Japanese Acupuncture Clinic

Tamie Taniguchi Bilazzo Lic. Ac. M.A.O.M.

Health Questionnaire

This Health Questionnaire was made for patients who come to see me for autoimmune diseases and other chronic diseases which manifest in multiple symptoms. Please fill out the section “applicable to your need” as accurately as you can. This is essential for the diagnosis procedure and helps me to provide you with better treatment.

This information is absolutely confidential.

Date

Name

Email Address

Street Address

City

ZIP

Phone (Cell)

(Home)

(Work)

Date of Birth

Height

Weight

Referred By

What has been diagnosed by your doctor?

Complaints / Concerns

What do you hope to achieve with me?

List all current medications you are taking:

List all current supplements you are taking:

List any food or other sensitivities I should be aware of:

What are the top 3 health concerns you would like me to focus on?

List any other health issues:

When was the last time you felt well?

Did something trigger a change in your health? If so, what?

What makes you feel worse?

What makes you feel better?

Let me know what you have tried in the past. Describe problems (e.g. Post Nasal Drip) and prior treatment and approach (e.g. Nasal Rinse).

Patient BIrth History

- ◯ term
- ◯ premature
- ◯ vaginal delivery
- ◯ c-section delivery

Pregnancy complications:

Birth complications:

Were you bottle fed or breast fed?

- ◯ bottle fed
- ◯ breast fed (enter how long)

Childhood

At what age were you introduced to solid foods?

At what age were you introduced to dairy?

At what age were you introduced to wheat?

Did you eat a lot of candy or sugar as a child?

- ◯ no
- ◯ yes

Did you have frequent ear infections?

- ◯ no
- ◯ yes

As a child, were you up to date with immunizations?

- ◯ no
- ◯ yes

Do you feel that immunizations have had an impact on your health?

- ◯ no
- ◯ yes

Did you have any strong reactions to certain vaccinations?

- ◯ no
- ◯ yes

Grade School

Did you develop any food or seasonal allergies?

- ◯ no
- ◯ yes

Did you develop asthma?

- ◯ no
- ◯ yes

Did you have any serious infections or experience any trauma?

- ◯ no
- ◯ yes

List any other health issues:

High School

Did you have acne that required antibiotics?

- ◯ no
- ◯ yes

Did you have mono?

- ◯ no
- ◯ yes

List any other health issues:

College

List any health issues:

Adulthood

List any health issues:

List the date when you had the following preventative tests done:

Full physical exam	
Bone density	
Colonoscopy	
Cardiac stress test	
EBT heart scan	
EKG	
Hemoccult test (stool test for blood)	
MRI	
CT scan	
Upper endoscopy	
Upper GI series	
Ultrasound	

Do you have heart problems?

- ◯ no
- ◯ yes

Do you have a pacemaker?

- ◯ no
- ◯ yes

Do you have any scars on your face, neck, abdomen or along the spine?

- ◯ no
- ◯ yes

Do you have a deviation of your nasal septum?

- ◯ no
- ◯ yes

Do you have any ear problems?

- ◯ no
- ◯ yes (describe) _____

Do you have any allergies?

- ◯ no
- ◯ yes (describe) _____

Do you have multiple chemical sensitivities?

- ◯ no
- ◯ yes (describe) _____

Do you have multiple food sensitivities?

- ◯ no
- ◯ yes (describe) _____

Do you have a latex allergy?

- ◯ no
- ◯ yes

Do you have metabolic/endocrine problems?

