Wilder Health ~ Acupuncture and Herbal Medicine
102 N Main St. Halfway OR 97834
Email: wilderhealth@gmail.com

Dear Patient,

- Welcome to your first acupuncture and herbal treatment with Hopi Wilder, L.Ac.

- Please wear loose fitting clothes that can be rolled up and down. Let me know if you are cold and need a blanket or are uncomfortable at any time with your "bell".

- Please avoid wearing cologne or perfume in the clinic.

- Come to your treatment well hydrated and having eaten within four hours. Large meals within the hour are to be avoided. It is acceptable to eat anytime afterwards.

- Please respect other people's treatments by talking quietly while in the clinic and refraining from using your cel phones.

- Patient is responsible for payment at time of service. Cash, check and insurance are accepted. If you are paying with insurance the insurance rate is expected until your deductible is met. Then, all you are responsible for is your co-pay.

Initial Consultation, Health History and Treatment (1.5 hours)	$95
Private one hour, cash, check, credit card and insurance rate	$75
Community clinic	$15-40
Herbal Consultation (after first visit)	$75

- Cancellations must be made at least 24 hours in advance in order to avoid being charged. Patients canceling the same day of treatment will be charged 50%. Missed appointments will be charged 100% unless there is a bona fide emergency.

- I hope you enjoy your journey to greater health. I can always be reached by phone or email if you have any questions or concerns.

- Please keep this for your records. Thank you!

Signature: ______________________________ Date: ____________________

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PATIENT INFORMATION INFORMATION	CONTACT
Date______________________________________ Name_____________________________________ Address___________________________________ City State Zip_____________________________ Age__________ Birth date __________________ Height _______Weight___________Sex_________ Marital Status _____________________________ Occupation ________________________________ Company name______________________________ Primary physician ___________________________ Physician phone number_____________________ How did you hear about us?__________________ ____	Home phone _______________________________ Work phone ________________________________ Other/cell phone ____________________________ Email _____________________________________ Health Insurance____________________________ Phone # ___________________________________ Policy #___________________________________ Address ___________________________________ Another person we may contact if needed: Name _____________________________________ Relationship________________________________ Home phone ________________________________

HEALTH HISTORY

What are your primary health concerns?

1. ______________________________________
2. ______________________________________
3. ______________________________________

How is your sleep? _________________________

____

How is your digestion? ______________________

What do you eat for breakfast? ________________

Lunch ______________________________________

P.M. _______________________________________

Allergies. ___________________________________

Habits: □ cigarettes □ coffee □ tea □ soda □ alcohol □ cannabis □ sugar □ pain-relievers □ other ________

Exercise: __________________x/week? __________

List medications or food supplements, and/or concurrent therapies. ___________________________________

____

List serious illnesses, accidents or surgeries, and/or hospitalizations. ____________________________

____

Circle illnesses that have occurred in blood relatives:

□ Diabetes □ High blood pressure □Stroke
□ Mental Illness □ Cancer □ Heart Disease
□ Kidney Disease □ Epilepsy

Lab test you have had recently:_________________

____

Check symptoms you have or have had in the last year:

□ Depression
□ Difficulty in focusing
□ Dizziness
□ Easily startled
□ Excessive worry
□ Excessive anger
□ Excessive fear
□ Fatigue/tiredness
□ Headaches
□ Loss of sleep/poor sleep
□ Loss or gain of weight
□ Nervousness/irritability
□ Overwhelmed by life
□ Psychiatric diagnosis

Check conditions you have or have had in the past:

□ AIDS
□ Allergies
□ Anemia
□ Arthritis
□ Bleeding disorders
□ Breast lump
□ Cancer
□ Diabetes

How long has it been since you have had a complete Medical exam? ____________________________

Health History…continued

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES
- □ Tremors/Cramps
- □ Swollen joints

Pain, weakness, numbness in:
- □ Arms or Hips
- □ Back/Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other__________________

EYES/EAR/NOSE/THROAT/RESPIRATORY
- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN
- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats

GENITO/URINARY
- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Lowered libido

CARDIOVASCULAR
- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL
- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

FOR MEN ONLY
- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble

FOR WOMEN ONLY
- □ Bleeding between periods   Age 1st period:_______
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS Describe: ______________________________
- □ Previous miscarriage
- □ Scanty menstrual flow
- □ Breast implants, cosmetic surgery

Could you be pregnant?_____________

Anything else you would like to add? ____________

____

The information on this form is correct to the best of my knowledge.

Signature____ Date___________________