



Name: _____ Date of Initial visit: _____

Address _____

State _____ Zip _____ Best phone to reach you _____ 2nd best phone _____

Email _____ Can Armonía Health LLC add you to its email list? YES NO

Date of Birth _____ Age _____ Occupation _____

Marital/Relationship status _____ Referred by _____

Client Confidentiality & Consent to Treat Form

I understand my session with the practitioner, Li-Lan Hsiang Weiss, Licensed acupuncturist, is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals nor does she perform spinal manipulations. The diagnosis that I may receive is from a Chinese medicine perspective and/or an assessment based on her Arvigo Techniques of Maya Abdominal Therapy® training and may or may not correlate with a medical diagnosis I already have. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions to the best of my understanding and take it upon myself to keep the practitioner updated on my health.

My session may involve one or more of the following therapies: acupuncture, Arvigo® Maya abdominal massage, guasha, glass cupping, moxabustion, energetic and spiritual healing. Take home recommendations and a follow up treatment plan shall be presented to me by the end of my initial session. The practitioner encourages open dialogue and will do her best to answer any questions I may have. I shall do my best to be an active participant in my own healing process. I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that complications may result from acupuncture treatment. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, pneumothorax, and aggravation of present symptoms. I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person.

I understand that acupuncture and Chinese medicine are not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of, or concurrently with acupuncture treatment.

HIPAA regulations require all practitioners obtain a signed release form from their patient/client before taking any information about them. Clients should receive a copy of the form they signed (upon request) and the practitioner maintains a copy for their records. I give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her if he/she deems necessary. I understand this information may be shared under legal obligations or with another medical professional or health care provider to enhance my quality of care.

Our office prefers **48 hours** notice if you need to cancel or change your appointment; less than 24 hours notice of cancellation may incur a missed appointment fee of 50% of the session rate. We appreciate your consideration and respect with this matter.

Current session rates, payable in cash, check, or credit card to Armonía Health LLC upon service are:

- Initial Arvigo® session (2 hr): \$150
- Initial Fertility session (2 hr): \$150
- Follow Arvigo & acupuncture (75-90 min): \$100
- Initial session during pregnancy (75 min): \$100
- Initial acupuncture with consultation: \$100
- Follow up acupuncture: \$80 for 60 min, \$100 for 90 min

Client Signature: _____ Date: _____

Printed name: _____

Reason For Visit

Primary reason(s) for visit: _____

If there is a particular condition, when did your first notice it? _____

What brought it on? _____

Describe any stressors occurring at the time _____

What activities provide relief? _____ what makes it worse? _____

Is this condition getting worse? _____ interfere with work _____ sleep _____ recreation _____

Have you had bodywork, acupuncture, energy work before? _____ What type? _____

Medical History

Are you currently under the care of another health care provider(s)? _____ Reason (s) _____

Name(s) of Practitioner _____ Address: _____

Phone _____ email _____

Current Medications and /orSupplements/Remedies: _____

Allergies: specify allergen and reaction: _____

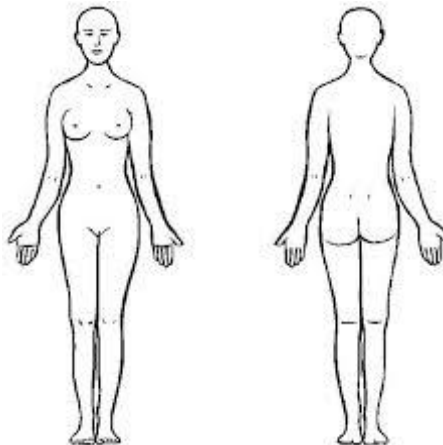
Surgical History (year and type) and/or Recent Procedures: _____

Hospitalizations: _____

Accidents or Traumas _____

Falls/Injuries to Sacrum/head/tailbone (describe) _____

Current and/or past areas of pain or discomfort



Please review and check the following:

	Past	Present		Past	Present
Headaches Type:			Numbness in feet or legs when standing		
Asthma			Sore heels when walking		
Cold Hands or feet			Anxiety		
Swollen ankles			Depression		
Sinus Conditions Frequent Colds			Sleep Disturbance		
Seizures			Fainting Spells		
Low Back Pain			Muscular Tension: Location:		
Skin Disorders: Type			Varicose Veins Hemorrhoids Location		
Sciatica			Herniated/Bulging Discs		
Painful/Swollen Joints			Artificial/Missing limbs		
High or Low Blood Pressure			Contact Lenses		
Dentures/Partials			Cancer (past or current) Type		

Other (not mentioned above)

Digestion and Elimination

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____ Water Intake(glasses/day) _____ Caffeine _____

Do you use Tobacco? _____ Quantity _____ /ppd Alcohol? _____ Quantity _____ ounces/ day

Marijuana? _____ Quantity _____ Other: _____ Have you been under treatment for substance use? _____

What is the worst item in your diet _____ What foods are your weakness _____

Are you subject to binge eating? _____ What foods _____

Do you experience bloating/gas/burps after eating? _____ What foods trigger this? _____

How often are your bowel movements? _____ Constipation? _____

Blood in stool ? _____ Mucus in stool? _____ Pain when stooling? _____

Know food sensitivities: _____

EMOTIONAL & SPIRITUAL

What is your opinion of yourself? _____

If possible, please describe the most negative emotion you experience _____

When do you most often feel this emotion: _____ Where are you? _____

Do you pray, have a spiritual practice, or meditate? _____

On a scale of 1 – 10 (1 being the lesser, 10 the greater) Please rate yourself:

Faith _____ Hope _____ Charity _____ Generosity _____ Sense of Humor _____

Sense of Fun _____ Fear _____ Grief _____ Other (describe briefly) _____

What are hobbies/ activities that provide you with a sense of pleasure and accomplishment?