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Pre-Diabetes
- ☐ Hypothyroidism (Low Thyroid)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Endocrine Problems
- ☐ Infertility
- ☐ PCOS
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Frequent Weight Fluctuation
- ☐ Binge Eating Disorder
- ☐ Night Eating Syndrome

Surgeries

- [ ] Appendectomy
- [ ] Hysterectomy =/- Ovaries
- [ ] Gall Bladder
- [ ] Hernia
- [ ] Tonsillectomy
- [ ] Joint Replacement - Knee/Hip
- [ ] Heart Surgery - Bypass Valve
- [ ] Angioplasty - Stent
- [ ] GI Surgery
- [ ] Caesarean Section

Blood Type

- ◯ A
- ◯ AB
- ◯ B
- ◯ O
- ◯ Rh+
- ◯ Unknown

List dates and reasons for any hospitalizations:

Family History

Please list your immediate family history (e.g., Mother - diabetes, asthma, eczema, Father - hives, food allergies, Gout, Daughter - ADHD, celiac disease, Aunt - Hashimoto's disease, anemia, and obesity):

Do you have any ear problems?

- ◯ no
- ◯ yes (describe)

Please list all illnesses, surgeries and accidents:

Travel History

Foreign travel?

- ◯ no
- ◯ yes (list when and where) _____

Wilderness camping?

- ◯ no
- ◯ yes (list when and where) _____

When traveling or camping, have you ever experienced severe Gastroenteritis or Diarrhea?

- ◯ no
- ◯ yes

Dental History

Silver mercury fillings?

- ◯ no
- ◯ yes

Gold fillings?

- ◯ no
- ◯ yes

Gum surgery?

- ◯ no
- ◯ yes (list how many and locations) _____

Root canals?

- ◯ no
- ◯ yes (list how many and locations) _____

Implants?

- ◯ no
- ◯ yes

Tooth pain?

- ◯ no
- ◯ yes

Bleeding gums?

- ◯ no
- ◯ yes

Gingivitis?

- ◯ no
- ◯ yes

Problems with chewing?

- ◯ no
- ◯ yes

TMJ / nighttime grinding?

- ◯ no
- ◯ yes

Do you floss regularly?

- ◯ no
- ◯ yes

Nutrition History

Highest adult weight:

Lowest adult weight:

Has your weight ever fluctuated more than 10 pounds?

- ◯ no
- ◯ yes

Have you ever made any changes in your eating habits because of your health?

- ◯ no
- ◯ yes

If yes, what kinds of diets you have tried?

- [ ] low fat
- [ ] low carbohydrate
- [ ] high protein
- [ ] diabetic
- [ ] dairy-free
- [ ] 100% gluten-free
- [ ] gluten-limited
- [ ] vegan
- [ ] paleo

Are you willing to diet if necessary?

- ◯ no
- ◯ yes

How often do you weigh yourself?

- ◯ daily
- ◯ weekly
- ◯ monthly
- ◯ rarely
- ◯ never

Do you avoid any particular foods?

- ◯ no
- ◯ yes (list foods and reasons for avoiding)

Do you grocery shop?

- ◯ yes
- ◯ no (list who shops for you)

Do you read food labels?

- ◯ no
- ◯ yes

Do you cook?

- ◯ yes
- ◯ no (list who cooks for you)

How many meals do you eat out or take out per week?

- ◯ 1-2
- ◯ 1-3
- ◯ 3-5
- ◯ >5

What are your barriers to eating well?

The most important thing you should change about your diet to improve your health is:

Smoking

Do you currently smoke?

- ◯ no
- ◯ yes

If yes, how many packs per day?

How many attempts to quit?

Previous smoking: How many years?

How many packs per day?

Do you experience or have you experienced second-hand smoke exposure?

- ◯ no
- ◯ yes

Caffeine Intake

Do you consume caffeine?

- ◯ no
- ◯ yes

If yes, what time of the day do you crave caffeine the most?

- ◯ first thing in the morning
- ◯ mid-morning
- ◯ after lunch
- ◯ mid-day
- ◯ all the time

How many 8oz cups of coffee do you have per day?

- ◯ 0
- ◯ 1
- ◯ 2-3
- ◯ >4

What is your favorite type of coffee? (e.g., Starbucks Moccachino)

How many 8oz cups of tea do you have per day?

- ◯ 0
- ◯ 1
- ◯ 2-3
- ◯ >4

How many 12oz cans or bottles of caffeinated or diet sodas do you have per day?

