Welcome to Affinity Acupuncture and Rolfing/
Dr. Connie Christie, DAOM, LAc & Associates
Please note that all information is strictly confidential.

First Name: _____ Today's Date: _____

Last Name: _____ Pronouns: _____

Date of Birth: _____ Age: _____

Single Married Life Partner Divorced Widowed

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Do you want to get our quarterly newsletter? Yes No

May we correspond with you via text for scheduling? Yes No

All care related correspondence must be done via phone call or email.

Occupation: _____ Name of Company: _____

In Case of Emergency Contact: _____

Relationship & Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? _____

Insurance Information: If Affinity Acupuncture and Rolfing will be billing your insurance, please fill out the following:

Insurance Name and Phone Number: _____
Name of Guarantor (Primary Plan Holder): _____
Guarantor's Date of Birth: _____
ID Number: _____ Group Number: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am financially responsible for any balance not paid by my insurance company or Medicare. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: _____ Date _____

Reason for Today's Visit:

What is the reason for your visit today?

_____

How, when and where did this condition begin?

_____

What types of treatments have you tried, if any?

_____

How does this condition impair your daily activities?

_____

What makes it better or worse?

_____

Please list your main health problems that you would like to be free of in order of importance:

1. _____
2. _____
3. _____

Height:_____

Weight:_____

Your Medical History:

Surgeries, Major Illnesses, Hospitalizations, Falls and Major Accidents (incl. Dates):

_____

Any falls/injuries to sacrum/head/tailbone (describe):

_____

Any birth trauma that you know of:

_____

Family History:

Health and major emotional states as a child:

_____

List any major health issues in your family (going back to grandparents)

_____

Family History of Substance: Abuse Suicide Other Trauma

History of Abuse: check if applicable: physical emotional sexual other

Please list any **medications/vitamins/supplements** you are currently taking:

Medications	Reason	When &For how long

Herb/Medication **allergies** and reaction (if any):

_____

Do you have, or have you ever had any of the following illnesses?

AIDS	Allergies	Arthritis	Asthma
Cancer	Chronic Fatigue	Diabetes	Gall Stones
Heart Disease	Hepatitis	High Blood Pressure	Herpes
HIV+	Kidney Stones	Mental Illness	Mononucleosis
Osteoporosis	Parasites	Rheumatic Fever	Seizures
Stroke	Thyroid Problems	Ulcers	Venereal Disease

Other _____

Lifestyle:

How good do you feel your nutrition is?

_____

Typical

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Worst food in your diet? _____

What foods do you crave?_____

Water intake per day? _____

Caffeine(what form & how much)_____

Do you use

Tobacco? Yes No How much?_____

Alcohol? Yes No How much?_____

Work: Do you enjoy your work? Yes No Hours per week working:_____

Exercise: Do you Exercise? Yes No Number of times/ week:_____

Type of exercise:_____

Sleep:

Do you have trouble falling asleep? Yes No

Time to bed:_____Time to rise: _____

How many hours of sleep do you get per night?_____

Are you rested in the morning? Yes No
Do you wake in the night? Yes No

How is your home environment?

_____

Describe any stressors occurring at this time:

_____

What are hobbies/activities that provide you with a sense of pleasure and accomplishment?

_____

What is your opinion of yourself?

_____

What is the most negative emotion you experience?_____

When and Where?_____

Urination: Please check any of the following symptoms you are currently experiencing:

Burning Urgent Retention Scanty Profuse Dribbling
Greater than 1x a night

Bowel Movements: Frequency: _____ Feels complete? Yes No
Painful? Yes No
Consistency (check): Well-formed Hard Loose Alternates

Undigested food Blood Mucus Sink Float

Head: Please check any of the following symptoms you are currently experiencing:

Ear pain Dry mouth Migraines Ringing in ears

Clogged/popping ears Frequent headaches

Body Fluids: Do you perspire abnormally during the day?_____At night?_____
Are you always thirsty?_____

Men Only:

Have you been diagnosed with prostate problems? Yes No

Do you experience premature ejaculation? Yes No

Do you have problems with Impotence? Yes No

Have you been diagnosed with Infertility? Yes No

Diseases/ Disorders:

Women Only:

At what age did you get your first period?_____

What was that like?_____

Date of last menstrual cycle?_____

Are you currently using contraception? Yes No How long have you used contraception throughout your life?_____

Dates/Type:_____

Are you pregnant now? Yes No

How many pregnancies have you had?_____

No. of deliveries:_____

Dates:_____

No. of Terminations:_____

Dates:_____

Complications?_____

No. of Miscarriages:_____

Dates:_____

Complications?_____

Maternal Family History of (please check): Infertility Fibroids Endometriosis Cancer (type)_____Menstrual Problems PMS Menopause

Medications your mother took when she was pregnant with you (if any)

_____

Number of days from the start of one period to the start of the next:_____

Are your menstrual cycles spaced regularly? Yes No

Average number of days of flow:_____ Flow is: Light Normal Heavy

Color is: Pale Normal Dark Bright Red Brown

Are blood clots present? Yes No

Does your period cause you pain or cramping? Yes No

When? Before During After Period

Do you get nausea or vomiting with your period? Yes No

When? Before During After Period

Do you experience any of the following before your period each month?

Water retention Breast tenderness or swelling Mental depression Irritability

Food cravings Migraines Other_____

Do you ever bleed or spot between periods? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

Do you have any vaginal discharge between periods? Yes No Color_____

Do you have/have you ever had?

Abnormal pap smear? Yes No When/Why?_____

A cervical biopsy, operation, cauterization, conization? Yes No

Venereal disease? Yes No Chlamydial infection? Yes No

Yeast infections? Yes No Sores on your genitals? Yes No

Uterine fibroids or polyps? Yes No Endometriosis? Yes No

Varicose veins? Yes No Sore heels when walking? Yes No

Incompetent Cervix? Yes No Painful intercourse? Yes No

Numb legs/feet when standing still? Yes No

Pelvic inflammatory disease? Yes No

Difficulty experiencing orgasm? Yes No

Were you treated for it? Yes No

How_____

Date of last pap smear? _____

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe:

Is there anything else that we should know to best understand and help you?

Thank you for taking the time to fill out this form thoroughly. It will help us serve you better.

Signature:_____ Date: _____

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Administration Forms

Please read and sign the following forms included here:

1. **Welcome Letter**
2. **Informed Consent to Treat**
3. **24 Hour Cancellation Policy**
4. **HIPPA Receipt of "Notice of Privacy Practices"**
5. **Covid-19 Policy**

Welcome Letter

Dear New Patient,

Welcome to **Affinity Acupuncture & Rolfing**. We are honored and delighted that you have chosen us as your healthcare providers. We strive to provide a blend of proven ancient Chinese Medicine practices with cutting edge modern advancements, and are committed to your treatment being successful. We look forward to partnering with you to address your health concerns, and we will do all we can to ensure you achieve the most successful result possible for you.

The doctor-patient relationship requires both cooperation and mutual trust. We will strive to provide you with the best possible medical care, and ask that you participate in this effort to the best of your ability.

This welcome letter was prepared to acquaint you with the clinic policies of **Affinity Acupuncture & Rolfing.** Please review our FAQ under resources on our website if you are a new to acupuncture.

Tips for Your Acupuncture Treatments

1. Wear loose fitting clothes that can be easily rolled up above your elbows and knees. Also, you may need to expose your abdomen from your rib cage to the top of your hips, so please avoid one -piece suits or dresses.
2. Be sure you have eaten at least a light meal within a few hours prior to arriving.
3. Avoid alcohol on the day of your treatment.
4. Drink plenty of water and stay hydrated after your appointment
5. For best results, avoid strenuous activity immediately following a treatment. Set aside enough time so that you are not rushing to and from your visit.
6. As we follow through on your treatment plan, look for signs of improvement and take encouragement from them. Your belief and expectation has a strong influence on your body, and - is a key factor in healing.

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Please ask questions whenever you do not understand your treatment or medical advice.

Affinity Acupuncture & Rolfing practitioners act as a team. Each provider is individually responsible for their own treatment style although we strive to communicate together regarding your care and treatment plan. As a team, we share health information.

Fragrance Free Zone: Many of our patients are sensitive to smells. Please avoid wearing any perfume, cologne, or scented lotions to your appointment.

Cell phones and Electronics: Out of consideration for others, please completely turn off your mobile devices or put them in silent mode.

