GREENAPPLE sports & wellness

NEW PATIENT INTRODUCTION

Name _____ Date _____

Home Address _____

Birth Date _____ Work Phone _____

Mobile Phone _____ Home Phone _____

Email Address _____

SSN _____--_____--_____ Marital Status- Single Married Divorced Other Occupation_____

Referred By _____

Emergency Contact _____ Phone _____

Purpose of this Appointment _____

Have you seen other doctors for this condition? ❑ Yes ❑ No

If So: Name _____

Medications Presently Taken _____

Welcome to Greenapple Sports & Wellness!

We are glad that you have chosen us to help serve you healthcare needs. For your information, we use disposable sterile acupuncture needles, which are disposed following OSHA guidelines for biomedical waste.

Consent for Treatment

I, the undersigned, freely consent to treatment at Greenapple Sports & Wellness. I understand that treatment may include the use of acupuncture needles, electrical acupuncture, TDP lamps, cupping, and acupressure.

I fully understand that the risk of treatment although very limited could include the following: slight burns from the mineral heat lamp or slight bruising from cupping and needles. If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I accept that Greenapple Sports & Wellness cannot be held liable for any intentional misrepresentations by myself. I state that I have read the "Consent for Treatment" form in its entirety and understand and accept the risks involved in the treatment.

Patient Signature_____ **Date**_____

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COMPREHENSIVE ACUPUNCTURE EXAMINATION

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

Name _____ Date _____

Birth Date _____ Height _____ Weight _____

Major Complaints _____

_____

_____

_____

_____

Other Complaints _____

_____

Date of onset (when you first noticed your problem)? _____

Pain is: ❑ Minimal ❑ Slight ❑ Moderate ❑ Severe

How long have you had this condition? _____

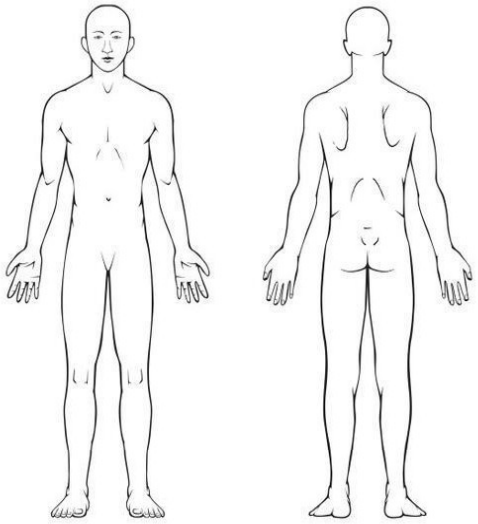
Have you had this in the past? ❑ Yes ❑ No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ❑ Getting worse ❑ Constant ❑ Comes and Goes

Please mark your areas of pain



Medications/Drugs/Herbs you are currently taking _____

_____

List Surgeries/Operations you have had and dates _____

_____

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): ❑ Arthritis ❑ Asthma ❑ Anemia ❑ Heart trouble ❑ Cancer
❑ Diabetes ❑ Epilepsy ❑ Stroke ❑ Kidney or bladder trouble ❑ Gallstones ❑ Ulcers ❑ High blood pressure
❑ Chronic fatigue ❑ Hepatitis ❑ Jaundice ❑ Sudden weight loss ❑ Sudden weight gain

Other _____

FAMILY HISTORY: (Has any member of your family had any of the above)? ❑ Yes ❑ No If yes, which member and what did they have?