- ◯ 0
- ◯ 1
- ◯ 2-3
- ◯ >4

List your favorite type of caffeinated or diet soda:

Rate your willingness to temporarily remove caffeine from your diet if advised:

- ◯ definitely yes
- ◯ maybe yes
- ◯ try to cut down
- ◯ absolutely NO

Sugar Intake

Do you have frequent sugar cravings?

- ◯ no
- ◯ yes

If yes, what time of day do you crave sugar the most?

- ◯ first thing in the morning
- ◯ mid-morning
- ◯ after lunch
- ◯ mid-day
- ◯ all the time

How often do you eat sugary foods or beverages in a week?

Do you add artificial sweeteners to your food / beverages?

- ◯ no
- ◯ yes (list sweeteners) _____

Rate your willingness to temporarily remove sugar from your diet if advised:

- ◯ definitely yes
- ◯ maybe yes
- ◯ try to cut down
- ◯ absolutely NO

Alcohol Intake

How many drinks do you have per week? 1 drink = 5oz wine, 12oz beer, 1.5oz spirits

- ◯ 0
- ◯ 1-3
- ◯ 4-6
- ◯ 7-10
- ◯ >10

Rate your willingness to temporarily remove sugar from your diet if advised:

- ◯ definitely yes
- ◯ maybe yes
- ◯ try to cut down
- ◯ absolutely NO

Drugs

Are you currently using any recreational drugs?

- ◯ no
- ◯ yes

If yes, list the type of drugs:

_____

Have you ever used IV or inhaled recreational drugs?

- ◯ no
- ◯ yes

Exercise

What is your current exercise program? List the type of activity, number of sessions / week and duration:

Rate your level of motivation for including exercise in your life:

- ◯ low
- ◯ medium
- ◯ high

List any problems that limit activity:

Psychosocial

Are you happy most of the time?

- ◯ no
- ◯ yes

Do you feel that your life has meaning and purpose?

- ◯ no
- ◯ yes

Do you like the work you do?

- ◯ no
- ◯ yes

Stress Coping

Have you ever sought counseling?

- ◯ no
- ◯ yes

Are you currently in therapy?

- ◯ no
- ◯ yes (describe)

Do you feel that you have an excessive amount of stress in your life?

- ◯ no
- ◯ yes

Do you feel that you can easily handle the stress in your life?

- ◯ no
- ◯ yes

Rate the following daily stressers on a scale of 1-10:

Work	
Family	
Social	
Finances	
Health	
Other	

Do you practice meditation or relaxation techniques?

- ◯ no
- ◯ yes (list how often) _____

If yes, check all that apply:

- ☐ Yoga
- ☐ Meditation
- ☐ Breathing
- ☐ Tai Chi
- ☐ Prayer
- ☐ Other _____

Readiness Assessment

On a scale of 1-5, **1 being not willing and 5 being very willing**, how willing are you to do the following in order to improve your health?

Significantly modify your diet:

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Take several nutritional supplements each day:

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Keep a record of everything you eat certain days:

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Modify your lifestyle (e.g., work demands, sleep habits):

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Practice a relaxation technique:

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Engage in regular exercise:

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Comments:

On a scale of 1-5, **1 being not confident and 5 being very confident**, how confident are you in your ability and follow-through on the above health-related activities?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

If you are not confident in your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

On a scale of 1-5, **1 being unsupportive and 5 being very supportive**, how supportive do you think the people in your life will be to you implementing the above changes?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Comments:

Symptoms Checklist

Autoimmune & Inflammatory Conditions:

- [ ] allergy
- [ ] food allergy
- [ ] sinus allergy
- [ ] rheumatism
- [ ] lupus
- [ ] herpes zoster
- [ ] Crohn's disease
- [ ] tendonitis
- [ ] fibromyalgia
- [ ] swollen glands
- [ ] plantar fascitis (heel pain)
- [ ] Hashimoto's disease (thyroid)
- [ ] CFS
- [ ] warts
- [ ] AIED (ear)
- [ ] easily catch cold
- [ ] atopic dermatitis
- [ ] myofascial pain
- [ ] chronic sore throat

