Notice of 24 hour Acupuncture Cancellation Policy:

We are now implementing a 24 hour cancellation policy. In order to provide all of our clients and patients with scheduling availability, and in consideration of Josh's efforts to serve those who need him, if you cancel with less than 24 hours' notice (with the exception of emergencies or illness) you will be charged with an acupuncture visit of $75.00. This policy allows opportunity for patients on a waiting list to get an appointment within a reasonable timespan and respects Josh's time. Moving forward, we will require a Credit Card to be kept on file in our records to enforce this policy and ensure our providers are compensated for their time and lost revenue.

Thank you for your understanding!

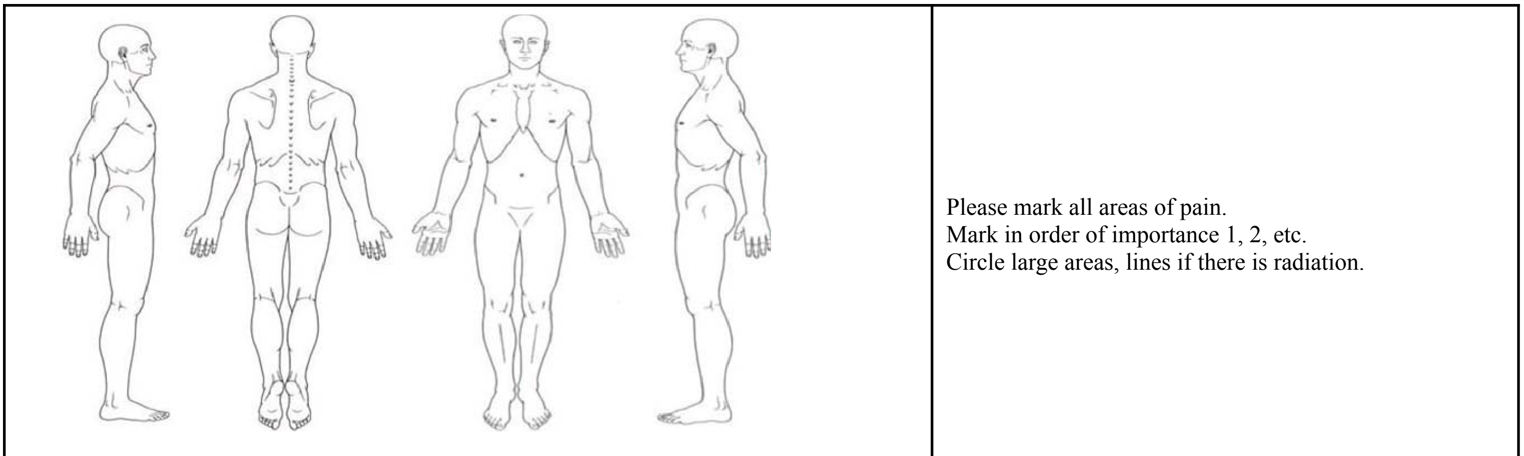
__________________________________(sign) ___________________ (date)

Align Sports Chiropractic & Health Center
A: 520 Philadelphia St, Indiana PA 15701 P: 724 801 8622 F: 724 801 8758

Patient Information	Name		Date
Height	Weight	Gender	DOB
Marital Status		Phone	
Address		Email	
		May we contact you via: ☐ Phone ☐ Text ☐ Email	
Who referred you/How did you find us?			
Emergency Contact	Name		
Phone		Relationship	

Chief Complaint(s): What are the main reasons for your visit?	
1.	Started when:
2.	Started when:

History of Present Illness (HPI): Please mark for **Primary Complaint**	
Describe what happened and when:	
Location:	When is it worse:
How does it feel:	Associated Symptoms:
What makes it better:	Other treatments:
Severity 0-10:	



Please mark all areas of pain.
Mark in order of importance 1, 2, etc.
Circle large areas, lines if there is radiation.

History of Present Illness (HPI): Please mark for **Secondary Complaint**	
Describe what happened and when:	
Location: How does it feel: What makes it better: Severity 0-10:	When is it worse: Associated Symptoms: Other treatments:

