WELCOME!

We are a 501(c)(3) NON-PROFIT Integrative Health Wellness Center. Your patronage directly contributes to our mission of ensuring access to quality acupuncture, chiropractic, massage and naturopathic medical services to everyone, regardless of income.

Our set and sliding scale prices include GRATUITY. You may leave something additional for your clinician if you wish, but it is neither expected nor necessary.

WE LOOK FORWARD TO BEING YOUR PARTNERS IN HEALTH & WELLNESS!

Adams Avenue Integrative Health
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www.adamsavenue.althealnet.org

This is a CONFIDENTIAL questionnaire to determine the most appropriate treatment plan for you.

Name: ____ Date:____________________

Home Address: ____City:_________________ State: ______________

Zip: ___________ Email Address: ____

Phone: _______________________ Secondary Phone: _____________________ Ok to leave messages? ☐Y ☐N

Emergency Contact: ________________ Emergency Phone: ____________________Occupation: ________________

Sex ☐ M ☐ F ☐Other Height: ______ Weight: ______ Birth Date: ____________ Do you have Medicare? ☐Y ☐N

How did you hear about our clinic?

- ☐ Google
- ☐ Website
- ☐ Facebook
- ☐ Twitter
- ☐ Flyer
- ☐ Groupon/Living Social
- ☐ Alternative Happy Hour
- ☐ Healing Arts Festival
- ☐ SD Reader
- ☐ Doctor Referral
- ☐ Another AAIH Patient (please list):___________________________
- ☐ Other (please list):___________________________

Have you previously had acupuncture?
☐ Yes ☐ No

Have you previously had chiropractic?
☐ Yes ☐ No

Have you had previous massage therapy?
☐ Yes ☐ No

Alternative Healing Network offers a sliding scale for services at certain locations, based on self-reported income. Please indicate your ANNUAL income below:

- ☐ Below $25,000
- ☐ $25,001-35,000
- ☐ $35,001-45,000
- ☐ Above $45,000

Please check the reason for coming today (check all that apply):

- ☐ Pain Management (headache, back pain, etc)
- ☐ Mental Health (depression, anxiety, anger, etc)
- ☐ Hormonal Imbalances (fertility, menses, etc)
- ☐ Digestive Problems
- ☐ Allergies
- ☐ Insomnia
- ☐ Weight Loss
- ☐ Wellness Care/Prevention/Relaxation
- ☐ Addiction (substance abuse, alcohol, food, etc)
- ☐ Smoking Cessation
- ☐ Injury (sports, automobile, fall, etc)
- ☐ Other:_________________________________

I understand that the majority of the work done at Alternative Healing Network Wellness Centers is considered Wellness Care and is therefore not covered under most insurance policies. Alternative Healing Network accepts insurance payments only when eligibility has been confirmed prior to the beginning of your treatment. You may request a 'Superbill' during your visit to submit to your insurance company for possible reimbursement. If requesting a Superbill for a treatment after the day it was performed, there is a 7 day processing period. Alternative Healing Network does not guarantee you will receive reimbursement for any payments made for services or products.

All payments for services rendered are due at the time of service, unless previous arrangements have been made.

Patient Signature (Guarantor): ____ Date:_________________

Why are you seeking care?	When did this first become an issue?	What do you think caused this?	How severe is it on a scale of 1-10? (1 = mild; 10=very severe)	What makes it better? What makes it worse?	What have you tried so far for relief?

1. Past Medical History including accidents, surgeries (including cosmetic), and hospitalizations:
   ______________________ Date: __________
   ______________________ Date: __________
   ______________________ Date: __________
   ______________________ Date: __________
   ______________________ Date: __________
   ______________________ Date: __________
   ______________________ Date: __________
   ______________________ Date: __________

2. Please list if you are taking any medications, herbs, supplements, sleep aids or over-the-counter drugs (and please check 'advised' if you have been advised to take the following, but chose not to):

What are you taking?	Dosage	Reason	How long?	Prescribed by	Advised to take (but not)

3. Please list all Allergies: ____

Food Cravings: ________________________ Food Sensitivities: _____________________________