Muscular Skeletal:

- [ ] wrist pain
- [ ] elbow pain
- [ ] arm/shoulder pain
- [ ] stiff neck
- [ ] hot painful joints
- [ ] chronic sciatica pain
- [ ] hip joint pain
- [ ] medial knee pain
- [ ] lateral knee pain
- [ ] patella tendon pain
- [ ] low back pain
- [ ] bunions
- [ ] ankle pain
- [ ] thumb pain
- [ ] tightness between scapulas (one-sided)
- [ ] mid back pain
- [ ] upper back pain
- [ ] flat feed or foot problems

Neuro-psychological:

- [ ] anxiety
- [ ] panic attacks
- [ ] nervousness
- [ ] bad temper
- [ ] irritable
- [ ] easily susceptible to stress
- [ ] dream-disturbed sleep
- [ ] lack of joy/humor
- [ ] dark-colored urine
- [ ] scapula pain / spasm
- [ ] facial blushing
- [ ] restlessness
- [ ] sweaty hands
- [ ] depression/fear
- [ ] grief/sadness
- [ ] vertigo/dizziness
- [ ] lack of coordination
- [ ] overthinking
- [ ] difficulty focusing
- [ ] excessive sweat
- [ ] excessive worry
- [ ] nausea/vomiting
- [ ] seasonal affective disorder

Heart & Vascular:

- [ ] rapid pulse (>100/min)
- [ ] slow pulse (<60/min)
- [ ] irregular pulse
- [ ] sleep apnea
- [ ] feeling of pressure in the chest
- [ ] shortness of breath
- [ ] breast tenderness
- [ ] palpitation
- [ ] cold sweat
- [ ] cold hands and feet
- [ ] HBP
- [ ] LBP
- [ ] calf cramps
- [ ] Raynaud's disease
- [ ] blood clots
- [ ] varicose/spider veins
- [ ] swelling of hands and feet
- [ ] anemia
- [ ] feel dizzy or faint when standing up quickly or standing for a long time

General:

- [ ] strong thirst
- [ ] low metabolism
- [ ] bleed and bruise easily
- [ ] salty taste in mouth
- [ ] Gout
- [ ] loss/thinning hair
- [ ] edema/water retention
- [ ] energetic evening through midnight
- [ ] easily get car sick
- [ ] craving for sweets
- [ ] craving for salt
- [ ] long shower or bath makes you feel dizzy
- [ ] get spacey/exhausted around 3PM
- [ ] hate to wake up early in the morning
- [ ] no energy
- [ ] no appetite
- [ ] moody
- [ ] feel spacey
- [ ] mucousy

Gastrointestinal:

- [ ] constipation
- [ ] loose stool
- [ ] diarrhea
- [ ] no appetite
- [ ] excessive appetite
- [ ] bloating
- [ ] indigestion
- [ ] gas
- [ ] belching
- [ ] ulcer
- [ ] gastritis
- [ ] heartburn
- [ ] nausea/vomiting
- [ ] esophagus pain
- [ ] IBS
- [ ] abdominal pain
- [ ] stomach pain
- [ ] pain under the right rib cage
- [ ] hemorrhoids
- [ ] blood in stool
- [ ] pasty stool

Hormone Imbalance:

- [ ] hypothyroid
- [ ] hyperthyroid
- [ ] lack of stamina
- [ ] pressure behind eyebrow
- [ ] high blood sugar
- [ ] low blood sugar
- [ ] difficulty falling asleep
- [ ] wake up around 1-3AM
- [ ] wake up around 4-5AM
- [ ] frequent wake up
- [ ] short-term memory problem

Head & Eye:

- [ ] chronic headache
- [ ] migraine
- [ ] heaviness on the head
- [ ] pain behind the eye
- [ ] poor/blurred vision
- [ ] visual migraine
- [ ] darkness under the eyes
- [ ] color blindness
- [ ] night blindness
- [ ] flashing (eyes)
- [ ] spots in front of eyes (floaters)
- [ ] eye strain/pressure

Respiratory:

- [ ] asthma
- [ ] bronchitis
- [ ] weak cough
- [ ] wheezing
- [ ] pneumonia
- [ ] weak voice
- [ ] frosty phlegm
- [ ] yellow phlegm
- [ ] white phlegm
- [ ] difficult inhale
- [ ] difficult exhale
- [ ] difficulty breathing when lying down

Ear, Nose & Throat:

- [ ] deafness
- [ ] itchy ear/pain/pressure
- [ ] tinnitus (low)
- [ ] tinnitus (high)
- [ ] frequent ear infections
- [ ] no sense of smell
- [ ] sinusitis
- [ ] facial pain
- [ ] yellow mucus
- [ ] stuffy nose
- [ ] constant running nose
- [ ] nose bleed
- [ ] post nasal drip
- [ ] strep throat infections
- [ ] feels like always something stuck in throat
- [ ] chronic dry/scratchy throat
- [ ] difficulty swallowing

Skin:

- [ ] rashes
- [ ] eczema
- [ ] psoriasis
- [ ] acne
- [ ] hives
- [ ] allergic dermatitis
- [ ] recent moles
- [ ] dandruff
- [ ] itching
- [ ] skin discoloration
- [ ] brittle nails
- [ ] vertical ridged nails
- [ ] fungal infections

Oral disease:

- [ ] bleeding gums
- [ ] sores on lips/tongue
- [ ] dental abscess
- [ ] grinding teeth
- [ ] bad breath
- [ ] TMJ
- [ ] toothaches without cavities

Male:

- [ ] impotence
- [ ] premature ejaculation
- [ ] BPH
- [ ] prostatitis
- [ ] pain in testicles
- [ ] low libido
- [ ] kidney stones
- [ ] night urination 2+ times
- [ ] Varicocele
- [ ] dribbling after urination
- [ ] pain with urination
- [ ] nocturnal emission

Female:

- [ ] infertility
- [ ] PMS (mood)
- [ ] menstrual problems
- [ ] menopause symptoms
- [ ] endometriosis
- [ ] uterine fibroids
- [ ] POD
- [ ] ovarian cysts
- [ ] prolapse
- [ ] low libido
- [ ] lichen scleroses
- [ ] premature gray
- [ ] UTI
- [ ] left abdominal pain

New Patient Information

Please…
…refrain from wearing excessive jewelry.
…refrain from wearing perfume, strongly scented oil or lotion.
…refrain from bringing a cup of coffee, tea, soft drink or any foods. Water bottles are fine.
…arrive at the clinic on time (please see "Late Arrivals" below).
…do not cancel on the day of your treatment (yes, there are always exceptions !).
…let me know if you have signs of cold (cough, fever, chill, fatigue) and sinus infection.
…turn off your cellular phone unless you are expecting an important call from your doctor, your children's school nurse, etc. Please let me know upon your arrival if you need to keep your cellular phone on.

Sanitation and Attire: This clinic uses sterile, disposable needles. Non-insertion techniques are available for children and needle-phobic patients (not for fertility patients). This clinic uses linens, not rolled paper. Since linens cleaned by linen services are treated with strong chemicals and come back very starchy, I clean all linens at my house. However, please feel free to bring your own lines and blankets if you prefer. I suggest you to bring a pair of shorts. Female patients—please wear a bra during the treatment (not sports bra). Draping (blanket) will be provided.

Requests to practitioner: Please email me if anything I need to know about you before the first appointment. For example, you may be extremely noise sensitive, easily overheated, or claustrophobic, etc… I would like you to be as comfortable as possible. Each of the clinic's three rooms has an iPod nano holding 3000 soothing tracks. Please let me know upon arrival if you have any preference of music such as classical, ocean sounds, classical, new age, meditative music.

