Thrive Health, Inc.
Clare Mallory O'Nan, O.M.D., M.Ac., Dipl.Ac. (NCCAOM), L.Ac.
500 Russell Street #29, Starkville MS 39759
662.597.1003

Please Note:

Some of the questions on the following pages may seem irrelevant to why you are here; please answer *everything* as thoroughly as possible regardless.

Traditional Chinese Medicine views the body in a completely different way from the medicine we are used to here in the West, and the more information I have regarding your overall health (physical, mental, and spiritual) the more effective your treatment course will be.

Thank you for your cooperation, and I look forward to being your partner in health and wellness,

Clare Mallory O'Nan, L.Ac., O.M.D.

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Information and Office Policies

Welcome, and thank you for choosing me as your acupuncturist. I look forward to working with you. Please take a moment to read the following information and office policies. We will have time during our first visit for you to ask me any questions you might have about my background or Chinese medicine in general. If you have any other concerns, please feel free to bring them up at any time.

In order for acupuncture to be the most effective, it is important to remember to eat before your appointments. For your own comfort, loose-fitting clothes are recommended.

In consideration of other patients, please try to be on time for your appointments.

At your first visit, most of our time will be spent discussing your main complaint and history. Together with your acupuncture treatment, this usually lasts one and a half hours; subsequent visits last approximately 45 minutes. My fee is $200 for the first office visit, and return visits are $100. If additional modalities are needed (electrical stimulation, scalp acupuncture, moxa), there is an additional charge of $10 for the first modality and $5 for each additional modality. **We do not offer discounts.**

I accept payment by cash, check, or charge (Visa/Mastercard). There is a $25 penalty for a bounced check. If a second check bounces, I will require cash-only payment from then on. I do not accept insurance, but I am happy to provide a superbill for you to send to your insurance company that may result in full to partial compensation.

PLEASE READ AND INITIAL: While we know that life happens and emergencies come up, we also have a business to run and often can't fill last-minute cancellations. **If you have to cancel your appointment on the same day, the full fee of $100 will be added to your account (unless you have a membership plan). If you "no-show" for your appointment, we will require a credit card on file prior to booking any future appointments and will run the card for the full fee the day of the appointment whether or not you show up.** Barring true emergencies, **there are NO EXCEPTIONS to this policy.** We appreciate your cooperation. _____ **(initial)**

Client Acknowledgement:

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I understand the contents of this disclosure and agree to abide by these policies.

_____ _____

Signature of Client Date

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Consent Form

I, the undersigned, hereby authorize Clare O'Nan, L.Ac., who is currently licensed in the State of Mississippi (License AC00008) to perform the following acupuncture procedures:

Acupuncture: The insertion of special sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body.

Cupping: A technique used to relieve symptoms by applying cups made of glass, bamboo, or other materials to the skin with a vacuum created by heat or other devices.

Moxibustion (Moxa): The burning of herbs on or near the body to warm it, strengthen it, and relieve symptoms. Moxa comes in several forms, such as stick, string, ball, cone, or rice grain.

Acupressure/Reflexology: A technique of Chinese medical pressure based on acupuncture theory, used for a variety of common disorders.

Dietary Advice: Food and herbal advice based on traditional Chinese medical theory.

Western Herbs/Homeopathics: Advice based on the study of herbs and homeopathic medicine.

Electro acupuncture: The running of very low electrical current through one or more needles to help heal the body.

I recognize the potential risks of these procedures as described below

Although extremely uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites; minor bruising or temporary discoloration of the skin; infection; "needle sickness" (weakness, fainting, nausea); and potentially an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pacemakers should inform their practitioners prior to treatment.

I understand that acupuncture is not a substitute for conventional medical diagnosis and treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Clare O'Nan, L.Ac., regarding the cure or improvement of my conditions.

I hereby release Clare O'Nan, L.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 my consent and to discontinue participating in these procedures at any time.

_____ _____

Signature of Client Date Signature of Legal Guardian Date

_____

Signature of Witness Date

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NOTIFICATION TO ACUPUNCTURIST OF PHYSICIAN EVALUATION
Pursuant to the requirements of MS Code of 1972 Section 73-71-7
of the Acupuncture Practice Act, effective July 1, 2017

Patient Name (print) _____

I am notifying the acupuncturist above of the following:

I have been evaluated by a physician for the condition being treated within 6 months before the acupuncture was performed. I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist.

Signature _____ Date _____

OR

I am requesting treatment for one of the conditions below, which does not require a physician evaluation.

Smoking addiction
Weight loss
Substance abuse

Signature _____ Date _____

Note:
1. Please be advised that acupuncture is not a substitute for conventional medical diagnosis or treatment. The acupuncturists will discuss treatment techniques and get informed consent from the patient.
2. If your condition does not improve you will be referred to your primary care doctor for an evaluation.

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Health History Questionnaire

Please take a moment to thoroughly fill out this questionnaire so that we may provide you with a complete evaluation. All of your answers will be held absolutely confidential. If you have any questions, please ask.

