Sundala wellness

NOTE: The information provided on this form is confidential. Date: ____/____/_____

Name_____ Age _____ Male ☐ Female ☐

Address _____ Email_____

Occupation _____ Date of birth ____/____/____

Cell phone _____ Home _____ Work _____

How did you hear about Sundala? _____

Are you under a physicians care? If so what is their name/number? _____

What would you like treated by Acupuncture? _____

How long have you had this condition? _____ Onset sudden or gradual _____

What makes your symptoms worse? _____ Better? _____

What medical diagnosis were you given?_____

What other treatments have you received for this? _____

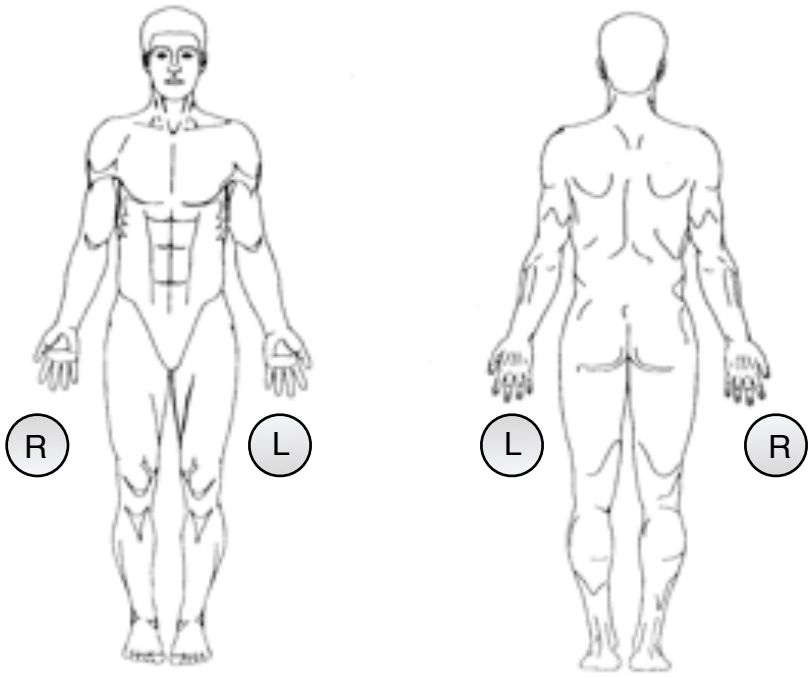
How has this condition changed your life?_____

Are you taking any medication/herbs/vitamins? If so, please list_____

_____

Are you **currently** pregnant? Yes ☐ No ☐

On the following drawing, please shade in the areas that you are having **pain / pins & needles / numbness**:



Medical History

Birth: Anything significant? (breech, premature, jaundice, difficulties)_____

Vaccination history: Any reactions to vaccinations or have you had any unusual vaccinations?
_____

Any illness, injuries, surgeries, accidents: (please list in chronological order)

Childhood	Adolescence	Adulthood
Age _____	Age _____	Age _____
Age _____	Age _____	Age _____
Age _____	Age _____	Age _____

Family history: note all major illnesses in your close family (diabetes, stroke, cancer, etc)

Have you had any of these?

- ☐ AIDS / HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Asthma
- ☐ Hepatitis A / B /C
- ☐ Herpes Oral / Genital
- ☐ Anorexia
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Hypo // Hyperthyroid
- ☐ Osteoarthritis
- ☐ Bulimia
- ☐ Lyme
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Removal of lymph nodes
- ☐ Rheumatoid Arthritis
- ☐ Vaccination
- ☐ Seizures
- ☐ Tuberculosis
- ☐ Infertility
- ☐ Genetic disorders
- ☐ Skin Disorders
- ☐ Birth trauma

NUTRITION // FOOD

How is your appetite: ☐ Good ☐ Poor ☐ No appetite ☐ Hungry all the time

Do you have any food cravings: _____

List any food intolerances & symptoms of intolerance:

_____

How do you feel emotionally around food? _____

Describe meals for a typical day			
Breakfast	Lunch	Dinner	Snacks

How often do you have the following: ___ day___week	Rate your Taste Preference 1 (like most) - 5 (like least)	How many glasses per day do you consume:	Do you prefer to drink beverages:
Meat	Salty	Water	Hot
Caffeine	Sweet	Soda	Cold
Sugar	Spicy	Alcohol	Room Temp
Dairy	Sour		With Ice
Gluten / Wheat	Bitter		

