Policies

Cancellation Policy

While we realize life is unpredictable and busy, we have implemented these policies to be fair to both the practitioner and our clients that make every effort to attend their scheduled appointments.

4 hour cancellation notice is required for all treatments, or a 50% cancellation fee will be charged.
No-shows will be charged full service price.
Scheduling an appointment is your acceptance of these policies.

Lateness

If you arrive late for your scheduled appointment your treatment session may be abbreviated. Please try to be on time so you can get the fullest benefit from your treatment.

Insurance

We do not accept insurance. We are happy to provide you with a superbill that you can submit to your insurance company. You may want to check with your insurance company to determine if acupuncture is covered. Please give us a few days notice if you require a superbill.

Align Spa **Mar Corelli, L.Ac., CH, LMT**

Traditional Chinese Medicine is a comprehensive system that takes into consideration many aspects of your health. The following information will help determine your treatment, and is held in strict confidentiality.

Patient Information **Today's date_____**

Name:	Age: Height: Weight:
Address: City: State: Zip:	
Home Phone Number:	Work Phone Number:
Cell Phone Number:	Email:
Which phone number should we use to contact you?	
DOB:	Are you pregnant? Y / N Trying to become pregnant? Y / N
Occupation:	Marital Status:
Primary Care Physician: Phone Number:	
In Emergency Notify:	Referred by:
Have you tried acupuncture or Chinese herbal medicine before?	

Please list your major health concerns in order of importance to you:

1. _____ Date of Onset:_____
2. _____ Date of Onset:_____
3. _____ Date of Onset:_____

Have you been given a diagnosis for the problem by your doctor? (use corresponding numbers for each health concern)
1. _____ 2._____ 3. _____

Have you been treated with any therapies for these conditions? (kind of therapy and results)
1. _____
2. _____
3. _____

What makes it better? (e.g. heat, stretching, exercise, rest, ice)
1. _____
2. _____
3. _____

What makes it worse? 1. _____
2. _____
3._____

Past Medical History (please circle those that apply to your medical history)

AIDS/HIV	Emphysema	Kidney disorder	Seizures/Epilepsy	Other_____
Alcoholism	Eating disorder	Low blood pressure	Stroke	_____
Allergies	Fibromyalgia	Mental Illness	Substance abuse	_____
Arthritis	Gout	Multiple sclerosis	Thyroid disorder	
Arteriosclerosis	Heart disease	Pacemaker	Tuberculosis	List Allergies or Sensitivities
Asthma	Hepatitis/Liver disease	Pneumonia	Ulcers	_____
Attempted suicide	Herpes	Rheumatic arthritis	Venereal disease	_____
Blood disease	High blood pressure	Sciatica	Whooping cough	_____
Cancer or tumor	Immune Disorder	Sinus Infections		_____
Diabetes	Joint replacement	Skin Disease		

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

_____

_____

Patient Name: _____

Lifestyle: (please circle)	**N=None; L=Light; M=Moderate; H=Heavy**																			
Alcohol	**N**	**L**	**M**	**H**	Coffee	**N**	**L**	**M**	**H**	Salt	**N**	**L**	**M**	**H**	Exercise	**N**	**L**	**M**	**H**	Water	**N**	**L**	**M**	**H**
Tobacco	**N**	**L**	**M**	**H**	Appetite	**N**	**L**	**M**	**H**	Sugar	**N**	**L**	**M**	**H**	Stress	**N**	**L**	**M**	**H**	Caffeine	**N**	**L**	**M**	**H**

What types of exercise do you do? (Please list)_____
_____

Tests and Immunizations (Please list the date or year of your most recent visit)

Chest X-ray _____	TB Skin Test_____	EKG_____	Blood Work_____
GI Series _____	Flu Shot_____	Stress Test_____	Stool Test_____
Sigmoidoscopy_____	Pneumonia Shot_____	Thyroid_____	Other_____
Colonoscopy_____	Complete Physical _____	Urine Test_____	_____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences you have had (e.g. divorce, family death, bankruptcy, etc).
Date_____/_____Event_____
Date_____/_____Event_____
Date_____/_____Event_____

Are you a vegetarian? Y / N A vegan? Y / N On a special diet? Y / N (please list what kind) _____
_____

Family History (List any family physical or mental illness and age of death):
Mother_____
Father_____
Maternal Grandmother_____
Maternal Grandfather_____
Paternal Grandmother_____
Paternal Grandfather_____
Siblings_____
Children_____
Children_____

Medications (List those you are currently taking)

