Mason Chiropractic & Wellness Center

www.MasonWellness.com
2630 Layer Road S.W. Warren, Ohio 44481
Phone: (330) 219-6250
Email: MasonWellness@yahoo.com

NEW PATIENT INTAKE FORM

DEMOGRAPHICS:

Name: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

E-mail Address: _____

Emergency Contact: Name: _____ Phone: _____

How did you hear about this clinic? _____

REASON(S) FOR TODAY'S VISIT: _____

☐ Yes, I have been treated by Acupuncture before. Date of last treatment: _____

☐ Yes, I am currently under a Physician's care for: _____

Name of Physician: _____ Phone: _____

☐ Yes, I am currently taking prescription drugs. Please list below:

Drug Name & Dosage	**For What Purpose/Condition**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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☐ Yes, I am currently taking supplements and/or vitamins. Please list below:

Supplement/Vitamin Name & Amount	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

☐	Yes, I have an infectious disease. Please describe:	

☐ Yes, I have allergies. Please indicate:

☐ Foods – Describe: _____

☐ Medications – Describe: _____

☐ Bites/Stings – Describe: _____

☐ Seasonal – Describe: _____

☐ Animals – Describe: _____

☐ Other – Describe: _____

FAMILY MEDICAL HISTORY: (Please check if any of the following applies to any family members)

☐ AIDS	☐ Alcoholism	☐ Allergies	☐ High Blood Pressure
☐ Asthma	☐ Diabetes, Type I or II	☐ Heart Disease	☐ Cancer
☐ Seizures	☐ Stroke	☐ Mental Illness	☐ Other:

Describe:

Mother's Health:	☐ Living	☐ Deceased	☐ Unknown	
Father's Health:	☐ Living	☐ Deceased	☐ Unknown	
Siblings? _____ Health:	☐ Living	☐ Deceased	☐ Unknown	
Grandparent's Health:	☐ Living	☐ Deceased	☐ Unknown	

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PERSONAL HEALTH HISTORY: (Please check if any of the following apply)

- ☐ Aids
- ☐ Alcoholism
- ☐ Asthma
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Birth Trauma (yours)
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Endocrine Disorder
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Thyroid Disease
- ☐ Childhood Fevers
- ☐ Childhood Illnesses
- ☐ Major Surgeries (please list all with approx. dates):

☐ Significant Trauma (auto accidents, falls, etc. Please list with approx. date of injury):

CURRENT SYMPTOMS: (Please check if any of the following apply)

- ☐ Headaches
- ☐ Vision Problems
- ☐ Jaw/Teeth Pain
- ☐ Ear Pain
- ☐ Sinus Pain/Problems
- ☐ Throat Pain/Problems
- ☐ Breathing Difficulties
- ☐ Chills
- ☐ Fever
- ☐ Indigestion
- ☐ Insomnia
- ☐ Nervousness
- ☐ Other:
- ☐ Urination Difficulties
- ☐ Infertility
- ☐ Impotence
- ☐ Muscular Pain
- ☐ Joint Dysfunction/Pain
- ☐ High/Low Blood Pressure
- ☐ Depression
- ☐ Overly Emotional
- ☐ Fatigue
- ☐ Dizziness
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Constipation/Diarrhea
- ☐ Skin Disorders
- ☐ PMS
- ☐ Menstrual Disorders
- ☐ Menopausal Problems
- ☐ Anxiety
- ☐ Chest Pain
- ☐ Excess Thirst
- ☐ Lack of Thirst
- ☐ Spontaneous Sweating
- ☐ Night Sweating
- ☐ Lack of Sweating

LIFE STYLE: (Please check if any of the following apply)

- ☐ Live Alone
- ☐ Live with Spouse/Significant Other
- ☐ Live with Roommate(s)
- ☐ Live with Parents
- ☐ Live with Children
- ☐ Enjoy your Work
- ☐ Enjoy your Home
- ☐ Enjoy your Social Life
- ☐ Work 9-5
- ☐ Work 2nd Shift
- ☐ Work 3rd Shift
- ☐ Work Inconsistent Hours
- ☐ Manage Own Business
- ☐ Unemployed
- ☐ Student Full Time
- ☐ Have Family Support
- ☐ Exercise Seldom
- ☐ Exercise Occasionally
- ☐ Exercise Often
- ☐ Enjoy Hobby
- ☐ Religious
- ☐ Spiritual Connection
- ☐ Student Part-Time
- ☐ Have Financial Support

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DIET AND PERSONAL HABITS: (Please check if any of the following apply)

- ☐ Currently use Tobacco, # packs per Day?
- ☐ Former Tobacco Use, Year Quit?
- ☐ Exercise Regularly
- ☐ Vegan
- ☐ Eat a lot of Fried Foods
- ☐ Eat a lot of Sweets
- ☐ Normal Weight for Height
- ☐ Very Overweight
- ☐ Currently drink alcohol, # drinks per week?
- ☐ Currently use recreational drugs
- ☐ Vegetarian
- ☐ Healthy Diet
- ☐ Eat a lot of Dairy
- ☐ Eat a lot of Red Meat
- ☐ Underweight
- ☐ Overweight

ADDITIONAL INFORMATION ABOUT YOURSELF: (Please write here)

Please check if you experience any of the following on a regular basis:

HEAD, EYES, EARS, NOSE, THROAT:

- ☐ Glasses
- ☐ Night Blindness
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Spots in Eyes
- ☐ Spots in Visions
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Nosebleeds
- ☐ Heaviness of Head
- ☐ Ear Ringing
- ☐ Hearing Loss
- ☐ Earaches
- ☐ Ringing in Ears
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Throat Drainage
- ☐ Throat Tickle
- ☐ Sore Throat
- ☐ Swollen Glands
- ☐ Lump in Throat
- ☐ Enlarged Thyroid
- ☐ Teeth Removed
- ☐ Numerous Cavities
- ☐ Teeth Grinding
- ☐ TMJ
- ☐ Gum Problems
- ☐ Lip Sores
- ☐ Mouth Sores
- ☐ Excessive Saliva
- ☐ Facial Pain
- ☐ Facial Numbness
- ☐ Sinus Problem
- ☐ Sinus Drainage

RESPIRATORY

- ☐ Difficulty Breathing
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Acute Cough
- ☐ Tight Chest
- ☐ Asthma
- ☐ Wheezing
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Phlegm/Congestion
- ☐ Rattling Sound with Breath
- ☐ Can't Sleep Lying Down

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CARDIOVASCULAR

- ☐ Hypertension (High Blood Pressure)
- ☐ Blood Clots
- ☐ Hypertension (Low Blood Pressure)
- ☐ Chest Pain
- ☐ Rapid Heart Rate
- ☐ Fainting
- ☐ Palpitations
- ☐ Edema (Swelling)
- ☐ Irregular Heart Rate
- ☐ Slow Heart Rate
- ☐ Pacemaker

GASTROINTESTINAL

- ☐ Nausea
- ☐ Diarrhea
- ☐ Dark Colored Stool
- ☐ Vomiting
- ☐ Constipation
- ☐ Light Colored Stool
- ☐ Acid Regurgitation/Reflux
- ☐ Use Laxatives
- ☐ Mucus in Stools
- ☐ Gas/Flatulence
- ☐ Use Antacids
- ☐ Blood in Stools
- ☐ Hemorrhoids
- ☐ Hiccups
- ☐ Use Fiber
- ☐ Rectal Pain/Itching
- ☐ Bloating
- ☐ Use Digestive Enzymes
- ☐ Fissures
- ☐ Bad Breath
- ☐ Intestinal Pain
- ☐ Bowel Movement 1x/Day
- ☐ Vomiting Blood
- ☐ Poor Appetite
- ☐ Bowel Movement Great than 1x/Day
- ☐ Bowel Movement Less than 1x/Day

GENITO-URINARY

- ☐ Pain with Urination
- ☐ Bed Wetting
- ☐ Impotence
- ☐ Frequent Urination
- ☐ Wake to Urinate
- ☐ Premature Ejaculation
- ☐ Urgent Urination
- ☐ Frequent UTI's
- ☐ Nocturnal Emissions
- ☐ Incomplete Urination
- ☐ Sexually Transmitted Disease
- ☐ Blood in Urine
- ☐ Increased Libido (Men)
- ☐ Decreased Libido (Men)
- ☐ Dribbling
- ☐ Kidney Stones

MUSCULO-SKELETAL

- ☐ Muscle Weakness
- ☐ Chronic Pain (long-term pain)
- ☐ Limited Range of Motion
- ☐ Muscle Cramps
- ☐ Acute Pain (short-term pain)
- ☐ Arthritis
- ☐ Muscle Spasms
- ☐ Injuries
- ☐ General Aches
- ☐ Joint Pain
- ☐ Muscle Atrophy
- ☐ Location of Pain:
- ☐ Joint Instability
- ☐ Falls

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NEUROLOGICAL

- ☐ Fainting/Syncope
- ☐ Drowsiness
- ☐ Tremor
- ☐ Stroke/CVA/TIA
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Convulsions
- ☐ Seizures
- ☐ Vertigo
- ☐ Poor Memory
- ☐ Paralysis
- ☐ Numbness

NEUROPHYSIOLOGICAL

- ☐ Depression
- ☐ Irritable
- ☐ Easily Stressed
- ☐ Easily Frustrated
- ☐ Worry Easily – Anxious
- ☐ Unresolved Grief
- ☐ Frightened Easily
- ☐ Numbness
- ☐ Abuse Survivor
- ☐ Receiving Counseling
- ☐ Received Counseling
- ☐ Poor Memory