EXERCISE // ENERGY

How is your energy? _____

What time of day is your energy HIGHEST_____LOWEST_____

Do you fatigue easily?_____

Does movement make you: LESS TIRED ☐ MORE TIRED ☐

What type of exercise do you do?_____How often? _____

Do you have any usual sweating or do you not sweat?_____

Do you get dizzy during of after exercise? _____

EMOTIONS

How do you feel emotionally?_____

Do you hold your stress in your body? If so, where? _____

How do you relax? _____

How do you feel about your work? _____

Do you have any of these issues? Panic attacks ☐ Depression ☐ Anxiety ☐

Bad Temper ☐ Nervousness ☐ Panic Attacks ☐ Poor memory ☐

Difficulty concentrating ☐ Morning moody ☐

Are you in a relationship? No ☐ Yes ☐ If so, are you happy?_____

Do you use: Anti-depressants ☐ Sleeping pills ☐ Other:_____

SLEEP

How long do you sleep? _____hrs/night

I have difficulties (check all that apply): Falling asleep ☐ Staying asleep ☐ Disturbed sleep ☐

I wake up at _____am/pm and I am unable to fall back to sleep again because_____

_____

How long do you normally sleep? _____ hrs/night

I have difficulty with: Falling asleep ☐ Staying asleep ☐ Disturbed sleep ☐

SKIN // HAIR

I have (check all that apply):

Dry Skin ☐ Skin Rashes ☐ Itching ☐ (where _____)

Acne ☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature greying ☐ Psoriasis ☐

RESPIRATORY (EENT)

Do you smoke? If so _____p/day for _____ yrs

I have (check all that apply):

Frequent colds ☐ Chronic runny nose ☐ Cough up blood ☐ Pain inhaling ☐

Trouble catching breath ☐ Asthma ☐ Nose bleeds ☐ Red eyes ☐

Dry mouth ☐ Shortness of breath ☐ Bleeding gums ☐ Chronic sinusitis ☐

Ear pain ☐ Cold sores ☐ Ringing in ears ☐ Clogged/popping ears ☐

Motion sickness ☐ Frequent sore throat ☐

Cough up mucous ☐ : how much // color of phlegm _____

Frequent headaches // migraines ☐ : describe _____

Any other issues: _____

CARDIOVASCULAR

Blood pressure _____ / _____

Have you been diagnosed with heart trouble? Yes ☐ No ☐

I have (check all that apply):

Chest pain ☐ Palpitations ☐ Irregular heart beat ☐ Varicose veins ☐ Cold extremities ☐

Poor circulation ☐ Diabetic Neuropathy ☐

GASTROINTESTINAL

I have (check all that apply):

Belching ☐ Nausea ☐ Vomiting ☐ Ulcers ☐ Acid Regurgitation ☐ Heartburn ☐

Hernia ☐ Indigestion ☐ Severe stomach pains ☐ Constipation ☐ Diarrhea ☐ Hemorrhoids ☐

Use Laxatives ☐ Undigested food in stool ☐ Gas ☐ Hard stool ☐ Itchiness ☐

MUSCLES // JOINTS // BONES

Do you have pain // tightness? Where? _____

My pain is (check all that apply):

Sharp ☐ Aching ☐ Numb ☐ Deep ☐ Burning ☐ Dull ☐ On the surface ☐ Tingling ☐

Worse with heat ☐ Better with heat ☐ Worse with cold ☐ Better with cold ☐ TMJ ☐

Worse with movement ☐ Better with movement ☐

I have (check all that apply):

Swollen joint ☐ Joint pain ☐ (where?_____) Tendonitis ☐

Rheumatoid arthritis ☐ Bone pain ☐ Muscle cramps ☐ Sprain / Strain ☐

URINARY // GENITAL:

Urination: How often _____p/day Color: Pale yellow ☐ Dark yellow ☐

I have or have had (check all that apply): Trouble starting urine stream ☐

Frequent urination ☐ Incontinence ☐ Trouble holding urine ☐ Pain urinating ☐

Burning urination ☐ Dribble when sneezing ☐ UTI ☐ Kidney stones ☐

Do you have pain with intercourse? Yes ☐ No ☐

WOMEN

What age did you begin menstruation? _____ Number of days b/w cycle? _____

Number of days of flow? _____

Color of blood? Bright red ☐ Dark red ☐ Light pink ☐ Purple clots ☐ Red clots ☐

I have or have had:

Irregular menstruation ☐ Heavy flow ☐ Light flow ☐ No flow ☐ since what date:_____

Vaginal mucous mid month ☐ Pain during flow ☐ Pain before flow ☐ Spotting ☐

Lumps in breast ☐ Congested breast ☐ Breast tenderness ☐ Mucous from breasts ☐

Any other PMS symptoms: _____

Are you on hormone replacement or birth control? If so, please name your Rx:

_____

Number of pregnancies _____ Number of deliveries _____ Abortion/miscarriages_____

Do you use birth control and if so, what? _____

Menopause symptoms _____

How is your sexual energy / libido? Strong ☐ Weak ☐

MEN

I have (check all that apply):

Prostatits ☐ Impotence ☐ Penile blood/mucous discharge ☐ Genital pain ☐ Premature ejaculation ☐

Reduced sexual energy ☐ Testicular pain/swelling ☐ Inguinal hernia ☐ Varicocele ☐

PLEASE READ AND SIGN

While Oriental Medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is "recommended" that you consult a physician regarding any conditions for which you are seeking acupuncture treatment(s). This is a recommendation ONLY. The state of NY does NOT require an MD script for Acupuncture. If you are seeking Physical Therapy then it is important to check with your insurance company if a script is required.

I, (print name) _____ have been advised by Sundala, Inc. to consult a physician regarding the conditions, for which I seek acupuncture and /or Physical Therapy treatment(s).

_____ _____

Signature of patient or representative Date

INFORMED CONSENT

I consent to Acupuncture treatments and related procedures, associated with Oriental Medicine, by Bianca Beldini, DPT, MSOM, L.Ac I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha and electrical stimulation.

I consent to Physical Therapy treatments and related modalities with Bianca Beldini, PT if being treated solely for Physical Therapy.

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 needle sight, which may last a few days. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, however since this office uses only sterilized, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of using moxibustion.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgments during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand that the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

I will notify the Acupuncturist or Physical Therapist, who is caring for me, if I become pregnant.

By voluntarily signing below, I show that I have read or have had read to me, this consent to treatment. I 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 both the present condition and for any future conditions for which I seek treatment(s).

_____ _____

Signature of patient or representative Date

Cancellation Policy

I agree to pay $50 if I do not comply with notifying Sundala Center for Wellness within 24 hours before my scheduled appointment time.

_____ _____

Signature of patient or representative Date

FINANCIAL AGREEMENT//HEALTH INSURANCE

We would like to take a moment to welcome you to our office and assure you that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

DEDUCTIBLE: SUNDALA IS LEGALLY RESPONSIBLE TO COLLECT YOUR DEDUCTIBLE. ONCE YOUR DEDUCTIBLE HAS BEEN MET, YOUR INSURANCE WILL BEGIN TO COVER ALL OR A PERCENTAGE OF YOUR COVERAGE. THIS DEDUCTIBLE BEGINS AT THE START OF YOUR INSURANCE COVERAGE WHETHER IT IS UNDER A CALENDAR YEAR OR ANNUAL YEAR POLICY.

BCBS and NYSHIP PATIENTS: These two insurance companies send payments TO YOU! It is your responsibility to sign the check and submit them to SUNDALA. If we do not receive the checks within 30 days of payment or the check has been cashed, SUNDALA will send you a bill for the entire amount of the check that was released to you.

Explanation of Insurance Coverage:

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangements

We require that you pay _____ towards today's charges and _____on each visit. Your full portion of the bill is expected to be when payment is received from your insurance carrier. Any unpaid balances will be considered past due 30 days following insurance reimbursement Past due balances may have an interest charge of 1.5 % applied per month. If you have a specific contracted amount for copayment/coinsurance, that amount is due on each visit. You will receive an invoice monthly from our billing company Billeeze reflective of your co-insurance responsibility.

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. However if you pay for your visits in full the assignment will not be reported by this provider and any payment will be sent directly to you.

Release of Information

By signing this form you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome your to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above.

____ _________________________

Signature of Patient // Representative Date