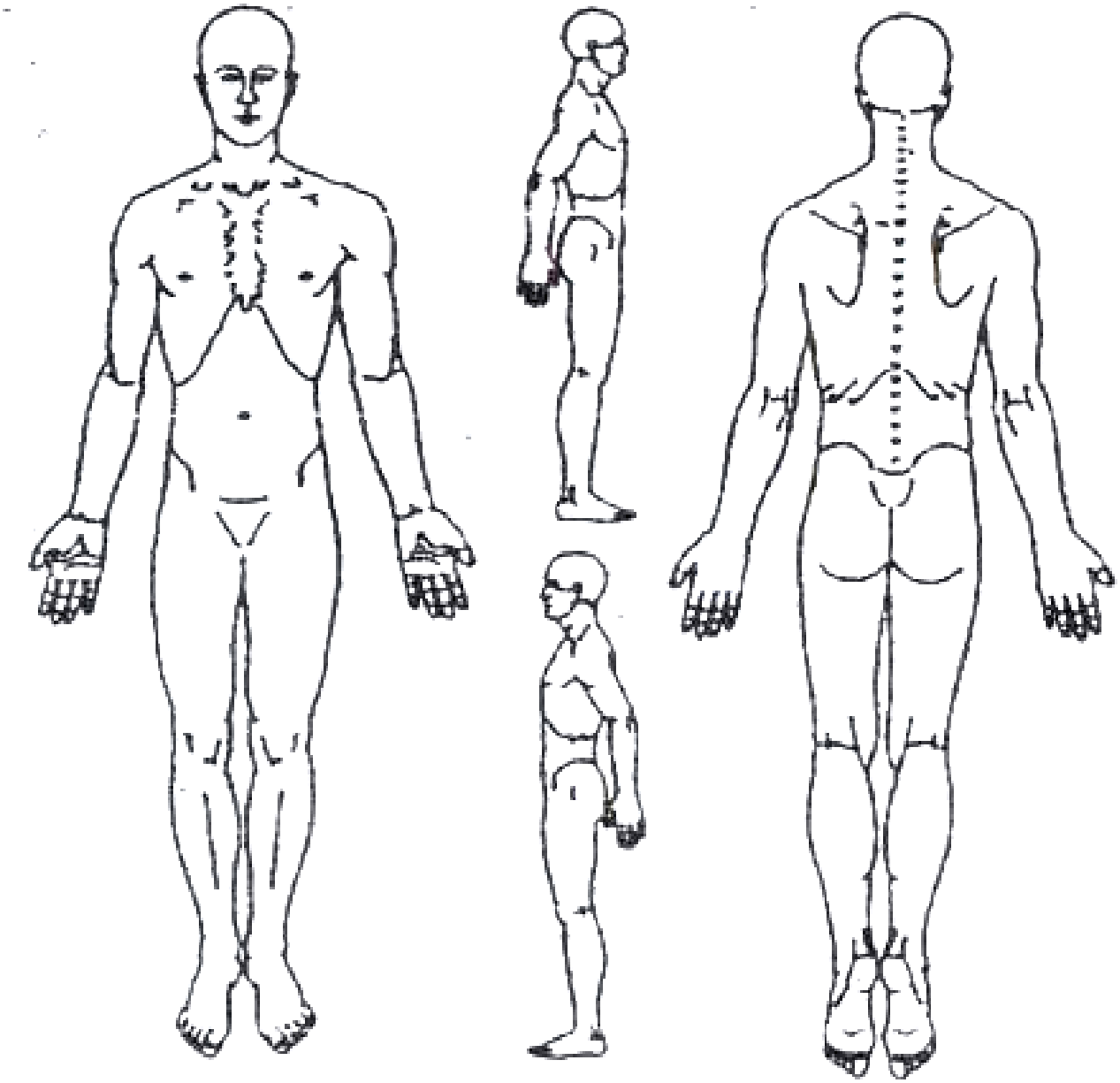
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____

Herbs and Supplements (List those you are currently taking)

Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____
Name_____Reason_____How long_____

Patient Name:_____

Please mark the area(s) on the diagrams where you are experiencing pain or tension. Next to your marked area(s), please make a note of the pain / tension level you are experiencing by writing a number **1-10 (10 being extremely painful)** . **Please also note if the pain comes and goes, is sharp, localized, radiates, dull, constant, moves from location to location, and how long you have been experiencing the pain.**



If you have had a symptom in the **PAST** and do not have it now, check the box like this: ☒
If you are having the symptom **CURRENTLY**, fill in the box like this: ■

