Welcome!

I am very excited and look forward to working with you to achieve a superior state of health. You can count on me to assist you in accomplishing your health-related goals. I want you to achieve balance, vitality and longevity.

Our staff at Tompkins Wellness Center is honored to work with you. They will do whatever is possible to make your experience here a pleasant one whether it pertains to your appointment, scheduling or otherwise.

We believe the body works as a whole. We will look at your health from head to toe, so that you can achieve a better body, for a better life. We will also address mental/emotional health that is often ignored or dismissed in a patient's total health picture. Your role as a patient is to be open, honest, and ready for positive change.

As someone said, “I believe the value of preventative medicine is to correct and repair imbalances before modern medicine ever names them.” It is very exciting to see people no longer needing the medications they once needed as a result of the repair and long-term correction the body has made as a result of proper fortification and intervention. It is my pleasure to welcome you to our office. It’s amazing how the body is capable of healing! Let’s expect and anticipate measurable changes as we work together to accomplish your health-related goals!

Yours in health,

Dr. Tompkins and Staff

Date:_____ **Confidential Patient Health Information**

Personal History

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Email:_____
Home Phone:_____ Birth Date:_____ Age:____ Sex: ◯ M ◯F
Cell Phone:_____ Text: Y of N Married Single Widowed Divorced Separated
Business Employer:_____ Type of Work:_____
Business Phone:_____ Driver's License:_____
Name and ages of Children:_____
Referred to this office by:_____
Name/Address of Emergency
Contact:_____
Who is responsible for payment:_____

Current Health Condition

Unwanted Health Condition_____
Other Doctors Seen For This Condition_____
Type of Treatment_____
Results_____
When Did This Condition Begin?_____
Is Condition: Job Related_____ Auto Accident_____ Home Injury_____ Fall____
Other_____
Drugs You Now Take: ◯ Nerve Pills ◯ Painkillers/Muscle Relaxers ◯ Insulin
◯ Vitamins ◯ Herbs ◯ Supplements
◯ Blood Pressure Medicines ◯ Other_____
Do You Wear a Shoe Lift? ◯ Yes ◯ No
Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?_____
_____

Past Health History

Please Check and Describe

Major Surgery/Operations

◯ Appendectomy ◯ Tonsillectomy ◯ Gall Bladder ◯ Hernia
◯ Back ◯ Broken Bones ◯ Other_____
Major Accidents/Falls _____
Hospitalizations other than above_____
Previous Chiropractic Care ◯ None ◯ Doctor's Name and Date of Last Visit _____
_____

Below are a list of diseases which may be unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

☐ Pneumonia	☐ Mumps	☐ Influenza	**INTAKE**
☐ Rheumatic Fever	☐ Small Pox	☐ Pleurisy	☐ Coffee
☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Tea
☐ Tuberculosis	☐ Diabetes	☐ Epilepsy	☐ Alcohol
☐ Whooping Cough	☐ Cancer	☐ Mental Disorders	☐ Cigarettes
☐ Anemia	☐ Heart Disease	☐ Lumbago	☐ White Sugar
☐ Measles	☐ Thyroid	☐ Eczema	

Have you been tested HIV positive? ☐ Yes ☐ No

CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

MUSCULO-SKELETAL

☐ Low Back Pain
☐ Pain Between Shoulders
☐ Neck Pain
☐ Arm Pain
☐ Joint Pain/Stiffness
☐ Walking Problems
☐ Difficulty Chewing/Clicking Jaw
☐ General Stiffness

☐ Gas/Bloating After Meals
☐ Heartburn
☐ Black/Bloody Stool
☐ Colitis

FEMALES ONLY:

When was your last period?_____
Are you Pregnant?
☐ Yes ☐ No ☐ Not Sure

GENITO-URINARY

☐ Bladder Trouble
☐ Painful/Excessive Urination
☐ Discolored Urine

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat :
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

GASTROINTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gallbladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

THE FOLLOWING SECTION IS FOR THE PATIENT TO READ AND SIGN

Tompkins Wellness Center Policies

Payment of Bills

Payment is due at time of service or when supplements are ordered. We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you have made with us or are unable financially to make the payments for services rendered, advise our staff immediately so new arrangements can be made. If you choose not to make payments to our office for the balance owed, we will report your outstanding balancer to the credit bureau and a collection agency. If legal action is required, you will be responsible for the balance owed to our office as well as any legal fees incurred by Tompkins Wellness Center. Inv.

Insurance

We do not file with any insurance company unless due to Medicare or an auto accident. However upon request, we do provide the necessary codes on a “super bill” which you can submit to your insurance company for reimbursement. Super bills can be provided up to 90 days prior to the request date. Please note that in regards to an accident we only bill the patient’s primary insurance, not third party.

Worker’s compensation

It is our policy to not become involved in Personal Injury lawsuits or Worker’s Compensations claims. Nor will we voluntarily become involved in litigation on behalf of a patient in these types of claims or lawsuits.

Cell Phones

Please be courteous to others and turn off all cell phones.

Perfumes and Colognes

We do treat patients with severe allergies to scents. We ask that you please refrain from wearing any strong scents while entering our office.

Supplements

It is our goal to provide sustainable nutritional support. We track and monitor inventory to ensure proper availability to the best of our ability. In order to do so we encourage patients to take full responsibility of supplements purchased and ordered. If in any case, a return of product is necessary, unopened and unused supplements, within expiration dates, may be exchanged or credited for other supplements at 75% of its original sale price.

****Cancellations**

In order for you to receive the best results, we strongly encourage all appointment times to be kept. Missing appointments results in a slower and ultimately more costly recovery. If, for any reason, you are unable to keep an appointment time, we require at least 24 hours notice. If less than 24 hours notice is given, we will need to charge a $25.00 fee, and for *no shows* the full price of the missed appointment. We provide a free text reminder service to your cell phone and email address.

_____ _____

Signature Date

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or wetern herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile, disposable needles, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am, or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explaining al possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for muy present condition and for any future condition(s) for which I seek treatment.

_____	_____
Print Name of Patient	Print Name of Acupuncturist
X_____	X_____
Signature of Patient (or Representative)	(Print Name of Witness/Translator)
_____	_____
Date Consent Completed	(Signature of Witness/Translator)

Tompkins Wellness Center

Price List

New Patient Exam	$150
Re-Exam	$45
Adjustment-Adult	$55
Isolated Cervical Spinal Adjustment	$15
Acupuncture Only	$50
Acupuncture with Adjustment	$90
Nutritional Test	$50
Office Visit	$50
Emotional Release Treatment	$50
Parasite Elimination Technique	$25 per session
Urinalysis	$25
NAET Treatment	$50

Office Fees

Return Check Fee	$25
Same Day Cancellation Fee	$25
No Show	Subject to appt fee missed

I have been shown the price list and understand payment is due when services are rendered.

_____

(Name) **(Date)**

Medical Information Release Form

(HIPAA Release Form)

Name:_____ Date of Birth:____/____/____

Release of Information

☐ I authorize the release of information including the diagnosis, records;

Examination rendered to me and claims information. This information may be released to:

☐ Spouse_____

☐Child(ren)_____

☐ Other_____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell number_____

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐_____

The best time to reach me is (day)_____ between (time)_____

Signed:_____ Date: ____/____/____

Witness:_____ Date: ____/____/____