Welcome !

Please Print: **Name:**_____ **Date**_____
Address:_____ **City**_____
ST____ **Zip**_____ **Home Tel(**____**)**_____**Cell(**____**)**_____
Bus. Tel(____**)**_____ **Email:** _____
Occupation:_____**Employer**_____
Referred by: _____ **Date of Birth:**_____
Reason For Appointment: _____
_____
How does it interfere in your daily activity? _____
_____

Please state injuries/medical treatments/surgeries including medications relative to above reason.

_____
_____
_____

Any past injuries/medical treatments/surgeries/medications that relate to your visit

_____
_____

Circle if you have any concerns with or need to note the following:
Acid Reflux ADD/ADHD Allergies Anxiety Arthritis Asthma Blood Bone Disease Bowel Disorder Cancer Cholesterol Chronic Fatigue Chronic Pain Circulation Constipation Depression Diabetes Digestion Ears Equilibrium Emotions Energy Eyes Gas Grief Headaches Heart Infection Kidney Metal Implants Muscular Neurological Night Sweats Phlebitis Respiratory Sinusitis Skin Sleep Thyroid TMJ Urinary Varicose Veins Others_____
List Any Specifics To Those Circled _____
_____

Woman: **Pregnant Menopause PMS Syndrome Hormone Replacement**
any disorders that affect overall health_____
_____

Men: **Prostate other disorders** _____
Please provide name/address of your physician /health care provider _____
_____

Kindly observe a 24 hour notice for cancellation, other wise full payment is due. Thank you for your understanding.

Signature_____

all information is held confidential according to HIPPA Laws and Regulations

HIPAA Consent Agreement for the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I understand that as part of my healthcare, **Unified Body Therapy** 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 and as a means of communicating to other health care providers.

- a source of information for applying my diagnosis and treatment information to my bill and a means by which a third-party payer can verify that services billed were actually provided. It is also a tool for routine healthcare operations.

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

- I understand that I have the right to review and/or revoke any portion of this notice in writing prior to signing this consent. I understand that this business 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 Unified Body Therapy Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing after I sign, except to the extent that Unified Body Therapy Practice has already take action in reliance thereon.
  I request **the following restrictions** to the use or disclosure of my health information:
  _____
  _____
  _____
  _____

- Signature of Patient or Legal Representative Witness Date Notice Effective Date or Version
  ____Accepted _____ Denied
  Date_____

- Signature_____

Unified Body Therapy

Informed Consent Form For Acupuncture & Oriental Medicine

I, the undersigned, hereby authorize Charles Cooper Jr. to perform the following procedures as needed:

Acupuncture: The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.
Acupressure, and Manual Therapy: The use of Traditional Chinese medical massage and therapeutic bodywork.
Infrared Heat Therapy: Applying heat generated by an infrared lamp over a specific area.
Moxabustion: Heated moxa stick used over specific areas of the body.
Electroacupuncture: Using minute amounts of electricity to stimulate specific acupuncture points.
Heat and/or Cold Packs: Used for reducing inflammation and relaxing tense muscles.
Therapeutic Exercises: Gentle stretching within safety range of the body's present capabilities.

I recognize the potential benefits and risks of these procedures as described below:

Potential Benefits: Drugless relief of presenting symptoms and improved balance of body. Its purpose is to promote health and assist with organic and functional disorders. This can include muscular-skeletal injuries, pain, digestive disorders, respiratory diseases, men and women's health issues.

Potential Risks: Acupuncture and moxabustion has been shown by medical authorities to be relatively safe. Uncommon potential risk may include but not limited to temporary discomfort or pain, minor bruising, blistering, bleeding, dizziness, fainting, nausea, temporary discoloration of the skin, and heat markings. To improve, a possible temporary aggravation of symptoms existing prior to the acupuncture treatment may occur.

Use of Disposable Needles: To reduce the remote possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles.
After each treatment they are disposed of as medical waste, needles are never reused.
Additionally, your acupuncturist is trained in Clean Needle Technique and Universal Precautions.

Patients with bleeding disorder, pacemakers, wearing other electronic medical device or pregnant should inform the practitioner prior to receiving treatment.