Describe your exercise routine (type, frequency) _____

What changes would you like to achieve in 6 months: _____

One Year: _____

Do you have experience receiving energy work? _____ Would you like to know more about it? _____

Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method

Fertility Awareness Other: _____ Length of time using method _____

Last Pap smear _____ Results (if known) _____

Are you under the treatment for fertility challenges? _____ Describe current treatment to date : _____

(IUI, IVF, etc) _____

Gynecological Provider: _____ Address _____ Phone _____

Menstrual History Review and check as indicated:

Age of Menses: _____ What was this like for you? _____

Last Menstrual Period: _____ Length of Menses _____

Are you trying to Conceive? _____ Possibility of Pregnancy _____

Painful Periods	Past Present	Irregular cycles Early Late	Past Present
Heaviness in Pelvis prior to menses		Dark Thick Blood at: Beginning End Both	
Excessive Bleeding Pads per Hour		Headache or Migraine with menses	
Dizziness		Bloating	
Water Retention		Ovulation: Painful Failure to	
Endometriosis Location (if known)		Fibroids Location (if known)	
Uterine or Cervical Polyps		Uterine Infection(s)	
Vaginal Infection(s)		Cysts Location:	
Bladder Infection(s)		Urinary Incontinence	
Painful Intercourse		Vaginal Dryness	
Episodes of Amenorrhea How long?			

Pregnancy History:

Number of Pregnancies:	Complications:	Miscarriages:	Terminations:
Number of Births: Dates:			
Premature Births:	Spotting during Pregnancy	Weak Newborns at Birth	Incompetent Cervix

Briefly describe your experience with:

Pregnancy: _____

Labor: _____

Birthing _____

Post Partum: _____

Maternal Family History of (*please circle*) Infertility Fibroids Endometriosis-----PMS Menopause

Cancer(type) _____ Menstrual Problems _____ Other _____

Medications your mother took when she was pregnant with you (if any) _____

Your Birth Trauma (if known) _____

Other:

Rate your interest in Sex: High _____ Moderate _____ Low _____ None _____

Do you have or ever had difficulty experiencing orgasms _____

Do you have a history of rape _____ trauma _____ incest _____ If so, -when _____

Did you undergo counseling for this _____

What was this like for you _____

Menopause

Age symptoms began: _____ Are they getting worse _____ better _____ same _____

Are you on/ or ever been on hormone replacement therapy? _____ if so, how long _____

Name and dose _____

Reason for stopping _____

Age of Mother at menopause: _____ Concerns/Experience _____

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here:

Chinese Medicine Symptom Checklist

Name: _____ Date: _____

Please check any of the following symptoms you experience frequently or have a tendency towards.

- | | | |
|---|--|---|
| <input type="checkbox"/> Fatigue/Low Energy | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Tired after eating | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Knee pain |
| <input type="checkbox"/> Low appetite | <input type="checkbox"/> Memory problems | <input type="checkbox"/> Low sex drive |
| <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Sores on the tongue | <input type="checkbox"/> High sex drive |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Startle easily | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Laugh inappropriately | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Abdominal bloating | | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Heartburn/Reflux | | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Frequent irritability/Frustration | <input type="checkbox"/> Ringing in ear |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Depression/Tendency to feel sad | <input type="checkbox"/> Wear socks to bed |
| <input type="checkbox"/> Frequent hiccups or belching | <input type="checkbox"/> Frequent sighing | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Flatulence | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Congenital abnormalities |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pain under the ribcage | |
| <input type="checkbox"/> Excessive vaginal discharge | <input type="checkbox"/> Floaters | |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Can't see well at night | |
| <input type="checkbox"/> Tendency to worry/obsess | <input type="checkbox"/> Red eyes | |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Wake between 1-3am | |
| <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Trouble falling asleep | |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Dizziness | |
| | <input type="checkbox"/> Tight muscles | |
| | <input type="checkbox"/> Painful periods | |
| <input type="checkbox"/> Recurrent colds/Infections | <input type="checkbox"/> Irregular periods | |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Inability to cry | |
| <input type="checkbox"/> Allergies | | |
| <input type="checkbox"/> Sweat easily | | |
| <input type="checkbox"/> Do not sweat | | |
| <input type="checkbox"/> Blood or mucus in stool | | |
| <input type="checkbox"/> Pain in the teeth or gums | | |
| <input type="checkbox"/> Skin problems | | |
| <input type="checkbox"/> Shortness of breath | | |
| <input type="checkbox"/> People often ask you to speak up | | |
| <input type="checkbox"/> Feel Sad | | |