METAMORPHOSIS
HOLISTIC HEALTH LLC

Intake General Male

4513 Vernon Boulevard Suite 11 Madison, WI 53705
Tel: 608-957-4725
Website: www.metaholistic.com

Date:

Last name / First name / Circle: Miss Ms. Mrs. Dr.

Birth date / Age / Circle # of preferred contact

Emergency Contact / Emergency Phone /

Address / Phone (home or work) /

City / Zip Code / Phone (cell) /

Email / Occupation /

Height / Weight /

Have you had Acupuncture before? Yes No

Have you had Chinese herbal medicine? Yes No

Have you had Energywork or Reiki? Yes No

Reason for Visit /

Family Physician name / Family Physician phone /

Western Medical diagnosis (if applicable) /

Other medical treatment received (circle) / Fertility clinic Physical therapy Massage Naturopathy Chiropractic Other:

Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

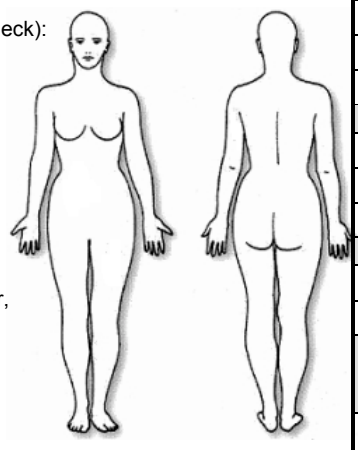
	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological condition		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV / AIDS		Sprain/strain/fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Thyroid - Hypo or Hyper		Digestive problems		Hemophiliac		Wear a pacemaker
	Lung condition		Epilepsy		Possibility of pregnancy		Upcoming surgeries

On the figures below, please circle the areas of concern/pain ;

Sensations/pain characteristics (check):
Sharp __ Burning __ Moving __
Tingling __ Dull __ Severe __
Stabbing __ Shooting __
Throbbing __ Numbness __

What relieves the pain (ice, rest, activity, massage, heat…)?
_____
_____

What aggravates the pain (weather, heat, cold, rest, activity…)?
_____
_____
_____
_____
_____



Please list any prescription medication or over the counter drugs currently taking:

1.	2.
3.	4.
5.	6.

Please list herbal medicine and other supplements currently taking:

1.	2.
3.	4.
5.	6.

Please list any allergies (food, drugs, environmental, etc.):

1.	2.
3.	4.

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs: _____ Coffee: _____ Soda: _____

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about Metamorphosis? (Internet, Friend, Doctor, Fertility Clinic) _____

Please print, complete, and bring in forms for your initial appointment. Thank you.

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For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan
___ Irritability / frustration / impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / dry / itchy eyes
___ Headaches / migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / Sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
___ Frequent urination
___ Bladder infection
___ Lack of bladder control
___ Wake to urinate
___ Feel cold easily
___ Cold hands / feet
___ Night sweats / hot flushing
___ Low sex drive
___ High sex drive
___ Loss of head hair
___ Hearing problems
___ Crave salty food
___ Fear
___ Poor long term memory
___ Ankle swelling
___ Tinnitus

Fei
___ Dry cough
___ Cough with phlegm
___ Nasal discharge / drip
___ Sinus infection / congestion
___ Itchy / painful throat
___ Dry mouth / throat / nose
___ Skin rashes / hives
___ Snoring
___ Grief / sadness
___ Shortness of breath
___ Allergies / asthma
___ Weak immune system
___ Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue / after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Prefer warm / cold drinks
___ Sweat easily

Please list your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Are your bowel movements regular? How many times per day/week? Are they formed, loose, hard, constipated, or do they alternate from loose to difficult to pass?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What color/shade of yellow is it? Do you have a history of urinary tract infections?

How many glasses of water do you drink in a day?

How many times in your life have you taken antibiotics (approx. #)? How many times have you taken oral steroids?

Please describe in general what you eat, and what you crave. (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Do you wake and have difficulty falling back to sleep?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

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On your journey toward better health, what expectations do you have of Metamorphosis Holistic Health? Please list the wellness goals you wish to obtain here:

Please consider letting us know what you need most from us during our time together (check as many as you wish):

____ **Perspective** (provide a fresh or different way of looking at a situation)

____ **Validation** (provide encouragement and acknowledgement)

____ **Message** (share fitting knowledge, opinions, or wisdom)

____ **Energy** (provide positive energy and support)

____ **Advice** (provide recommendations and suggestions)

____ **Feedback** (offer observations, insight, ideas, and opinions)

____ **Solutions** (share solutions to problems or issues)

____ **Plan** (co-develop a plan of action with you)

____ **Structure** (provide support and a check-in structure for you)

____ **Challenge** (provide a challenge to you to stretch or make a change)

____ **Tough love** (when necessary, have the conversations you may least want to have)

____ **Resource** (suggest/refer you to experts, books, tools, assessments)

____ **Caring** (provide listening, patience, safety, and love)

____ **Removed** (you may just want to come and relax, nothing more)

If there is anything else you would like us to know about you in order to make your experience here better, please share it here:

Patient Treatment Information and Informed Consent

Acupuncture is performed by the insertion of *pre-sterilized, disposable acupuncture needles* through the skin, and/or with the application of heat, magnet or electro stimulation to the skin, or both, at specific sites on the body. Stimulation of said needles may be achieved by hand manipulation, electrical stimulation or the application of moxibustion on the needle itself.