Liver/Gallbladder
- ☐ Depression / Stress
- ☐ Headaches / Migraines
- ☐ Red/Dry/Itchy Eyes
- ☐ Visual Problems / Blurred Vision
- ☐ Diminished night vision
- ☐ Eye Floaters
- ☐ Herpes
- ☐ Gallstones
- ☐ Feeling of lump in throat
- ☐ Clenching teeth
- ☐ Muscle Cramping
- ☐ Muscle Twitching
- ☐ Neck / Shoulder Pain / Tightness
- ☐ Numbness in Extremities
- ☐ Hernia
- ☐ Dizziness
- ☐ Vertigo
- ☐ Seizures/Tremors
- ☐ Poor Circulation
- ☐ Soft / Brittle Nails
- ☐ Bitter Taste in Mouth
- ☐ Tendonitis
- ☐ Pain below Rib Cage
- ☐ Localized weakness
- ☐ Crave Sour Taste
- ☐ Greasy Foods cause Abdominal Pain
- ☐ Easily Startled
- ☐ Tend to be Irritable/Angry

Lung/Large Intestine
- ☐ Bloody Cough
- ☐ Dry Cough
- ☐ Chronic Cough
- ☐ Cough with Sputum
- ☐ Nasal Discharge ☐White ☐Yellow ☐Green
- ☐ Post Nasal Drip
- ☐ Sinus Infection
- ☐ Sinus Congestion
- ☐ Itchy, Red or Painful Throat
- ☐ Dry Mouth / Nose / Throat
- ☐ Skin Rashes/Hives
- ☐ Shortness of Breath
- ☐ Low Immunity
- ☐ Catch Cold Easily
- ☐ Bronchitis
- ☐ Snoring
- ☐ Allergies
- ☐ Asthma
- ☐ Swollen Glands
- ☐ Crave Spicy/Pungent Taste
- ☐ Feeling of Oppression in Chest
- ☐ Tend to be Sad / Feeling Grief

Heart /Small Intestine
- ☐ Heart Palpitations
- ☐ Rapid or Irregular Heart Beat
- ☐ Forgetful
- ☐ Pale Lips / Tongue
- ☐ Red Complexion
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Spontaneous Sweating w/o Exertion
- ☐ Blood Clots
- ☐ Tight Chest
- ☐ Difficulty Breathing
- ☐ Crave Bitter Taste
- ☐ Mouth / Tongue Ulcers
- ☐ Insomnia _____Hrs of Sleep Usually
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Vivid Dreams
- ☐ Tend to be Anxious / Restless

Spleen/Stomach
_____Energy Level: 1-10 (low to high)
- ☐ Muscles often feel Tired / Heavy
- ☐ Hard to get up in AM
- ☐ Low Appetite in AM
- ☐ More tired after a Meal
- ☐ Edema Hands / Feet
- ☐ Belching
- ☐ Bad Breath
- ☐ Gums Bleed Easily
- ☐ Bloating
- ☐ Lack of Taste
- ☐ Organ Prolapse (i.e. uterus)
- ☐ Bruise / Bleed Easily
- ☐ Gas
- ☐ Acid reflux
- ☐ Nausea / Vomiting
- ☐ Blood in stools
- ☐ Abdominal Pain / Cramping
- ☐ Chronic Loose Stools
- ☐ Tendency to Gain Weight
- ☐ Foggy Brain
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Bowel Movement frequency:_____
- ☐ Crave Sweet Taste
- ☐ Tend to Over-think / Worry

Kidney/Urinary Bladder
- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Wake to urinate
- ☐ Urinary Urgency
- ☐ Difficult urination
- ☐ Urination ☐Clear ☐Yellow ☐Dark ☐Cloudy
- ☐ Loss of Urine when Sneeze / Jump / Cough
- ☐ Weakness / Pain in Low Back
- ☐ Low or Excess Sex Drive (circle which)
- ☐ Feel Cold or Hot Easily (circle which)
- ☐ Cold Hands / Feet
- ☐ Osteoporosis
- ☐ Infertility
- ☐ Thyroid Problems
- ☐ Dark Circles under Eyes
- ☐ Kidney stone
- ☐ Impotence / Premature Ejaculation
- ☐ Prostate Issues
- ☐ Poor Memory
- ☐ Hair Loss
- ☐ Grey Hair (premature)
- ☐ Hearing Problems
- ☐ Tinnitus ☐Low Pitch ☐High Pitch
- ☐ Excess Cavities
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Crave Salt Taste
- ☐ Tend to be Fearful

Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxabustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise prescriptions, and lifestyle counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring. Temporary bruising and redness lasting a few days is a common side effect of cupping and gua sha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial affects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking my herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise her judgment in my best interest during the course of treatment, based upon facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment and payment incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep her updated on any changes.

Patient Signature Date

Parent or Guardian Signature for Patients under the age of 18 Date