Special Diets (Vegan, Vegetarian, Gluten Free, etc): ____

4. Please indicate any illnesses you or a blood relative (parent, grandparent, or sibling) have had:

	You	Relative	Who?		You	Relative	Who?
Cancer	☐	☐	____________	Diabetes	☐	☐	____________
Hepatitis	☐	☐	____________	Heart Disease	☐	☐	____________
High Blood Pressure	☐	☐	____________	Seizures	☐	☐	____________
Mental Illness	☐	☐	____________	Tuberculosis	☐	☐	____________
Depression/Anxiety	☐	☐	____________	Arthritis	☐	☐	____________
Alcoholism	☐	☐	____________	High Cholesterol	☐	☐	____________
Stroke	☐	☐	____________	Auto-immune disease	☐	☐	____________
Osteoporosis	☐	☐	____________	Allergies	☐	☐	____________
Thyroid Dysfunction	☐	☐	____________	Asthma	☐	☐	____________

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes

5. How would you rate these significant stressors?

	Extremely Stressful	Moderately Stressful	Not Stressful at All
Work/School	☐	☐	☐
Family Matters	☐	☐	☐
Moving	☐	☐	☐
Relationship/Marriage	☐	☐	☐
Finances	☐	☐	☐
Health Status	☐	☐	☐
Other (please list): ___________________	☐	☐	☐

6. What do you do to manage your stress or health condition now (check all that apply)?

Exercise	☐	Herbs	☐
Yoga/Meditate	☐	Supplements	☐
Massage	☐	Friends	☐
Family time	☐	TV/Media	☐
Personal Time/Rest	☐	Alcohol/Drugs	☐
Medication	☐	Other (please list)	☐ ______________________________

7. What is your current level of physical activity?

Not physically active	☐	Less than 1 hour/week	☐
Less than 30 minutes/day	☐	30 minutes-1 hour/day	☐
More than 1 hour/day	☐		

8. What type of physical activity do you do? ____

____

9. What time do you generally go to bed? _____________; get up? ______________

10. Do you wake up during the night? Yes ☐ No ☐ how many times? _____________

11. How long does it take to get back to sleep? _____________ Do you wake rested? _____________

12. What is your energy level?

	Morning	Midday	Evening	after Meals
Very Low	☐	☐	☐	☐
Low	☐	☐	☐	☐
Medium	☐	☐	☐	☐
High	☐	☐	☐	☐
Very High	☐	☐	☐	☐

13. Please indicate the use and frequency of the following:
Coffee/Black Tea: ____________ Tobacco: ____________ Daily Water Intake: ____________
Recreational Drugs: ____________ Alcohol: ____________ Soft Drinks: ____________

14. Do you drink alcohol? Yes ☐ No ☐
How much? Daily ☐ Weekly ☐ Monthly ☐

15. Do you smoke cigarettes? Yes ☐ No ☐ Used to ☐ when did you quit? _____________
How much do you currently smoke? __________
If you quit, how much did you used to smoke? ____________

3 Day Diet Recall

	Day 1	Day 2	Day 3
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Dessert			
Beverages			
Alcohol			
Coffee/Tea			
Nicotine			
Other			

For Women

Age of 1st period: __________ Are you pregnant? ☐ Y ☐ N # of pregnancies/abortions: _________________________
Age of last period: __________ # of live births: _________________ # of miscarriages: _________________________________
Number of days between periods: _______________ Have you ever had an abnormal pap smear? ___________________________
Number of days of flow: _____________ Color of flow: _______________ Blood Clots? ☐ Y ☐ N
How many tampons/pads do you use per day?
Day 1:_____ Day 2:_____ Day 3: _____ Day 4: _____ Day 5: _____ Day 6: _____ Day 7: _____
Ever been diagnosed with: ☐ Fibroids ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Ovarian Cysts ☐ PID ☐ Other: ___________
Location of menstrual pain: ☐ Lower abdomen ☐ Lower back ☐ Thighs ☐ Other: ________________________________

Nature of Pain (Please indicate before, during or after menses)
Cramping:________________ Stabbing: _________________
Burning: _________________ Aching: ___________________
Dull: ____________________ Bloating: __________________
Bearing down sensation: ____________________________

Other symptoms related to menses:
☐ Discharge ☐ Vaginal dryness ☐ Headache
☐ Nausea ☐ Constipation ☐ Diarrhea
☐ Mood Swings ☐ Hot Flashes ☐ Insomnia
☐ Night Sweats ☐ Swollen Breasts
☐ Decreased libido ☐ Increased libido

