

# Welcome

Evergreen Wellness Center, Inc.  
Functional Medicine & Acupuncture  
2950 Los Feliz Blvd. Suite 203  
Los Angeles, CA 90039

## Personal Information

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip  
Sex: \_\_M\_\_F Age: \_\_\_\_ Birthday \_\_\_\_\_  
\_\_\_\_ Single \_\_ Married \_\_ Widowed \_\_ Separated \_\_ Divorced  
Patient SS#: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_  
  
Whom may we thank for referring you?  
\_\_\_\_\_

## Consent of Payment

Who is responsible for this account? \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Member ID \_\_\_\_\_ Grp # \_\_\_\_\_  
  
Is patient covered by additional insurance? \_\_ Yes \_\_ No  
Subscriber's Name: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Insurance Co.: \_\_\_\_\_  
Group# \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.  
Responsible Party Signature \_\_\_\_\_  
Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

## Contact Information

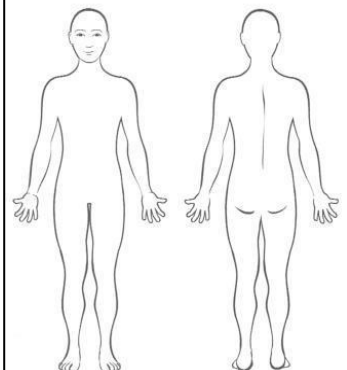
Home \_\_\_\_\_ Cell \_\_\_\_\_  
Best time and place to reach you \_\_\_\_\_  
Email \_\_\_\_\_  
IN CASE OF EMERGENCY, CONTACT:  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Ext \_\_\_\_\_

## Patient Condition

Reason for Visit  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
Weight \_\_\_\_\_ Height \_\_\_\_\_

## Condition Information

When did your symptoms appear? \_\_\_\_\_  
Is this condition getting progressively worse? \_\_ Yes \_\_ No \_\_ Unknown  
Mark an X on the picture where you continue to have pain, numbness, or tingling.  
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_  
Type of pain: \_\_ Sharp \_\_ Dull \_\_ Throbbing \_\_ Numbness \_\_ Aching  
\_\_ Shooting \_\_ Burning \_\_ Tingling \_\_ Cramps \_\_ Stiffness \_\_ Swelling \_\_ Other  
How often do you have this pain? \_\_\_\_\_  
Is it constant or does it come and go? \_\_\_\_\_  
Does it interfere with your: \_\_ Work \_\_ Sleep \_\_ Daily Routine \_\_ Recreation



## Initial Consultation

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Main Complaints:

1) \_\_\_\_\_ 2) \_\_\_\_\_

3) \_\_\_\_\_ 4) \_\_\_\_\_

How long have you suffered with this problem

\_\_\_\_\_

Any other complaints: \_\_\_\_\_

\_\_\_\_\_

Would you like improvement with any of the following?:

Digestion: Reflux, Gas, and Constipation

Sleep: Falling asleep or staying asleep

Sense of Well-being

Energy

What have you tried doing to resolve this problem that Did Not work?

\_\_\_\_\_

\_\_\_\_\_

Have you become discouraged or stressed about handling this problem?

\_\_\_\_\_

\_\_\_\_\_

When your problem is at its worst, how does it make you feel?

\_\_\_\_\_

How does this problem interfere with the following areas in your life?

Work: \_\_\_\_\_

Family: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Life: \_\_\_\_\_

When it's at its worst, how much older does this make you feel? \_\_\_\_\_

Do you know how this problem may have started? \_\_\_\_\_

\_\_\_\_\_

What effect does this have on your body functions? \_\_\_\_\_

Are you here visiting us to:

- Resolve my immediate problem
- Life style program for optimized living
- Both
- Other: \_\_\_\_\_

How have you taken care of your health in the past?

- Medications
- Routine medical
- Exercise
- Diet and Nutrition
- Holistic
- Vitamins
- Acupuncture/PT/Chiro
- Other: \_\_\_\_\_

How did the previous methods work for you? \_\_\_\_\_

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What are you afraid this might be or will be affecting without change? Please check all that apply

- Job
- Kids
- Marriage
- Sleep
- Freedom
- Future abilities
- Finances
- Time

Are there any health conditions you are afraid this might turn into?

- Diminish Future abilities
- Surgery
- Stress
- Arthritis
- Weight gain
- Cancer
- Heart disease
- Diabetes
- Depression
- Other:

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific

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What would be different or better without this problem? Please check all that apply:

- Diminished stress
- More Energy
- Self-Esteem
- Confidence
- Sleep
- Work
- Outlook on Life
- Family

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If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? ( Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage, or bucket list)

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What potential barriers do you foresee that would prevent these things from happening?

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Do you feel it is possible to eliminate or prevent these potential barriers?

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What are your strengths that will enable you to accomplish your goals?

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Rate on a scale of 1-10:

\_\_\_\_\_ How important is it for you to resolve your health concerns?

\_\_\_\_\_ Do you feel that you are coachable and would enjoy a mentor in helping you?

\_\_\_\_\_ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

**THANK YOU!**

## Health History

Who is your primary care physician? ( doctor and/or practice) \_\_\_\_\_

### Please check to indicate if you are currently experiencing any of the following conditions:

- |   |  |   |  |                                     |
|---|--|---|--|-------------------------------------|
| <input type="checkbox"/> Neck Pain/ Stiffness | <input type="checkbox"/> Pins/ Needles in Arms | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Sudden Weight Loss    | <input type="checkbox"/> Nausea     |
| <input type="checkbox"/> Back pain/ Stiffness | <input type="checkbox"/> Pins/Needles in Legs  | <input type="checkbox"/> Depression         | <input type="checkbox"/> Loss of Taste         | <input type="checkbox"/> Cold Feet  |
| <input type="checkbox"/> Arm/Hand Pain        | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Loss of Memory        | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Leg/ Knee Pain       | <input type="checkbox"/> Sleeping Difficulties | <input type="checkbox"/> Tension            | <input type="checkbox"/> Jaw Problems          | <input type="checkbox"/> Fever      |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Loss of Smell         | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Allergies             | <input type="checkbox"/> Stomach Problems   | <input type="checkbox"/> Shortness of Breath   |                                     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Night Pain         | <input type="checkbox"/> Bowel/Bladder Changes |                                     |

### Please check to indicate if you have ever had any of the following:

- |   |   |   |  |   |
|---|---|---|--|---|
| <input type="checkbox"/> Aids/HIV         | <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Breast Lump          | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Fractures          |
| <input type="checkbox"/> Allergy Shots    | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Bulimia              | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Pinched Nerve      |
| <input type="checkbox"/> Anorexia         | <input type="checkbox"/> Liver Disease      | <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Typhoid Fever      |
| <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Measles            | <input type="checkbox"/> Parkinson's Disease  | <input type="checkbox"/> Scarlet Fever       | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Goiter           | <input type="checkbox"/> Migraines          | <input type="checkbox"/> Pneumonia            | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Gonorrhea        | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Polio                | <input type="checkbox"/> Suicide Attempt     | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Gout             | <input type="checkbox"/> Mononucleosis      | <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Thyroid Problems    | <input type="checkbox"/> Whooping Cough     |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Tonsillitis         | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Psychiatric Care     | <input type="checkbox"/> Tuberculosis        |   |
| <input type="checkbox"/> Hernia           | <input type="checkbox"/> Osteoporosis       | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Tumors/ Growths     |   |
| <input type="checkbox"/> Herniated Disk   | <input type="checkbox"/> Osteoporosis       |   |  |   |
| <input type="checkbox"/> Herpes           | <input type="checkbox"/> Pacemaker          |   |  |   |
| <input type="checkbox"/> High Cholesterol |   |   |  |   |

Are you currently under drug and/or medical care?  Yes  No If yes, explain \_\_\_\_\_

Please list any medications you are currently taking ( **Be sure to include dosage and frequency**): \_\_\_\_\_

Please list any surgeries and/or hospitalizations you have had ( **type & date**): \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any supplements you are currently taking ( vitamins/herbs/ minerals): \_\_\_\_\_

Is there a family history of any of the following conditions? ( **Indicate family member including parents, grandparents & siblings**)  Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_

