THE BALANCED BODY ACUPNCTURE NUTRTION & HERBS
5630 N. LAKE DRIVE WHITEFISH BAY, WI 53217 PHONE: 262-370-4451

Patient Information Sheet **Confidential**

Important: Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Cancellation Policy _I acknowledge that I will give at least 24 hour notice of cancellation to avoid a charge for the session. This is a courtesy to other patients who may need that appointment time. I will call if I anticipate being more than 15 minutes late for my appointment. Initials:

Date	**Full Name** **Preferred Name/Nickname**
Gender M F	**Date of Birth** **Age** **Marital Status** Single Married Separated Divorced
Address **City State Zip**	
Daytime Phone # (home, work, cell circle one)	**Alternate Phone # (home, work, cell circle one)**
Emergency Contact & Relationship	**Phone Numbers of Emergency Contact** **Primary** **Alternate**
Circle Health Insurance Coverage None PPO POS HMO Workers' Comp Auto Injury with MedPay Military Other	
Would you like to receive an appointment confirmation via email? Y N Would you like to receive a monthly email acupuncture newsletter? Y N Would you like to be updated on clinic events via email? Y N Please be assured that your email address will only be used by our office for the above intended purposes and will not be sold to other companies or individuals. Email:	
Primary **Care Doctor**	Specialty
Other **Doctors You See**	**Specialty**
Other **Doctors You See**	**Specialty**
How did you hear about us?	

Patient _____ Date _____

Patient _____ Date _____

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under appropriate person's column. "P" should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
Arthritis											
Asthma-Hay Fever											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Diabetes											
Disc Problems											
Emotion Problems											
Emphysema											
Epilepsy											
Headaches											
Heart Trouble											
High Blood Pressure											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Nervousness											
Neuritis											
Obesity											
Pinched Nerves											
Scoliosis											
Sinus Trouble											
Stomach Trouble											
Other:											

If any of the above family members are deceased, please list their age at death and cause.

_____

_____

List any surgeries you have had and year it was performed.

_____

_____

TRAVEL: Have you ever traveled or lived outside the U.S.? ☐ Yes ☐ No

Any health problems when abroad? ☐ Yes ☐ No If yes, what?_____

FEMALES:

Form of birth control_____	Pregnant ☐ Yes ☐ No	☐ Clotting	☐ Hot flashes
Last period_____	Last PAP test_____	☐ Heavy bleeding	☐ Vaginal dryness
Age started menstrual cycle_____	Age stopped_____	☐ Vaginal discharge	☐ Other:_____
☐ Menstrual pain	☐ Water retention	No. Pregnancies_____	_____
☐ Low backache	☐ Mood changes	No. Vaginal Deliveries____	No. Miscarriages_____
☐ Irregular	☐ Painful breast	No. Caesareans_____	No. Abortions_____

Patient _____ Date _____

MEDICAL CONDITIONS - Please list conditions & surgeries you have or have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food	**OCCUPATIONAL CONCERNS** Check (✓) if your work exposes you to the following.
Year	Condition/Surgery		Occupation:
			☐ Stress
			☐ Heavy Typing/Computer Use
			☐ Hazardous Substances
			☐ Heavy Lifting
			☐ Other

MEDICATIONS - Please list all prescription medication you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.

Prescription name	Purpose	How long	Dose	How often	Last Dose

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

LIVER/GALLBLADDER
___ Irritability
___ Depression
___ Headaches/migraines
___ Visual problems
___ Red eyes
___ Dry/itchy eyes
___ Spots in front of eyes
___ Blurred vision
___ Feeling of lump in throat
___ Clenching of teeth at night
___ Muscle cramping
___ Muscle twitching
___ Joints feel tight/stiff
___ Cold hands/feet
___ Soft/brittle nails
___ Craving/avoiding sour foods

KIDNEY/URINARY BLADDER
___ Urinary problems
___ Frequent urination
___ Incontinence
___ Weakness/pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual energy
___ Excess sexual desire
___ Poor memory
___ Loss of hair
___ Hearing problems
___ Ringing in ears
___ Craving/avoiding salty food