I hereby authorize and direct Metamorphosis Holistic Health LLC and any agents representing them to perform the following:
- Health history, pulse/tongue and range of motion evaluation, manual palpation of skin, muscles, sternum, abdomen and body;
- Acupuncture, scalp acupuncture, electro-acupuncture, acupressure, magnets, auricular/ear seeds, tacks;
- Reiki, energywork, stone/crystal/vibrational healing, shamanic healing techniques, EFT and other tapping techniques;
- Cupping, guasha, tuina massage, indirect moxibustion, Bio-Mat® infra-red/negative ion, infra-red and TDP lamp heat therapy;
- Topical application of liniments, massage oil and essential oils;
- Dietary recommendations, herbs, nutritional supplements, and essential oils;
- Life and health coaching regarding lifestyle, exercise, breathing, energetics, mindfulness and meditation (NOTE: We do not perform psychology services and will refer out to a licensed professional counselor if appropriate.)

What are the possible risks and side effects of acupuncture?
- Minor bleeding or bruising can occur from acupuncture;
- Needle sickness or fainting can occur in certain patients, particularly at the first treatment;
- Broken needles, minor ache or pain at site of needle insertion, or an electric shock sensation that is more rare;
- Infection and risk from needling in vicinity of an infection
- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive;
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.

What are the possible side effects of Chinese Medicine and other treatments provided at this clinic?
- Skin irritation is possible with very sensitive skin with use of essential oils, liniments, cupping or guasha;
- Sore muscles or aches, redness or bruising (can look like a circular hickey) of skin is a common side effect of cupping or guasha;
- Herbs and nutritional supplements from plant, animal and mineral sources that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses or inappropriate during pregnancy. Please advise your acupuncturist of any adverse symptoms immediately.

Apart from the usual medical details, it is important that you let your practitioner know:
- If you have ever experienced a seizure, fainting, or other odd detached sensations;
- If you have a pacemaker or any other electrical implants;
- If you are pregnant;
- If you have a bleeding disorder, or are taking anti-coagulants (blood thinners) or any other medication;
- If you have damaged heart valves or have any other particular risk of infection.

Appointment Policy
We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because a treatment room has been reserved for you, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, if you are going to be more than 10 minutes late, please call to confirm availability. A 24-hour notice for cancelled or rescheduled appointments is necessary in order to avoid the $37.50 cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours.

Additional Policies and Records Release Authorization
I understand that I am responsible for my bill.
I authorize the use of this form for all of my insurance and workman's compensation submissions.
I authorize release of information to all of my insurance companies.
I permit a copy of the authorization to be used in place of the original.
I direct and permit my previous health care providers to release medical records to Metamorphosis.
I understand a $37.50 cancellation fee will be charged if I cancel with less than 24 hours notice to Metamorphosis.
I authorize use of the results of my treatment in statistical reports with my identity remaining confidential.
I authorize Metamorphosis Holistic Health LLC and any agents representing them to administer care.

Statement Of Consent
I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment that, based upon the facts then known, is in my best interest. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by Metamorphosis, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Patient's Name: _____Birthdate: _____ Address: _____

_____ _____
Signature Print name of representative if represented by another

_____ _____
Date Signature of representative, parent or guardian if patient is a minor

HIPAA Consent Agreement

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

Full Name: _____ Birthdate: _____

Address:_____

_____ Communication Preferences:

Phone: _____ Email: _____ Phone ☐ Email ☐ Text ☐

Insurance Name:_____ Group and Personal ID#_____

Primary Insured Name (if other than patient):_____

Emergency Contact/Relationship:_____Phone: _____

I understand that as part of my healthcare, **Metamorphosis Holistic Health, LLC** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- For communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and medical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Privacy Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

- I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.
- I understand that I have the right to object to the use of my health information for directory purposes.
- I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Metamorphosis Holistic Health, LLC is not required to agree to the restrictions requested.
- I understand that I may revoke this consent in writing, except to the extent that the Metamorphosis Holistic Health, LLC has already take action in reliance thereon.

I request **the following restrictions or exceptions** to the use or disclosure of my health information:

_____

_____

_____

Date Notice Effective Date or Version ☐ Accepted ☐ Denied

Signature: _____ Date: _____

Signature of Patient or Legal Representative Witness: