Moderate pain | Severe pain | Terrible pain

Sleeping

No problem | Mildly disturbed | Greatly disturbed | Cannot sleep

Work - Can do:

Usual work | 25% of work | 50% of Work | No 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

Recreation - Can do:

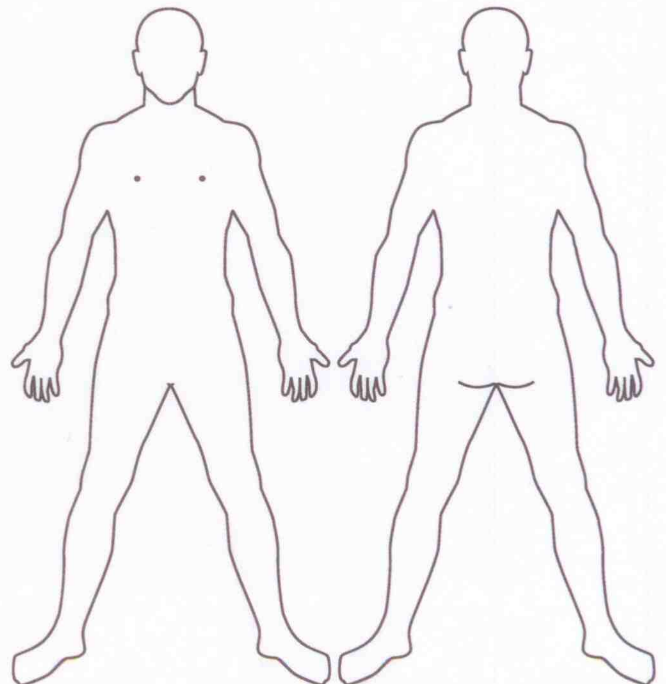
All activities | Some activities | No activities

Walking

Can walk any distance | Pain after 1/2 mile | Cannot walk

Sitting

No pain sitting | Some pain while sitting | Cannot sit



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Types of Care

According to your signs and symptoms please indicate where your current state of health falls along this Types of Care time line.

Acute Care
Obvious symptoms and signs
Get me out of pain and discomfort fast!

Most patients begin acupuncture treatment to provide relief from pain, discomfort and other symptoms, fast. Acute Care helps to ease your initial problem(s) quickly.

Maintenance Care
Symptom and signs disappear
Feeling good, no big problems!

Maintenance Care gives you a chance for deeper healing to occur. Strengthening your body's response to illness by stimulating your natural healing powers.

Wellness & Preventative Care
You feel great
Feeling great! Life is wonderful!

I want to achieve optimal health and well-being, free of disease and illness. Wellness Care is your best choice.

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive medical system to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, ______________________________ have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

(Signature) ______________________________ (date) ____________

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OFFICE POLICIES

APPOINTMENT CANCELLATION

You must call **24 HOURS in advance** (during office hours) prior to appointment to cancel an appointment. Otherwise, you will be considered a "no-show" and charged a $100 fee for new patients and a $50 fee for established patients. We value our time and want to ensure our patients receive the care they deserve.

PAYMENT POLICY

- **Payment at Time of Service**: Payment for appointments, supplements, products, and lab tests is due in full at the time of service and/or purchase. For your convenience, we will provide you with a completed "superbill" for you to submit to your insurance company for reimbursement whenever services are rendered and paid for. We do not bill for insurance in our office.
- **Delinquent Accounts**: If a patient/client or guarantor's check is returned due to non-sufficient funds, there will be a $30 charge. In addition, if payment is not received within 30 days, finance chargeds will begin accruing at 1.5% per month. Excessively overdue accounts will be forwarded to an outside collection agency and the patient/client or guarantor will be responsible for any feeds generated as a result of collection efforts.

PRICING

Mary Shackelton, MPH, ND

New Patient (60 mins) - $200
Follow Up (45 mins) - $125
Follow Up (30 mins) - $90
Follow Up (15 mins) - $55
Nutrient IV Therapy – starts at $90

Terri Rebibo Fox, MD, ABHIM

New Patient (60 mins) - $220
Follow Up (45 mins) - $165
Follow Up (30 mins) - $110
Follow Up (15 mins) - $55
School Physical - $100
Sports Physical - $85
Nutrient IV Therapy – starts at $90

Note: Phone appointments are priced the same as in office visits.

Damiana Corca, LAc, Dipl OM

New Patient (90 mins) - $125 + herbs
Follow Up (60 mins) - $75 + herbs
Follow Up Stress Relief (45 mins) - $45
Follow Up Addiction (45 mins) - $25
Herbal Consultation Only (60 mins) - $65 + herbs
Facial Rejuvenation Initial Screening & Consultation (20 mins) - $45
Facial Rejuvenation (75 mins) - $135

Qi Gong Prices

Private Qi Gong Classes - $55 (packages available)

RETURN POLICY

- **Supplements**
  Un-opened product within 30 days of the purchase date – 100% of the purchase price
  Opened product– No Refund (some exceptions may apply)
- **Skin Care Products** – returns decided on an individual basis; must have original receipt
- **Other Products** – must be unopened and come with the original receipt to receive a full refund.

TELEPHONE CALLS

Call 911 for emergency situations
Treatment Questions: **call** 303-449-3777 or **email** info@holisticacare.com

I hereby acknowledge that I have read and understand the above information and agree to the terms of payment.

Patient/Client's Signature: ______________________________ Date: ________________

Guardian's Signature (for minors only): ______________________________ Date: ________________

FINANCIAL RESPONSIBILITY (GUARANTOR) – PARENT/GUARDIAN

Name: ______________________________ DOB: ___/___/_____ Sex: __F __M

Address: ______________________________ City: ____________ State: ____ Zip: ________

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient/client and that I am subject to all financial terms listed below.

Guarantor's Signature: ______________________________ Date: ________________

TERMS OF ADMISSION

Financial Terms: I understand that I am responsible for all charges whether or not they are covered by my insurance. Holistica Integrative Care does not bill for insurance and accepts cash, check, VISA or MC for payment. I understand that payment for services, supplements, products, and lab tests are due in full at the time of service and/or purchase. I understand that a $30 fee will be charged for returned checks (non-sufficient funds), and if payment is not received within 30 days, finance charges will begin accruing at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency, and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance, and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.
Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to other unless you direct us to do so or applicable laws authorize or compel us to do so. Holistica Integrative Care is required to provide you, at your request, with a copy of it Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information and describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic and wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call our office at: 303-449-3777.
I hereby acknowledge that I have reviewed a copy of Holistica Integrative Care's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Holistica Integrative Care has made good faith effort to obtain my acknowledgement.

X ______________________________ Date: ________________
Patient/Client's Signature

X ______________________________ Date: ________________
Guardian's Signature