HEART/SMALL INTESTINE
___ Heart palpitations
___ Chest pain
___ Dizziness
___ Insomnia
___ Easily startled
___ Restlessness/agitation
___ Anxiety
___ Breathlessness
___ Vivid dreams
___ Dreams are bothersome
___ Lack of joy in life
___ Laughing for no reason
___ Craving/avoiding bitter foods

LUNG/LARGE INTESTINE
___ Dry cough
___ Cough with sputum
___ Nasal discharge
___ Poor sense of smell
___ Nose bleeds
___ Itchy, red or painful throat
___ Dry mouth
___ Skin rashes
___ Itchy skin
___ Grief, sadness
___ Shortness of breath
___ Allergies
___ Low resistance to colds or flu
___ Low physical stamina
___ Mild fever comes and goes
___ Craving/avoiding spicy foods

SPLEEN/STOMACH
___ Heaviness anywhere in body
___ Fatigue
___ Hard to get up in the morning
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising and bleeding
___ Bad breath
___ Low appetite
___ Snacking
___ Tendency towards hypoglycemia
___ Difficulty digesting oily foods
___ Nausea
___ Vomiting
___ Gas/belching
___ Bloating
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Indigestion/heartburn
___ Over-thinking
___ Tendency to become obsessive
___ Craving/avoiding sweets