SKIN AND HAIR

- ☐ Rashes
- ☐ Hives
- ☐ Ulcerations
- ☐ Eczema
- ☐ Fungal Infection
- ☐ Psoriasis
- ☐ Acne
- ☐ Itching
- ☐ Dandruff
- ☐ Premature Graying
- ☐ Hair Loss
- ☐ Hair Changes
- ☐ Hair Breaking
- ☐ Thin Slow Growing Nails
- ☐ Skin Changes

VITALITY AND IMMUNE SYSTEM

- ☐ Frequent Colds
- ☐ Frequent Flu
- ☐ Less Ability to Adapt
- ☐ Chronic Mental Cloudiness
- ☐ Low Energy
- ☐ Lethargic
- ☐ Slow Wound Healing
- ☐ Tender/Achy All Over

GYNELOGICAL ☐ N/A

- ☐ Pregnant
- ☐ Could be Pregnant
- ☐ Pregnancies #
- ☐ Miscarries #
- ☐ Abortions #
- ☐ Pre-Mature Births #
- ☐ Use Birth Control Pills
- ☐ Use Birth Control, Other
- ☐ Use No Contraceptives
- ☐ Use Hormone Replacement Therapy
- ☐ Menopausal
- ☐ Peri-Menopausal
- ☐ Decreased Libido
- ☐ Increased Libido
- ☐ PMS
- ☐ Pain Before Menstruation
- ☐ Pain During Menstruation
- ☐ Pain After Menstruation
- ☐ Bone Density Changes
- ☐ Fibrocystic Breasts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Mastectomy
- ☐ Lumpectomy
- ☐ Hysterectomy
- ☐ Excess Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Sores
- ☐ Vaginal Dryness
- ☐ Vaginal Itching
- ☐ Vaginal Pain
- ☐ Spotting Between Cycles
- ☐ Blood Clots
- ☐ Heavy Bleeding – Weeks
- ☐ Regular Self Breast Exams

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GYNELOGICAL – Continued

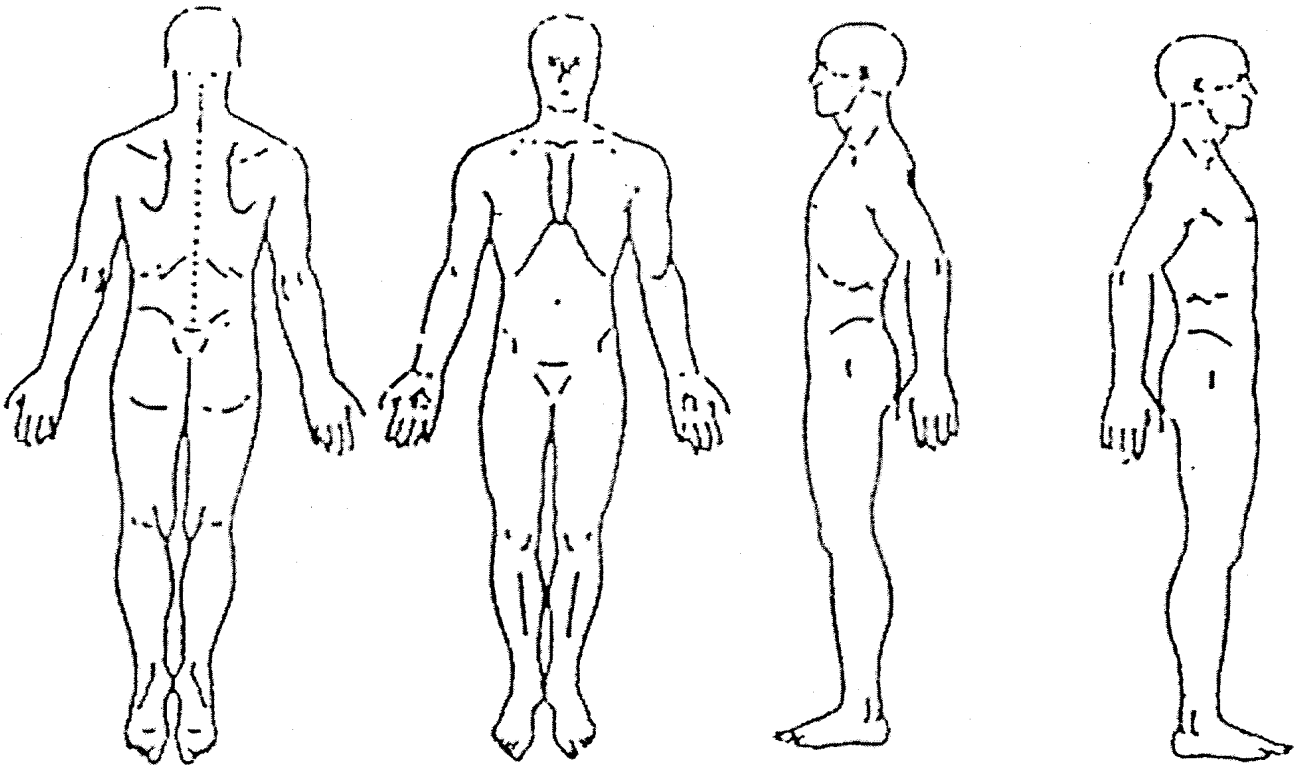
Age of Menarche? _____ Years Old
Age of Menopause? _____ Years Old