Schedule, reschedule, or cancel appointments: Please bring your calendar/schedule book/appointment book or simply your smart phone with you! I encourage you to schedule appointments in advance to ensure you receive and retain the time slot you most desire. If you make an appointment in advance but wish to reschedule, it is your responsibility to cancel the existing appointment. In case of inclement weather, I will contact you if the clinic will be closed and to reschedule your appointment. However, I have closed my clinic only twice due to snow storms in the past. Please call, email, or text me by 5PM one day BEFORE your appointment.

Patients who cancel or change their appointments at the last minute three times will no longer be treated. I will email and text you to confirm your appointment a day before your appointment day. If you prefer to receive a phone call instead, please let me know. A minimum of 24-hour notice is required for cancellation and rescheduling, or you will be responsible for 50% of the treatment fee. If you miss your appointment with no advance notice or cancel within 3 hours of your appointment, you will be responsible for the full treatment fee. Cancellation fees are waived in case of emergency or inclement weather.

Late Arrivals: Please be on time so that I will be able to give you a full treatment. I usually treat the front for 25 minutes plus and the back for another 25 minutes plus. I schedule patients at 15-minute intervals. If you are going to be 10-15 minutes late, please email or text me in advance so that I will be able to inform the next patient that "Tamie is 10-15 minutes behind the schedule" to see if it is acceptable to the patient.

Payment and Insurance: Some insurance plans do reimburse for acupuncture. It's your responsibility to call directly and ask to find out whether yours will do. Some health plans impose restrictions on their members, such as liniment the numbers of treatments per calendar year and/or the conditions treated (for example: painful period is covered but infertility is not covered, low back pain is covered but not neck pain etc…) so be sure to check on them. The phone number can be found on your insurance card. I am happy to provide you with receipts or monthly statement (superbill) you can submit for reimbursement from your insurance company or from your flexible spending account. Please pay full amount at the time of service. Check or cash are accepted forms of payment. If a check is returned, a fee of $25.00 will be applied to your account.

Name

Date

Consent to Treatment & Cancellation Policy Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist, Tamie Taniguchi Bilazzo Lic. Ac. at the Japanese Acupuncture Clinic. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by Tamie.

Acupuncture: I understand that acupuncture is performed by the insertion of sterile single use needles through the skin at the certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising (some people are prone to bruising), minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

With your consent, the following methods are available to be used in conjunction with your acupuncture treatment.

Supplements, Vitamins, Western herbs and Chinese Herbs: I understand that substances (supplements, vitamins, Western and Chinese herbal formulas) may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to supplemental treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Tamie Taniguchi Bilazzo Lic. Ac. at the Japanese Acupuncture Clinic as soon as possible.

Cupping and Gwa Sha: I understand that I may be asked to receive cupping treatment (good for cold, heavy congested cough, tight neck and back muscles), Gwa Sha (spoon technique used along the spine and neck to release the muscle tightness) at the end of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. The dark bruised like circle marking will last for a few days after the cupping treatment. I understand that I may stop the treatment if it is too uncomfortable. I will tell Tamie that if I have allergy to oils and lotions (peppermint/aloe/canfor).

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture treatment. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. I use this type of acupuncture for sciatica, hip, shoulder pain and sometimes used for fertility patient whom wish to increase the endometrial lining and patients who has shown slow response to their stimulation drugs.

Cancellation Policy

I understand if I need to cancel my appointment, then a 24-hour notice is required in order to waive the treatment fee. If I cancel my appointment in less than 24 hours, I agree to pay 50% of the treatment fee, unless it is an emergency that includes inclement weather, family, childcare or car emergencies. In the case of "no call no show" or "the last minute cancellation", I understand I need to pay the full amount of my treatment fee.

I have carefully read and understand all of the above information and I am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. By typing my name below, I give my permission and consent to treatment.

Name

Date