Health History

What are the health problems for which you are seeking treatment? _____

_____

_____

How long have you had this condition? _____

What other forms of treatment have you sought? _____

_____

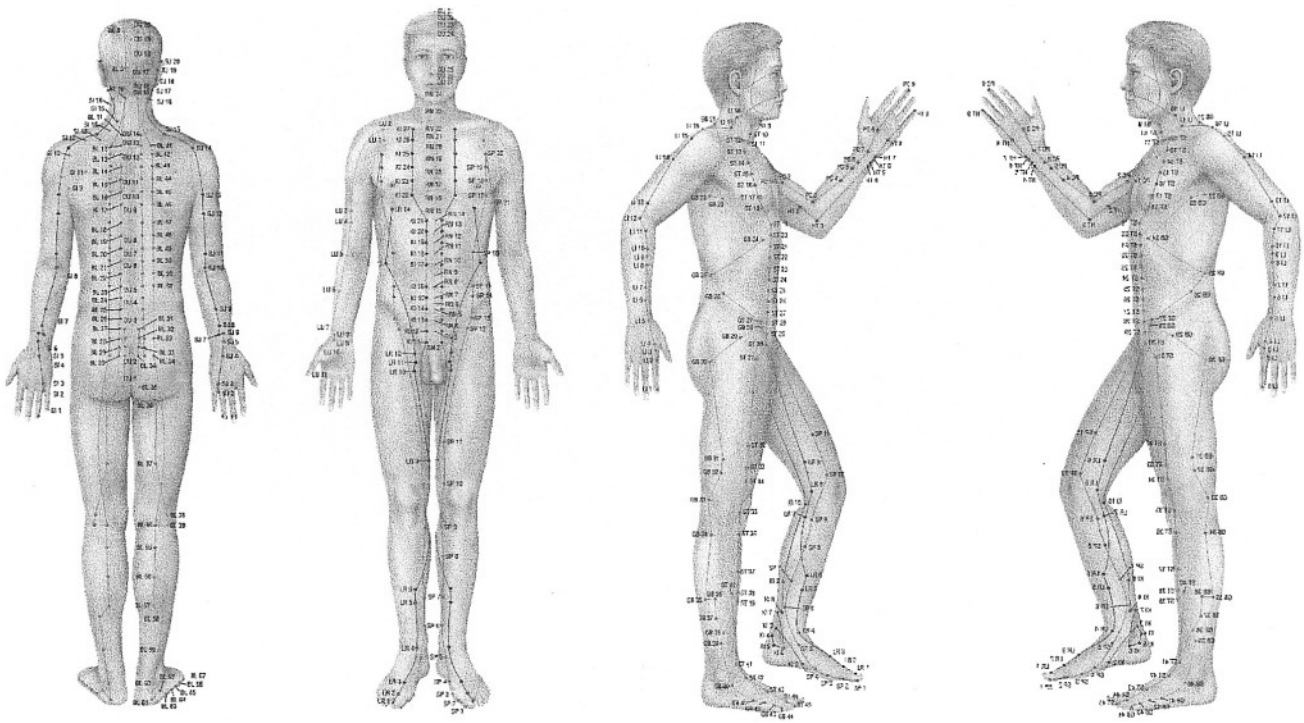
What helps your condition? _____

What aggravates your condition? _____

Please list any surgeries or major health incidents (accidents, etc.) in your life:_____

_____

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:



How would you characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

What would you like to achieve with acupuncture treatment? _____

_____

Healthy Living Questionnaire

Patient Name: _____ **Date:** _____

Age:_____ **Gender:** ❑ **Male** ❑ **Female**

Current Weight: _____

Do you consider yourself:
❑ **underweight** ❑ **overweight** ❑ **just right**

Unintentional weight loss or gain of 10 pounds or more in the last three months: Yes ❑ **No** ❑

Recent changes in your ability to:
❑ **see** ❑ **hear** ❑ **taste**
❑ **smell** ❑ **feel hot/cold sensations**

1. Check the Following Statements That Apply:
- ❑ Occasionally or frequently skip meals
- ❑ Suffer from fatigue
- ❑ Currently overweight
- ❑ Crave sweets or carbohydrates
- ❑ Crave stimulants, such as caffeine or soft drinks
- ❑ Suffer from chronic pain
- ❑ Suffer from headaches

2a. Activity Level – Check Your Current Level of Work or Lifestyle:
- ❑ **Level 1 – Very Light Work:** Sitting, standing, driving, reading, computer, etc.
- ❑ **Level 2 – Light Work:** Light housework, labor, childcare, mechanic, some sitting, etc.
- ❑ **Level 3 – Moderate Work:** Heavy gardening, housework, labor, no sitting, etc.
- ❑ **Level 4 – Heavy Work:** Heavy manual labor, construction, digging, etc.

2b. Exercise Level – Check Your Current Level of Exercise:
- ❑ **None**
- ❑ **Level A – Light Exercise:** 1-3 times per week, easy pace, stretching, walking, etc.
- ❑ **Level B – Moderate Exercise:** 2-3 times per week, moderate pace, some weights, etc.
- ❑ **Level C – Heavy Exercise:** 3-4 times per week, vigorous pace, weights, fast running, etc.

3. Balance Eating – Check Which Apply:
- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt Restriction
- ❑ Fat Restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction
- ❑ Specific food restrictions of:
  - ❑ dairy ❑ wheat ❑ eggs
  - ❑ soy ❑ corn ❑ all gluten
- ❑ Other_____

Servings per day:
Fruits (citrus, melons, etc.)_____
Dark green or deep yellow/orange vegetables_____
Grains (unprocessed)_____
Beans, peas, legumes _____
Dairy, eggs_____
Meat, poultry, fish_____

4. Eating Frequency – Check Which Apply:
- ❑ Skip breakfast or other meals_____
- ❑ Three meals/day
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze-small frequent meals (how many/day) _____
- ❑ Generally eat on the run

5. Exercise Frequency and Schedule – Check Which Apply:
- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 min or more duration per workout
- ❑ 30-45 min or more duration per workout
- ❑ Less than 30 min
- ❑ Use of personal trainer
- ❑ Member of fitness club
- ❑ Own exercise equipment
- ❑ Walk: days/week _____
- ❑ Run, jog, jump rope, other aerobic: days/week_____
- ❑ Weight lift: days/week_____
- ❑ Stretch: days/week_____
- ❑ Yoga: days/week_____
- ❑ Other_____ days/week_____

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6. Stimulant Use Habits – Check Which Apply:

❑ Tobacco:
- Cigarettes: #/day_____
- Cigars: #/day_____
- Pipe: #/day_____

❑ Alcohol:
- Wine: # glasses/day or week_____
- Liquor: # ounces/day or week_____
- Beer: # glasses/day or week_____