Date of Last PAP Smear? _____
Result of Last PAP Smear? _____
Date of Last Mammogram? _____
Result of Last Mammogram? _____

CURRENT MENSES:

Length of Cycle: _____
Duration of Flow? _____
Number Days per Month: _____
Number of Days (of Bleeding): _____

**** Please **MARK** any areas of pain on the diagram located on this form ****



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Consent to Treatment Form

Informed Consent for Acupuncture Treatment

I _____ hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, moxibustion, cupping & Graston (dermal friction technique), electrical stimulation, infrared heat lamp, breathing techniques, Chinese or Western herbal medicine, and nutritional counseling based on traditional Chinese medical theory.

Acupuncture

There is an energetic system of the body that provides control and coordination to the billions of processes inside the body that take place every second. The ancient Chinese organized and categorized these energy pathways into the system that is now known as acupuncture meridians. These meridians represent channels of energy flow through which coordination and control of the body's systems occur. As this meridian system works to maintain health it can also become impaired. When this happens decreased health can result. Acupuncture is a technique that utilizes specific, fine stainless steel needles inserted at specific points in the body in an attempt to normalize physiological function by correcting imbalances of these energy pathways.

Moxibustion is the application of indirect heat by burning a stick of compressed Folium Artemisia vulgaris, commonly known as Mugwort, over acupuncture points. (At our clinic we use an infrared heat lamp instead of compressed Folium Artemisia vulgaris).

Cupping utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.

I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I am relying on Dr. Mason to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants. If I have any of the above conditions, I have listed them here:

_____
_____
_____
_____
_____

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By voluntarily signing below I, _____, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Print Name of Patient Signature of Patient

Date: _____

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HIPPA

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Respect for patient privacy is highly valued at our office. As required by law, we will protect the privacy of your health information that may reveal your identity and provide you with a copy of this notice which describes the health information policy procedures of our office when providing healthcare services.

Required permission to use and disclose your protected health information.

We will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct office operations. This general written consent will be obtained the first time we provide you with the treatment services. This general written consent is a broad permission that does not have to be repeated each time treatment is provided.

How we may use and disclose your health information.

Uses and disclosures

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of the care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may disclose identifiable health information about you without your authorization in some situations as required by law, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information on you.

Your rights

In most cases, you have the right to look at or get a copy of health information about you at the office. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice and seek your knowledge meant of receipt of this notice.

_____ _____

Patient signature Date

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OFFICE POLICY

Mason Chiropractic & Wellness Center works to enhance your immune system, nervous system and acupuncture meridian system through multiple modalities, including lifestyle changes and dietary instructions, as well as supplements, chiropractic, acupuncture and medical assessments which are designed to attempt to enhance your body's ability to heal/function better. These therapies are offered in a private professional atmosphere geared to your individual comfort. In some cases one or more of the modalities offered at MCWC may not be advisable. It is, therefore, imperative that complete medical information be relayed to MCWC during your initial visit. Some of the questions to think about: physical complaints - what helps, what hurts? Past injuries, surgeries or hospitalizations? Medications: name, dosage & frequency. I should also be notified of any changes in your medical condition or medication during your treatment here.

Length of sessions is about 25 minutes. Call, text or e-mail for fees. Payments may be in the form of cash, check or credit card. If paying by check please write it out before your session made payable to Mason Wellness Center.

Office visits are given to you precisely on quarter hour increments and your promptness in this matter is appreciated. If you are scheduled for a 9:00 a.m. appointment and are 15 minutes late your session will be concluded at 9:30 a.m. and you will be charged for the full session.

Missed appointments will be charged unless a 24-hour notice is given.

Office hours start at 9:00 a.m. Monday through Friday with the last session starting at 6:00 p.m. Saturday AM appointments may be available.

With respect to others who may be allergic please refrain from wearing any perfume or scented oils on the day of your visit.

MCWC is dedicated to providing you the best possible care. We welcome your suggestions and are pleased to have the opportunity to be of service to you.