_____

ENERGY LEVEL: ❑ High (Time of day) _____ ❑ Low (Time of day) _____

STRESS: ❑ None ❑ Moderate ❑ Severe What causes it? _____

SWEATING: ❑ Night sweats ❑ Rarely sweat ❑ Excess sweating _____

CIRCULATION: Feelings of ❑ Hot ❑ Cold What area? _____
❑ Bleed easily ❑ Cold limbs Other _____

SKIN: ❑ Dry ❑ Itchy ❑ Moist/clammy ❑ Burning ❑ Changing moles or lumps (cysts/tumors) ❑ Boils ❑ Frequent skin rashes
❑ Acne ❑ Hair loss/thinning ❑ Dry scalp ❑ Skin puffy/wrinkled ❑ Bruises easily (black and blue spots) ❑ Hives

Other _____

Name_____

SCARS: (List ALL scars from accidents or surgeries) _____

_____

SLEEP PROBLEMS: ❑ Trouble falling asleep ❑ Trouble staying asleep ❑ Restful ❑ Excess dreaming

Other _____ How many hours do you sleep a night? _____

HEAD: ❑ Headaches (what area?) ❑ Dizziness ❑ Memory loss ❑ Loss of balance Other _____

EYES: ❑ Eye pain ❑ Dry eyes ❑ Blurred vision ❑ Darkness under eyes Other _____

EARS: ❑ Poor hearing ❑ Earaches ❑ Ear discharge/infections ❑ Ringing/buzzing in ears Other _____

NOSE: ❑ Frequent nose bleeds ❑ Sinus trouble ❑ Frequent colds Other _____

THROAT: ❑ Sore throat ❑ Hoarseness ❑ Difficulty swallowing ❑ Jaw problems ❑ Teeth/gum problems ❑ Swollen tongue

Other _____

CHEST: ❑ Hard to breathe ❑ Wheezing ❑ Shortness of breath ❑ Mucus rattles when breathing ❑ Trouble breathing at night

❑ Pain/pressure in chest ❑ Palpitations ❑ Persistent cough ❑ Coughing blood ❑ Coughing phlegm

Sputum color _____ Consistency _____

Other _____

BLOOD PRESSURE: ❑ High ❑ Low ❑ Do not know

BOWELS: ❑ Diarrhea ❑ Constipation ❑ Bloody stools ❑ Black stools ❑ Mucus in stools ❑ Hemorrhoids

❑ Lower bowel gas ❑ Stools have foul odor ❑ Colon problems Number of bowel movements a day _____

Other _____

URINE: Color_____ Amount _____ Frequent urination ❑ Daytime ❑ At night

❑ Strong smelling urine ❑ Hard to urinate ❑ Pain or burning on urinating ❑ Blood in urine

❑ Frequent infections ❑ Water retention Other _____

MUSCULOSKELETAL: Pain in: ❑ Neck ❑ Shoulder ❑ Between shoulders ❑ Arms/hands ❑ Hip ❑ Knee ❑ Fingers ❑ Big toe

❑ Upper back ❑ Mid back ❑ Lower back ❑ Bones sore/painful ❑ Loss of grip Swollen knees/elbows ❑ Leg cramps at night

❑ Weakness in legs ❑ Weak ankles ❑ Stiff all over ❑ Tingling in feet ❑ Muscle spasm/cramps ❑ Loss of feeling in hands/feet

❑ Painful joints ❑ Bursitis Other _____

NEUROLOGICAL: ❑ Nervousness ❑ Depressed ❑ Easily angered ❑ Easily irritated ❑ Frequent crying ❑ Worry/Anxiety

❑ Mood swings ❑ Memory confusion ❑ Poor concentration ❑ Suicidal ❑ Tremors ❑ Numbness/tingling limbs

❑ Poor coordination ❑ Muscle weakness ❑ Feel weak and shaky ❑ Seizures ❑ Neuralgia (nerve pain) ❑ Shingles

Other _____

FEMALES: Pregnant? ❑ Yes ❑ No Last monthly period _____ Last PAP test _____

Form of birth control: ❑ None ❑ Pill Other _____

Age started menstrual cycle _____ Age stopped _____ ❑ Menstrual pain ❑ Low backache

❑ Irregular ❑ Clotting ❑ Heavy bleeding ❑ Light scanty bleeding Color _____

❑ Water retention ❑ Mood changes ❑ Miss periods ❑ Low or no sex drive ❑ Painful breasts ❑ Hot flashes