❑ Caffeine:
- Coffee: # of 6 oz cups/day _____
- Tea: # of 6 oz cups/day _____
- Soda w/caffeine: # of cans/day _____
- Soda w/o caffeine: # of cans/day _____
- Other sources_____

❑ Water:
- # glasses/day _____

7. Stress Habits – Check Which Apply:

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents: Y ❑ N ❑
Do you suffer from insomnia/sleep disorders? Y ❑ N ❑
Do you often abruptly awake from sleep? Y ❑ N ❑
Do you suffer from depression/mood swings? Y ❑ N ❑

8. Supplement Use Habits – Check Which Apply:

❑ Multivitamin/mineral
❑ Vitamin C
❑ Vitamin E
❑ EPA/DHA
❑ GLA (Evening primrose)
❑ Calcium, source_____
❑ Magnesium
❑ Zinc
❑ Minerals, describe_____
❑ Friendly flora (acidophilus)
❑ Digestive enzymes
❑ Amino acids
❑ CoQ10
❑ Antioxidants (lutein, resveritol, etc.)
❑ Herbs – teas
❑ Herbs – extracts
❑ Chinese herbs
❑ Ayurvedic herbs
❑ Homeopathy
❑ Bach flowers
❑ Superfoods (bee pollen, phytonutrient blends)
❑ Liquid meals (Ensure)
❑ Other_____

9. Energy – Vitality

I'd like to:

❑ Have more energy
❑ Have longer endurance
❑ Have more motivation
❑ Sleep better
❑ Be less tired after lunch
❑ Feel more vital
❑ Regain vitality and vigor of my younger years
❑ Get less colds and flu
❑ Get rid of allergies
❑ Not use so many over the counter drugs
❑ Stop using laxatives
❑ Be free of pain

10. Longevity – Life Enrichment

I'd like to:

❑ Reduce my risk of degenerative disease
❑ Slow down accelerated aging
❑ Monitor biomarkers of aging
❑ Have less facial wrinkles
❑ Maintain a healthier life longer
❑ Change from a "treating-illness" orientation to a creating wellness lifestyle

11. Body Composition – Fat/Muscle

I'd like to:

❑ Be stronger
❑ Be thinner
❑ Be more muscular
❑ Burn more body fat
❑ Be more flexible
❑ Lose weight

12. Stress Reduction – Mental/Emotional

I'd like to:

❑ Be happier
❑ Be less depressed
❑ Be less moody
❑ Be less indecisive
❑ Be more focused
❑ Think more clearly
❑ Improve my memory
❑ Learn how to reduce stress
❑ Learn how to meditate

COMMENTS

THE BALANCED BODY ACUPUNCTURE NUTRITION & HERBS

5630 N. LAKE DRIVE WHITEFISH BAY, WI 53217 PHONE: 262-370-4451

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on 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 employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, laser acu-therapy, Tui-Na (Chinese massage), Chinese 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 move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. 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 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 explain all 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.

I understand the office medical and administrative staff 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, 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 my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient's representative f the patient is a minor or is physically or legally incapacitated:

Print Name of Patient _____

Print Name of Patient Representative _____

Signature of Patient Representative _____

Relationship or Authority of Patient _____

Name of Acupuncturist Bertram M Schneider L Ac

Patient's Name_____

Patient's Signature Date signed_____

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Financial Policy

Thank you for choosing THE BALANCED BODY-ACPUNCTURE NUTRITION & HERBS (and Associates) for your health care needs. We are committed to your improved health by providing appropriate, high quality, comprehensive family health care. While our intention is to assist you, it is your responsibility to ensure that all services rendered by THE BALANCED BODY - ACUPUNCTURE NUTRITION & HERBS (and Associates) on your behalf are paid in full.
In order to understand our Financial Policy, we have listed below our financial requirements.

Patients Without Insurance Coverage
Payment at the time of service is required. Cash, check, Visa, and MasterCard are accepted as payment options.