Today's Date: _____

CONTACT INFO

Name	*First*	*Last*		*Middle*
Address	*Street*	*City*	*State*	*Zip*
Telephone #	*(Home):*	*(Work):*	*(Cell):*	
Email				
Emergency	*Name:*		*Phone:*	

ADDITIONAL INFO

Personal	*Date of Birth:*	*Age:*
Medical	*Name of Your Primary MD:*	
	Date of Last Physical Exam:	*Significant results:*

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Current Problem/Reason for Visit

Is this accident related? ☐ Yes ☐ No If yes, date of accident: _____

What is your main complaint today?

When did this problem begin (please be specific)?

What do you think caused it?

What treatments have you tried already? What were the results?

Have you been given a diagnosis for this problem? If so, what and when?

To what extent does this problem interfere with your daily activities (work, sleep, eating, sex…)?

Have you ever received acupuncture before? ☐ Yes ☐ No

How did you hear about us?

If changing your diet or lifestyle would reduce your discomfort, would you be willing to change some things? ☐ Yes ☐ No

Do you have any reason to believe you are pregnant? ☐ Yes ☐ No

If so, how far along are you? _____

Comments: Please list any other problems you would like to discuss:

PAST MEDICAL HISTORY:

- ❒ Arthritis
- ❒ Heart Disease
- ❒ Low Blood Pressure
- ❒ Cancer
- ❒ Hepatitis
- ❒ Seizures
- ❒ Diabetes
- ❒ High Blood Pressure
- ❒ Stroke
- ❒ STDs
- ❒ Thyroid Disease
- ❒ Other

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Current Problem List/Reason for Visit, cont.

Surgeries (type and date):

Significant Trauma (auto accidents, falls, etc.):

Allergies (drugs, chemicals, foods):

Significant Occupational Stress (chemical, physical, psychological, etc.):

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.) and for what:

HABITS/SOCIAL:

Do you exercise? Please describe:

Please list any cravings you have on a regular basis:

Please indicate usage per day or week:

_____ Cigarettes per ☐ Day ☐ Week

_____ Alcoholic Beverages per ☐ Day ☐ Week

_____ Caffeinated Beverages (coffee, tea, cola, etc.) per ☐ Day ☐ Week

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Review of Symptoms

Please <u>circle</u> any of the following symptoms that you experience now and <u>underline</u> any that you have experienced in the past.

HEART

Dizziness	Insomnia	Awaken easily	Unable to fall asleep
Heavy sleep	Unable to stay asleep	Dream disturbed sleep	Poor Memory
Fainting	Palpitations	Anxiety	Nervousness
Sores on tip of tongue	Restlessness	Mental Confusion	Chest pain
Frequent dreams	Awaken unrefreshed	Murmurs	Disturbing dreams
Nightmares	Rapid heart beat	Irregular heart beat	Coffee (# cups per week ___)
Ankle swelling	High blood pressure	Low blood pressure	Heart murmurs

LUNG

Nasal discharge	Cough	Dry cough	Nose bleeds
Sinus congestion	Dry mouth	Dry throat	Dry skin
Dry nose	Allergies/hay fever	Sneezing	Alternating fever/chills
Overall aching	Stiff neck/shoulders	Sore throat	Difficulty breathing
Smoke cigarettes	Sadness	Melancholy	Asthma/wheezing
Phlegm	Shortness of breath	Frequent colds	Odd taste/smells
Rashes	Changes in skin	Coughing up blood	Dandruff
History of pneumonia	Slow wound healing	Chest congestion	Recent moles
History of skin cancer	Frequent sore throats	Aversion to talking	Difficulty breathing lying down
Take afternoon naps	Acne	Warts	Hoarse voice
Loss of smell	Stuffy/runny nose	Postnasal drip	

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SPLEEN/STOMACH

Low appetite	Pensive	Abrupt weight gain/loss	Abdominal gas/bloating
Gurgling noise in stomach	Large appetite	Change in appetite	Gnawing hunger
Food cravings	Obesity	Tire easily	Hemorrhoids
Prolapsed organs	Boils	Fungal infections	Bleed/bruise easily
Over-thinker	Worrier	Nose bleeds	Lack of concentration
Varicose veins	Rectal pain	Incomplete stools	Nausea
Hypothyroid (diagnosis)	Hyperthyroid (diagnosis)	Loose stools	Constipated
Diarrhea	Blood in stools	Mucus in stools	Undigested food in stool
Black stools	Abdominal pain/cramps	Snoring	Sensation of heaviness
Mental heaviness	Mental fogginess	Phlegm	Swollen joints
Burning after eating	Fatigue after eating	Bad breath	Heartburn
Mouth/canker sores	Acid regurgitation	Ulcer (diagnosis)	Belching
Hiccups	Stomach pain	Vomiting	Food allergies
Itching (where? _____)	Hives	Awaken fatigued	Difficulty keeping eyes open
Loss of taste	Food sits in stomach	Indigestion	Sweet taste in mouth
Rectal itching	Anemia	Worry a lot	Feel overwhelmed
Ruminate	Unable to focus on tasks	Dull thinking	