Music/Sound: There is typically music played during treatment. Please speak softly to not disturb other patients resting.

Always report any problems you have with herbs, nutritional supplements or any treatment. Different people react differently to the same treatment or herbal prescription. It is possible for us to properly manage your care only if you tell us about difficulties you are having, or if formulations are not effective or causing you discomfort.

Herbal Formulas/Supplement Price Policy. We may recommend a product to achieve the best outcome for your health and medical needs. We have stock so that you may begin your treatment promptly. We practice fair pricing and will refund the difference, if you find a better priced, retail store product. This does not include online products, but we monitor amazon prices and ours are better.

Payment and Insurance and Cancellation Policy

Payments: Payment is due at time of service. We take cash, check, Venmo and medical credit cards. For Rolfing, we only accept cash or zelle unless otherwise arranged.

Cancellation/Late Policy: If you cancel with less than 24 hours notice, or if you miss a booked appointment, you will be charged $95, the full cost of treatment. If you are more than 15 minutes late to an appointment, we may need to reschedule your appointment.

Non-Refundable Payment Policy: All services and herbs purchased are non-refundable. No refunds will be provided for the full or partial price for any used products or services

Refund Policy on Pre-Paid Packages: Refunds are accepted for "discount prepayment packages" within the first 30 days only. When refunded you will be charged at full rate for each

treatment you have used and be refunded the remainder.

Insurance: We participate in many insurance networks and as a courtesy will verify your benefits. Please understand that ultimately, you are responsible for payment should there be any discrepancies with your insurance company at a later date.

Parking: There is NO ON-PREMISE parking. There is plenty of street parking, free and metered taking quarters and credit cards.

Thank you once again for selecting **Affinity Acupuncture & Rolfing** for your care. Should you have any specific questions that have not been answered, please do not hesitate to ask.

Sincerely,
Dr. Connie L. Christie, DAOM, L.Ac. and the entire Affinity Acupuncture Team

Signature of Patient Date

Informed Consent to Treat

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 Dr. Connie L. Christie, DAOM, L.Ac. 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 Dr. Connie L. Christie, DAOM, L.Ac., including those working at Affinity Acupuncture and Rolfing clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), muscle testing, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness or tingling near the needling site that may

last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual (rare) risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile, single use, disposal needles and maintains a clean and safe environment. Burns and/or scarring are a rare potential risk of moxibustion and cupping. I understand that this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral source) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in larger doses which will not be prescribed. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify Dr. Christie or a clinical staff member who is caring for me if I am pregnant or become pregnant.

I do not expect Dr. Christie or the clinical staff to be able to anticipate all possible risks and complications of treatment, and I wish to rely on Dr. Christie and/or the clinical staff to exercise judgment during the course of treatment which she/them thinks at the time, based upon the facts 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, the above 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. I have stated all medical conditions that I am aware of and will update my practitioner of changes in my health status.

Affinity Acupuncture and Rolfing \Providers: **Dr. Connie L. Christie, DAOM, L.Ac. & Associates**

Patient Name
Parent or Guardian (if under the age of 18)

Signature of Patient Date

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HIPPA Receipt of "Notice of Privacy Practices"

I have reviewed a copy of the clinic's Notice of Privacy Practices. (Refer: https://acupuncturemarvista.com/privacy-policy/).

Signature of Patient Date

Signature (Parent, if patient is minor)
OK to share information with (spouse, translator, etc.)

24- Hour Cancellation Policy

We understand that you may need to cancel or change your appointment. In order to maintain quality patient-centered care, we require a 24-hour cancellation notice when you are unable to keep your scheduled appointment; otherwise you will be charged $95, full price of a standard treatment For rolfing, the first time fee is $100 (full price). Please note, insurance and third party coverage do not pay this fee.

I have read and understand the above policy.

Signature Date

Covid-19 Policy

Our Covid-19 policy follows the CDC and Los Angeles County guidelines and will be updated as required to reflect the current guidelines.

Are you vaccinated? Have you received a booster?

Vaccine type Dates of vaccination

No clients will be treated in the clinic with any viral symptoms such as a fever, cough, or shortness of breath.
I have read and understand the above policy.

Signature Date