Preferred Client Information

Name: (Mr./Mrs./Ms.) circle one **Date:**___/___/_____

Last:______________________________ ***First***:___________________________________

Birth Date: ___/___/______ ***Current Age:***____ ***Profession:*** _________________________

Married / Partnered / Single / Divorced / Widowed *Number of Children* __________

Contact Information:

Telephone: Work:___________________ Home:____________________________

Email:_______________________________ Cell:_____________________________

Can we send appointment reminders to your cell via text? (Yes / No)
Provider________________
(ex: Sprint, AT&T, etc.)

Address:

Line1:____

City:_________________________ State: ______ Zip:_______________

Emergency Contact:

Name:__________________________ Relation: _________Phone:___________

Were you referred to us by someone? (Y / N) circle one

If yes, by whom? ____
If no, how did you hear about us? _______________________________________

What is your chief complaint? ____

What are your other major complaints? ____

Have you ever had: a seizure? (Y / N) a stroke or brain bleed? (Y / N) a major head injury? (Y / N)

Do you have any children / nieces / nephews / grandchildren with health challenges (mental / emotional / physical)? ____________________

TRACKING YOUR PROGRESS

Fill this out in combination with the checklist of concerns before you start training and then every ten sessions.

NAME: ______________________________ DATE: ______________

SESSION (CIRCLE) 1 10 20 30 40

Medication I am on (how much, how often): ______________________________

CONCERN Pick the concerns you circled that you would like to change the most. Add any other concerns you want to track	FREQUENCY How many times did you feel this way in the past week, or how many days out of 7?	INTENSITY How strong was it 0-10	DURATION How long did it last? Do not count when you were sleeping
1.			
2.			
3.			
4.			
5.			

SETTING YOUR GOALS

Fill this out before you start your training with NeurOptimal®

I will know NeurOptimal® is working if….

1.
2.
3.

List 3 things you do currently that support your overall health.

____

____

____

List your 3 favorite vices (ex: smoking, social drinking, sweet tooth…)

____

____

____

Overall, do you feel that your lifestyle **contributes to OR takes away from** your health?

____

____ Soft drinks per day

____ Glasses of water per day

Do you exercise? ____

____ Alcoholic beverages per week

Do you smoke cigarettes? ____

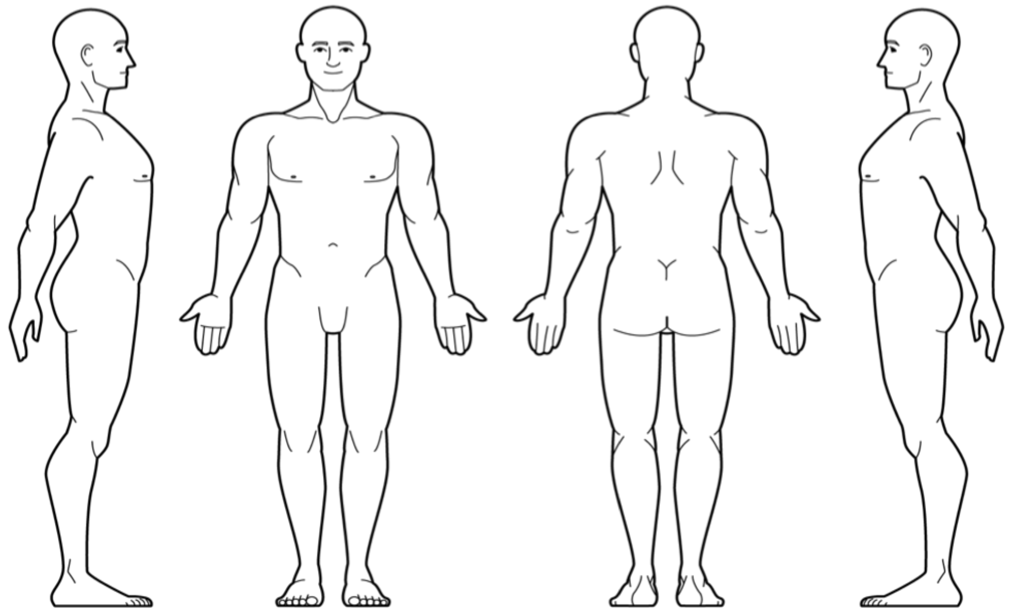
Are you a vegetarian? ____

Are you currently experiencing pain in your body?
If so, please use the key below to describe.

Pain and discomfort key:

X – Sharp / Stabbing
P – Pins / Needles
D – Dull / Ache
N – Numbness
T – Tightness

1-10 Scale
(1=least; 10=most)



Medications & doses:

____

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Herbs & Supplements:

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Allergies:

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Acupuncture

Informed Consent to Oriental Medical Healthcare

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Michael Meuth, licensed acupuncturist: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing (modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation), the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implicated.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pin or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise such judgment, during the course of my treatment, as the doctor feels as the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment at **Headway Health.**

Patient's name (please print)	Patient's signature
Date signed	Witness
Print name of patient's representative (if applicable)	Relationship or authority of patient's representative
Signature of patient's representative (if applicable)	Date signed

Headway is not responsible for untrue statements made by patients.

Acupuncture

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirements of 22 T.A.C §183.7 of the Texas State Acupuncture Examiners' rules (relating to Scope of Practice) and Texas Code Ann., §205.351, governing the practice of acupuncture)

Choose only one of the three options below.

I (patient's name) ____ am notifying Michael Meuth, L.Ac. of the following:

Yes ____ No ____ I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

_______________________________________ _______________________________________

Patient's signature (required) Date signed

OR

Yes ____ No ____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is ______________________________, and the most recent date of chiropractic treatment prior to acupuncture treatment is ____. After being referred by a chiropractor, if after 60 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice to follow this advice.

_______________________________________ _______________________________________

Patient's signature (required) Date signed

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for one of the following conditions:

___Chronic Pain
___Weight Loss
___Smoking Cessation

_______________________________________ _______________________________________

Patient's signature (required) Date signed

Headway is not responsible for untrue statements made by patients.

HIPPA

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that Headway "Notice of Privacy Policies" has been provided to me. I understand I have a right to review the "Notice of Privacy Policies" prior to signing this document. "The Notice of Privacy Policies" is also provided upon request.

Members of the staff may need to contact you with appointment reminders of information related to your treatment. If this contact is made by phone, and you are not at home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

____________________________________ ____________________
Patient Name Printed Date

____
Patient Signature

48 Hour Cancellation Policy

We strive to make my office run as smoothly as possible and to help make your experience here as satisfying and pleasant as possible.

To do this, we allow plenty of time for your visit. Unlike many physicians' offices that schedule six to eight patients per hour to compensate for those who do not show up, we regularly see only one or two people per hour. In order for our office to run as smoothly as possible we ask that you give us ample notice if you cannot make your appointment.

Please note that we have a **48-hour** cancellation policy. Please bring your calendar in order to set up your follow-up appointments. If you need to reschedule your appointment at anytime during your series, please give us at least 48 hours notice so that your time slot can be used by other clients. If we do not receive at least 24 hours notice, you will be charged in full for your missed appointment. Naturally, we will make an exception to this in the event of genuine emergencies, such as acute illness or accidents. This policy is not intended to be punitive; it simply allows us to keep an appointment schedule that allows quality care for every client.

Please sign below to acknowledge that you have read my scheduling policy and that you accept these terms. Thank you for your understanding and compliance of this necessary policy.

Signature:____________________________________ Date:____________________