LIVER/GALLBLADDER

Bitter taste in mouth	Anger easily	Frustration	Alternating diarrhea/constipation
Constipation	Tight sensation in chest	Depression	Irritability
Hip pain	Knee pain	Muscle pain	Vertex headaches (top of head)
Migraines	Grinding teeth	Jaw clicks	Frequently unable to adapt to stress

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Mood swings	Chest pain	Tingling sensation	Numbness
Muscle spasms	Seizures	Muscle twitching	Muscle cramping
Convulsions	Paralysis	Tremors	Limited range of motion, shoulder
Lump in throat	Elbow pain	Neck tension/pain	Limited range of motion, neck
Shoulder tension/pain	Joint pain	Drink alcohol	Upper back pain/tension
Hand/wrist pain	Gallstones	History of stroke	Recreational drug use
Itchy eyes	Bloodshot eyes	Dry eyes	Watery eyes
Gritty eyes	Blurry vision	Decreased night vision	Near/far sighted
Floaters	Eye pain	Eye discharge	Excessive tearing
Eye strain	Mental tension	TMJ/jaw pain	Vertigo/dizziness
Poor coordination	Fingernail problems	Painful scars	History of sexually transmitted diseases
Like to be in control	Agitated a lot	Lose temper easily	Difficulty making decisions
Easily stressed	Work/family problems	Hold grudges	Hyperactive
Pessimistic	Perfectionist	High-pitched ringing in ears	

KIDNEY/URINARY BLADDER

Cold hands	Cold fingers	Cold feet	Sweaty hands/feet
Cold toes	Cold back	Hot body temperature	Night sweats
Cold abdomen	Cold body temperature	Afternoon flushes	Hot flashes
Heat in hands/feet	Thirsty	Strong thirst for cold	Take water to bed
Perspire easily	Lack of perspiration	Sweat easily	Excessive sweating
Chills	Fever	General weakness	Thirst with no desire to drink
Localized weakness	Low energy	Fatigue	Easily catch colds

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Feel worse after exercise	Sudden energy drop	Swollen hands/feet	Poor balance
History of concussions	Frequent cavities	Tooth pain/problems	Easily broken bones
Easily startled	Sore/weak knees	Cold sensation in knees	Low back pain
Foot/ankle pain	History of fractures	Bone problems	Genital sores
Chronic infections	Diabetes (diagnosed)	CFS (diagnosis)	Significant childhood injuries
Kidney stones	Memory problems	Excessive hair loss	Bladder infections UTIs
Lack of bladder control	Genital sores	Kidney disease	Low-pitched ringing in ears
Wake to urinate	Hearing issues	Changes in hair	Earaches
Dark urination	Reddish urination	Urgency	Cloudy urination
Scant urination	Profuse urination	Strong odor to urine	Burning on urination
Painful urination	Vaginal discharge	High libido	Low libido
Too hot	Too cold	Poor endurance	Painful sex
Change in sexual energy	Bedwetting	Unusual fears	Forgetful
Often disoriented	Generally fearful	Low motivation	Prolonged recovery following illness

WOMEN ONLY

Heavy periods	Light periods	Painful periods	Irregular periods
PMS emotional	PMS physical	Endometriosis (diagnosis)	Fibroids (diagnosis)
PCOS (diagnosis)			

Age of first menses ____	Length of full cycle ____	Length of menses _____	Last menses start date _____
# pregnancies ____	# births ____	# premature births ____	# miscarriages ____
# abortions ____			

Any significant problems during pregnancy?

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Policy for Cancelled/Missed Appointments

Cancellation/Rescheduling Policy: While we know that life happens and emergencies come up, we set aside time for your appointment and often can't fill last-minute cancellations. We **request a 24-hour notice** for any cancelled appointment.

Same-day cancellations significantly affect our business; therefore, for same-day cancellations, barring true emergencies, you will be charged the full appointment fee of $80 **unless you have a membership plan**. **There are NO EXCEPTIONS to this policy**. In order to reschedule your missed appointment, we will need the full amount of the missed/cancelled appointment be paid in full.

I, the undersigned, understand the above clinic policy.

_____ _____
Signature of Patient Date

_____
Printed Name

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Acknowledgment of Receipt of Privacy Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Clare Mallory, L.Ac.'s Notice of Privacy Practices.

I understand that if I have any questions regarding this Notice of Privacy Practices, or of my privacy rights, I can contact Clare Mallory, L.Ac.

_____

Signature of Client Date

_____

Signature of Parent, Guardian, or Personal Representative Date

_____

Legal Relationship to Client

For Office Use Only

Client Name: _____

Date of First Service: _____

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OFFICE USE ONLY:

FIRST OFFICE VISIT

Name: _____
Date: _____

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