❑ Food cravings Other _____

Discharges: ❑ Yellow ❑ Thick ❑ White ❑ Odor ❑ Itching ❑ Liquid Other _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____ No. Cesareans _____

Operations: ❑ Cervix ❑ Uterus ❑ Ovaries Other _____

Name_____

MALES: ❑ Low sexual drive ❑ Lack of sexual drive ❑ Impotence ❑ Ejaculation causes pain ❑ Discharges
❑ Pain or burning while urinating ❑ Premature ejaculation ❑ Prostate trouble Other _____

APPETITE: ❑ Excessive appetite ❑ Poor appetite ❑ Appetite keeps changing ❑ Feel tired or weak if a meal is missed
❑ Excessive thirst ❑ Never thirsty Other _____

Specific food cravings? ❑ Yes ❑ No If yes, what? _____

Other _____

DIGESTION: ❑ Stomach gas ❑ Lower bowel gas ❑ Heartburn ❑ Burning/belching ❑ Stomach pain ❑ Stomach cramps ❑ Nausea
❑ Vomiting ❑ Bad breath ❑ Sores in mouth ❑ Weight gain ❑ Weight loss ❑ Bitter/sour taste in mouth ❑ Abdominal bloating

How long after eating? _____ Food allergies? ❑ yes ❑ No If yes, to what? _____

NUTRITION: List some of your favorite foods _____

_____

Do you: ❑ Skip breakfast ❑ Eat a snack ❑ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? ❑ Yes ❑ No How often? _____

Do you plan your meals according to the "Four basic food groups"? ❑ Yes ❑ No

How many glasses of water do you drink a day? ❑ Filtered ❑ Bottled

Do you use: Alcohol? ❑ Yes ❑ No Amount per week _____ Type _____

Tobacco? ❑ Yes ❑ No Packs per day _____ How many years _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? ❑ Yes ❑ No

Eat green or yellow vegetables at least twice a day? ❑ Yes ❑ No

Eat frequently between meals? ❑ Yes ❑ No

Chew your food thoroughly before swallowing it? ❑ Yes ❑ No

Drink juice, milk or other drinks instead of water when thirsty? ❑ Yes ❑ No

Eat meat or dairy products 2 or more times a day? ❑ Yes ❑ No

Eat the same foods almost every day? ❑ Yes ❑ No

Eat when you are not hungry? ❑ Yes ❑ No

Eat until you feel full? ❑ Yes ❑ No

Occasionally go on a "crash" diet? ❑ Yes ❑ No

Always add salt at the table? ❑ Yes ❑ No

Patient 's Signature _____

Missed Appointments and Late Cancellation Policy

Thank you for choosing Greenapple Sports and Wellness for your chiropractic care. Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try to do our best. In order to provide the highest quality services to our patients, we have enforced a Missed Appointment Policy. We understand there are times when you must miss a medical appointment due to emergencies. However, missed appointments impact the flow of patients in our clinics.

Please review the following agreement and sign at the signature line, indicating that you understand our policy.

Our no-show and cancellation policy applies to missed appointments, which include:

- **No-show: You don't arrive for your appointment, and you don't reach out to cancel.**
- **Late cancellation: You cancel your appointment less than 24 hours before your appointment time.**
- **Late reschedule: You reschedule your appointment less than 24 hours before your appointment time.**

You will be subject to a **$60.00** charge for any missed or cancellations not within the 24 hour period.

You can help us ensure all patients have the appointment access they need by:

- Arriving on time for your appointments.
- Understanding that if you arrive 15 or more minutes after your appointment time, we may need to reschedule your appointment.
- Notifying the clinic at least 24 hours in advance if you cannot make it to your appointment.

Missed appointments due to unforeseen emergency situations, such as medical emergencies or illness, ***may*** be considered an exception to the policy and will be at the discretion of the practice manager on a case-by-case basis.

As a patient or guardian for a patient receiving services from Greenapple Sports and Wellness, I understand and agree with the following:

Patient Name_____

Patient/Guardian Signature_____

Date_____