Patients With Insurance Coverage
Many health insurance plans now cover acupuncture treatment. At your request, we can verify acupuncture coverage for you. We are out-of-network providers regardless of what their representatives or websites & literature may say. You will be expected to pay at the time services are rendered. Cash, check, Visa, and MasterCard are accepted as payment options. You will be given an invoice to submit to your insurance company. They will reimburse you directly according to their fee structure.

Workers' Compensation Claims
Treatment will be provided with a workers' compensation claim approval. If your employer or their insurance carrier denies your claim, you will be held financially responsible for all charges incurred for services rendered on your behalf. Any quotes given regarding treatment are cash rates — insurance may be billed differently.

Auto Injury Claims
Treatment will be billed to the MedPay portion of your auto insurance policy. If your insurance carrier denies your claim due to exhausted benefits or any other reason, you will be held financially responsible for all charges incurred for services rendered on your behalf. No liens will be accepted. Any quotes given regarding treatment are cash rates — insurance may be billed differently.

I have read and understand the above information. I understand lam responsible (regardless of my insurance) for any and all charges incurred from service provided.

Print Name _____ Date _____
Signature

THE BALANCED BODY ACUPUNCTURE NUTRITION & HERBS

5630 N. LAKE DRIVE WHITEFISH BAY, WI 53217 PHONE: 262-370-4451

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Under the Health Insurance Portability & Accountability Act of 1996 "HIPAA," it is our legal duty to safeguard your Protected Health Information (PHI). Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with us. Before we make any important changes to our policies, we will immediately change this Notice and post a new copy of it in our office. You may also request a copy of this Notice from us, or you can view a copy of it in our office. This Notice will remain in effect until it is replaced or amended.

During the course of our relationship with you, we will use and disclose PHI about you for treatment, payment, and healthcare operations. We gather personal information and health information from you, other healthcare providers, and third party payers. Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside our practice. You may specifically authorize us to use PHI for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representative you choose to have your PHI.

Marketing
Our office will not use or disclose your PHI for marketing communications without your written authorization. This office may send birthday cards, thank you cards, notice of clinic events, newsletters, and/or appointment reminders.

Disclosure
This office may use or disclose your PHI without your consent or authorization when required by law.

Patient Rights

1. Upon written request, you have the right to review and receive copies of your PHI.
2. Upon written request, you have the right to receive a list of disclosures about your PHI.
3. You have the right to request additional restrictions on the use and disclosure of your PHI, as permitted by law.
4. Upon written request, and as permitted by law, you have the right to request that we amend your PHI.
5. You have the right to receive all notices in writing.

If you have questions about this Notice or any complaints about our privacy practices, please contact our office. Please send written complaints to the Secretary of the Department of Health & Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201.
This Notice went into effect on March 3rd, 2008.

I acknowledge consent for use and disclosure of PHI and receipt of this Notice of Privacy Practices.

Signature of patient or patient's personal representative Date

Printed name of patient or personal representative Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature on this HIPAA Notice of Privacy Practices, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

THE BALANCED BODY ACUPUNCTURE NUTRITION & HERBS
5630 N. LAKE DRIVE, WHITEFISH BAY, WI 53217 PHONE: 262-370-4451
Bertram M Schneider Lic. Ac.

Some advice to get the most benefit from your acupuncture treatments and to avoid side effects.

Before you come for your acupuncture visit:

- Bring a list of all medications and supplements you are taking.
- Loose clothing is more convenient. We ask the patient to undress if the painful area is difficult to access otherwise.
- Do not drink coffee at least 5 hours prior to your visit.
- Have a light meal or snack before the visit. Heavy meals can cause nausea. Empty stomach can be the cause of dizziness after the treatment.
- Drink enough water on the day of the treatment; 64 ounces is suggested.
- Do not eat or drink food that changes the color of your tongue.
- Do not drink alcohol.

After your acupuncture visit:

- Do not drink alcohol.
- Do not eat greasy or spicy food.
- Rest is preferable. Make the day as easy as possible.
- Do not exercise right after teatment.
- Do not shower right after treatmet.