Please notify your practitioner if you have any adverse effect from treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees are given to me regarding cure or improvement of my condition. I hereby release Charles Cooper Jr. Lic. Ac. from any and all liability, which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Patient's name (Please print)

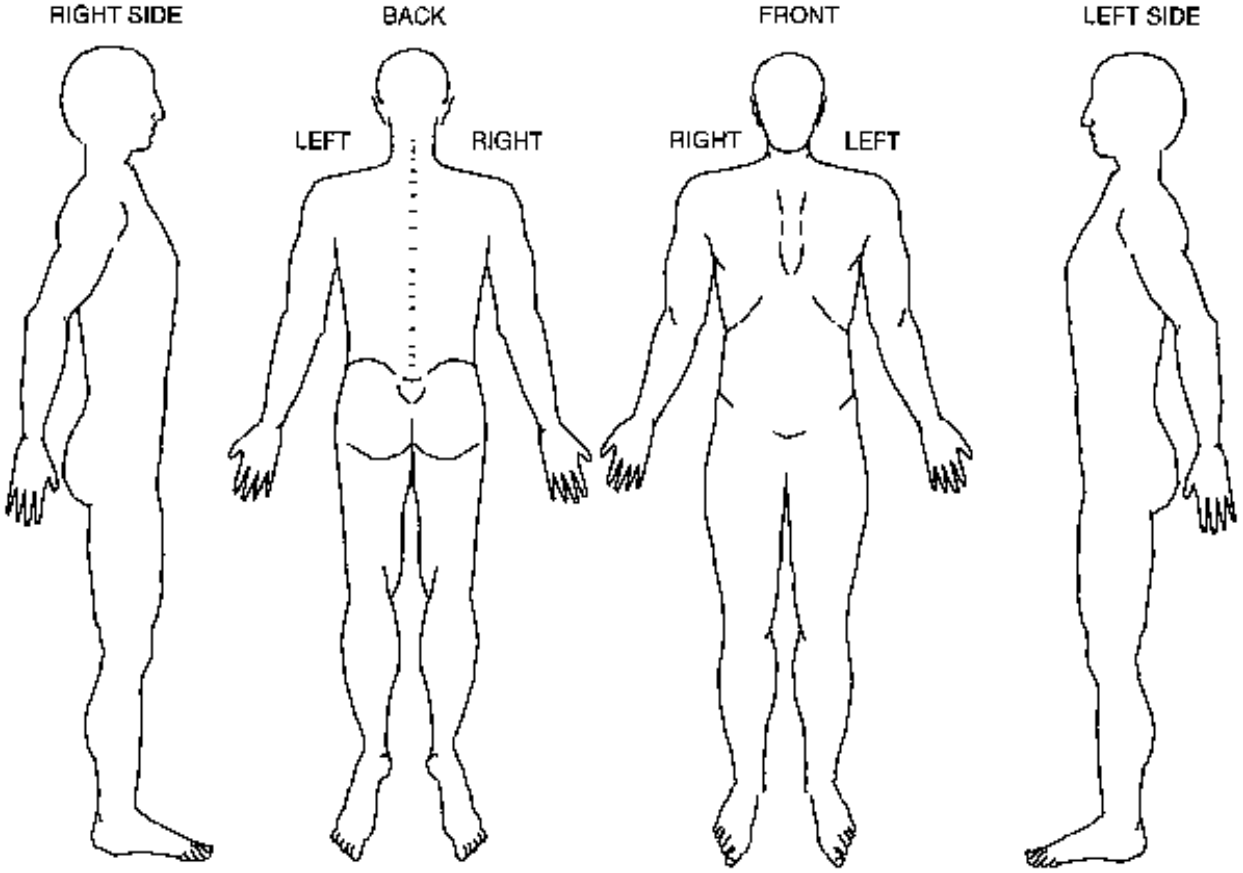
_____ Date_____

Patient's Signature_____

If patient is a minor:
Signature of Parent or Legal Guardian _____

Charles Cooper Jr. Lic. Ac. received his Master's Degree in Acupuncture from Academy For Five Element Acupuncture, passed the National Board Examination {NCCAOM} and is license in Massachusetts.

These are diagrams of the body. PLEASE SHADE/MARK WHERE YOU FEEL OR HAVE FELT THE ACHES AND PAINS



NOTE ANY FURTHER COMMENTS:

INTENSITY WITH 10 BEING THE VERY WORST to 1 Hardly Noticeable

A SPECIFIC FEELING: DEEP ACHE - SHARP/BITE - ELECTRICAL - DULL ACHE
THROBING/PULLING/GRABBING - IRRITATING SORENESS
OTHER =

Please circle and comment on what is important to you.

How do you view your over all energy?
Satisfied…. Steady….Lower then desired….Strong ….Up/Down to much…._____

Do you recognize a pattern in the quality of your energy in relationship to time? _____

Quality of Sleep? _____

How much coffee or other stimulants do you use to help with your energy? _____

What feeds your energy besides food?
Art… Relationship….Science….Work…. Animals….. Sports….Other:
_____

Do you have a particular food regimen? _____
_____

Exercise?_____

Favorite season or time of day?_____

What different models of body therapy/energy work have you experienced? Polarity Therapy Chiropractic Acupuncture Massage. Reiki. Other: _____

Do you have a belief system aka…Religion, Philosophy, Political Theory, Astrology, Numerology etc. that supports your decision process? _____

What are your goals for treatment? _____
_____
_____

Additional Comments/Questions
_____
_____
_____