Appetite during menses : ☐ Consistent ☐ Intermittent ☐ Poor ☐ Ravenous

For Men

Date of last prostate checkup: ____________________ PSA Results: ____
Lab Results: _______________________ Frequency of urination: daytime _______________ nighttime ___________________
Color of urine: ☐ Clear ☐ Murky Urine Odor: _______________________________________

Symptoms related to prostate:

☐ Prostate problems ☐ Delayed stream ☐ Dribbling ☐ Incontinence ☐ Retention of urine
☐ Rectal dysfunction ☐ Increased libido ☐ Decreased libido ☐ Premature ejaculation ☐ Impotence
☐ Back pain ☐ Groin pain ☐ Testicular pain ☐ Other: _________________________

Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
NO MARK = never experience 1 = sometimes experience 2 = frequently experience

__________ Lack of appetite
__________ Excessive appetite
__________ Loose stool or diarrhea
__________ Indigestion
__________ Vomiting
__________ Belching, burping
__________ Heartburn/acid reflux
__________ Feeling the retention of food in the stomach
__________ Tendency to become obsessive in work, relationships…

__________ Difficulty sleeping
__________ Heart palpitations
__________ Cold hands and feet
__________ Nightmares
__________ Mentally restless
__________ Laughing for no apparent reason
__________ Angina pains
__________ Abdominal pain
__________ Chest pain
__________ Sciatic pain
__________ Headaches
__________ Pain or coldness in the genital area
__________ Cough

__________ Shortness of breath
__________ Decreased sense of smell or taste
__________ Nasal problems
__________ Skin problems
__________ Feeling of claustrophobia
__________ Bronchitis
__________ Colitis or diverticulitis
__________ Constipation
__________ Hemorrhoids
__________ Recent antibiotic use

__________ Eye problems
__________ Jaundice (yellowish eyes or skin)
__________ Difficulty digesting oily foods
__________ Gall stones
__________ Light colored stool
__________ Soft or brittle nails
__________ Easily angered or agitated
__________ Difficulty in making plans or decisions easily
__________ Spasms or twitching of muscles

__________ Low back pain
__________ Knee problems
__________ Ear ringing
__________ Kidney stones or infection
__________ Decreased sex drive
__________ Hair loss
__________ Urinary problems
__________ Fatigue
__________ Edema
__________ Blood in stool
__________ Black tarry stool
__________ Easily bruised
__________ Difficult to stop bleeding
__________ Asthma
__________ Tendency to catch colds easily
__________ Intolerance to weather changes
__________ Allergies
__________ Hay fever
__________ Dizziness
__________ Tendency to faint easily
__________ High cholesterol levels
__________ Sudden weight loss

Cancellation Policy

- Adams Avenue Integrative Health requires 24 hours' cancellation for all appointments; patients cancelling within this period will be charged $30 to the credit card on file.
- Because we understand unexpected situations may arise, we will extend forgiveness for ONE cancellation within 24 hours.
- You will not be charged the $30 late cancellation fee if we are able to fill your spot or you able to reschedule on the same day, with the same clinician.
- For services that cost less than $30, the cancellation fee will be equal to that of the booked appointment.

_____ I have read and agree to Adams Avenue Integrative Health's cancellation policies

Privacy

- Your confidentiality is important to us. None of your personal information is shared or disclosed outside of our clinical team without your express written permission. If you happen to overhear someone else's private information, do not share this information with others. We ask that you show the same respect for others as you would expect for yourself.

_____ I have read and agree to Adams Avenue Integrative Health's privacy policy

Payments

- Fees for all services, nutritional and herbal products, and other IN HOUSE items are due and payable at the time items are received and/or services are rendered. Orthotics and any other special order products or items plus any shipping and handling charges (if applicable) are due and payable at the time of ordering.
- All services, nutritional and herbal products, orthotics and other items are non-refundable.
- Fees will be assessed on checks returned for any reason at the maximum amount allowed by the State.
- By signing this agreement you agree to accept full financial responsible for any and all charges incurred at *Adams Avenue Integrative Health.*
- All services are considered fee-for-service and payment is due at the time of service.
- If you have a copay for your services coverage must be verified prior to the delivery of your treatment.

_____ I have read and agree to Adams Avenue Integrative Health's payment policies

I have read, or have had read to me, the above terms of Policies and Responsibilities Agreement. I have had the opportunity to have any questions answered to my satisfaction. I agree to and accept fully these terms of agreement.

Patient (Guarantor) Signature ____Date: _______________