ROS Recent or Current Conditions	
Constitutional	☐ Fever ☐ Chills ☐ Weight Gain ☐ Weight Loss ☐ Poor Appetite ☐ Fatigue ☐ Insomnia ☐ Excess Sweat
Vision	☐ Blurry Vision ☐ Eye Pain ☐ Discharge ☐ Redness ☐ Decreased Vision ☐ Dryness ☐ Double Vision
ENT	☐ Ear Infection ☐ Hearing Loss ☐ Tinnitus ☐ TMJ ☐ Sinus Infection ☐ Post Nasal Drip ☐ Sore Throat
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Rapid HR ☐ Slow HR ☐ Heart Murmur ☐ Poor Circulation ☐ Edema
Respiratory	☐ Shortness of Breath ☐ Wheezing ☐ Chronic Cough ☐ Coughing Blood ☐ Excess Sputum ☐ Sleep Apnea
Gastrointestinal	☐ Gas ☐ Bloating ☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Blood in Stool ☐ Heartburn
Genitourinary	☐ Urgency ☐ Frequency ☐ Painful ☐ Retention ☐ Incontinence ☐ Blood in Urine ☐ UTI ☐ Venereal Disease
Skin	☐ Rash ☐ Hives ☐ Sores or Ulcers ☐ Itching ☐ Eczema/Psoriasis ☐ Mole Changes ☐ Nail Changes ☐ Hair Loss
Musculoskeletal	☐ Joint Pain ☐ Muscles Aches ☐ Weakness ☐ Numbness ☐ Leg Cramps ☐ Bone Pain ☐ Joint Swelling ☐ Hernia
Endocrine	☐ Hypoglycemic ☐ Goiter ☐ Feeling Hot or Cold ☐ Hyper/Hypo Thyroid ☐ Increased Thirst ☐ Increased Hunger
Neurological	☐ Seizures ☐ Tremors ☐ Migraines ☐ Dizziness/Vertigo ☐ Loss of Balance ☐ Slurred Speech ☐ Stroke
Blood/Lymph	☐ Low Blood Count ☐ Anemia ☐ Varicose Veins ☐ Easy Bruising ☐ Easy Bleeding ☐ Swollen Lymph Nodes
Allergy/Immune	☐ Hay Fever ☐ Frequent Colds ☐ Chronic Infections ☐ Slow Wound Healing ☐ Positive PPD Test

Women's Health	Day of Cycle:	☐ Irritability	Age Menarche:	**Men's Health**
☐ Fibroids	Length Cycle:	☐ Fatigue	Age Menopause:	☐ Prostate
☐ Endometriosis	Length Menses:	☐ Heavy Mense	# Pregnancies:	☐ Erectile Dysfunction
☐ PCOS	☐ Breast Tenderness	☐ Light Menses	# Births:	☐ Painful Erection
☐ PID	☐ Cramps	☐ Hot Flashes	# C-Sections:	☐ Infertility
☐ Infertility	☐ Clots	☐ Night Sweats	Currently Pregnant? Y / N	☐ Discharge
Birth Control Usage:				☐ Other

Past Medical Conditions
Please check all that apply

			☐ Allergies (specify)
	☐ Arthritis	☐ Headaches	
☐ Diabetes	☐ Osteoporosis	☐ Blood Clots	
☐ Chest Pain/Angina	☐ Asthma/COPD	☐ Peripheral Vascular Disease	☐ Cancer (specify)
☐ High Blood Pressure	☐ Stroke/TIA/CVA	☐ Tuberculosis	
☐ Heart Disease	☐ Seizures	☐ Stress/ Anxiety/ Depression	
☐ Heart Attack	☐ HIV/AIDS	☐ Congestive Heart Failure	
☐ Heart Palpitations	☐ Stomach Ulcer	☐ Thyroid Disease	☐ Other (specify)
☐ Heart Surgery	☐ Kidney Disease	☐ Liver Disease	
☐ Pacemaker	☐ Kidney Stones	☐ Hepatitis	

Current Medications and Supplements
(Name, dosage, frequency)

Social History	Occupation	Dominant Hand ☐ Left ☐ Right
Exercise		☐ Non-Smoker ☐ Ex-Smoker ☐ Smoker Packs/day_________ Alcohol ☐ Frequent ☐ Occasional ☐ Never
Family History		
Additional Information		

Patient's Signature	Date
Guardian's Signature Authorizing Care	Date

Practitioner's Signature	Date

Acupuncture Informed Consent

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 the licensed acupuncturists on staff at Align Sports Chiropractic & Health Center:

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 body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with my acupuncturist the nature and purpose of acupuncture and Oriental medical 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 implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine there are some risks to 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, pain or other strong sensation at the location of where a needle is inserted, or where cupping or herbal application is made to the skin, or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other very rare, but possible risks include pneumothorax (punctured lung), or puncture of other organs. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest.

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 and conditions of treatment. 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 Align Sports Chiropractic & Health Center.

<table>
<tr><td colspan="3">Patient Name (print)</td></tr>
<tr><td colspan="2">Patient Sign</td><td>Date</td></tr>
<tr><td>Representative (print)</td><td colspan="2">Relation to Patient</td></tr>
<tr><td colspan="2">Representative Sign</td><td>Date</td></tr>
</table>

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Align Sports Chiropractic & Health Center, creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care.

I understand that this information is used as a means of communication among Align Sports Chiropractic & Health Center personnel and with medical personnel outside of this practice.

I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients.

I have been provided an opportunity to review the Notice of Privacy Practices for the Align Sports Chiropractic & Health Center that provides a more complete review of information used and disclosures.

I understand that I have the right to review this Notice of Privacy Practice before signing this consent.

I understand that the Align Sports Chiropractic & Health Center may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the Align Sports Chiropractic & Health Center is not required to agree to the restrictions requested. The procedures to request restriction on information used and disclosure is contained in the Notice of Privacy Practices.

I Acknowledge that I have received a copy of the Notice of Privacy Practices of Align Sports Chiropractic & Health Center and agree to the liability limitations explained therein.

Patient Name (print)	
Patient Sign	Date
Representative (print)	Relation to Patient
Representative Sign	Date