Arthritis \_\_\_\_\_  Cancer \_\_\_\_\_  Other \_\_\_\_\_

Do you exercise:  Never  Daily  Weekly  Walks  Runs  Swims

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

What is your daily/ weekly intake of the following:

Caffeine \_\_\_\_\_ cups/day Alcohol \_\_\_\_\_ drinks/week Cigarettes \_\_\_\_\_ packs/day

*I certify that the above questions were answered accurately. I understand that providing the incorrect information can be dangerous to my health.*

**SIGNATURE (X)** \_\_\_\_\_

**DATE** \_\_\_\_\_

## INFORMED CONSENT TO CARE

I voluntarily consent to be treated by Evergreen Wellness Center, Inc. The clinic offers several treatment modalities. The course of treatment will be determined between the Healthcare practitioner and patient.

The treatments consist of, but are not limited to:

1. The use of acupuncture needles to stimulate acupuncture points and meridans
2. Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridans
3. Moxibustion
4. Acupressure
5. Dermal friction technique
6. Infrared
7. Nutritional advice based on traditional Chinese medical theory
8. Physical medicine services

I acknowledge that there are some risks to the treatment(s). These side effects may include, but are not limited to the following:

1. Some pain following treatment in the insertion area
2. Minor bruising
3. Infection
4. Needle sickness
5. Patients with severe bleeding disorders or pacemakers should inform the practitioner prior to any treatment. If you are pregnant or have history of seizures, you should also inform the practitioner.

Prior to receiving care a health history and physical examination will be completed. These procedures will assist the practitioner in determining which modalities are needed, or if any further examinations or studies are required.

I understand that there is neither an implied nor stated guarantee of success or effectiveness of a specific treatment or series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and to discontinue my treatment at any time.

I hereby authorize Evergreen Wellness Center, Inc. to release any information regarding my condition to the referring physician ( if any) and or to my insurance for the processing of any claim. With notification, I also authorize Evergreen Wellness Center, Inc. to obtain my medical records from other physicians or medical centers.

Payment in full is expected at the time of each appointment. I agree to give a 24 hour notice to the clinic if I must cancel or re-schedule an appointment. I understand that I will be charged a \$50.00 fee for any appointment that is missed or cancelled without first giving a 24 hour notice to the clinic. Exceptions may be made in a case of an emergency. I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

Thank you for your cooperation and consideration.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Legal Guardian ( if under 18): \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I acknowledge that I have reviewed the Notice of Privacy Practices of Evergreen Wellness Center, Inc. ( Please initial one of the following options and sign below.)

\_\_\_\_\_ I wish to receive a paper copy of Privacy Notice.

\_\_\_\_\_ I wish to receive an electronic copy of Privacy Notice.

My email address is: \_\_\_\_\_ @ \_\_\_\_\_

\_\_\_\_\_ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office.

Please initial below:

\_\_\_\_\_ I acknowledge that it is the policy of Evergreen Wellness Center, Inc. to leave reminder messages on my answering machine or with another person in my home. I may make a request of an alternative means of communication ( within reason) in my writing.

\_\_\_\_\_ I acknowledge that if I should have a problem or question in regard to my rights, I may speak with the Office Manager about my concerns.

\_\_\_\_\_

Signature of Patient/Guardian

\_\_\_\_\_

Date

\_\_\_\_\_

Witness (Office Staff)

\_\_\_\_\_

Date

# 10 Objections to Creating a Healthy, Abundant Life.



## 1. I don't have the personal knowledge to make the correct lifestyle choices.

- a. You have the power to choose to learn. If you are open to learning, our personal mentoring program will guide you along as easy to follow path. Our programs are structured in a manner that gives each and every patient the information needed to bring independence to their life. You do have the choice to avoid the all too common dependency of a care-giver or assisted living environment.

## 2. I don't have the time to take appropriate care of myself.

- a. We all live in a world that gives each of us 24 hours/day. What we do with that time is a personal decision based on values ( real or perceived). If you do not take time to care for yourself, you will have to take time to try and repair yourself. Pro-activity and maintenance are required for optimized health. It takes no more time to eat correctly than poorly. Proper exercise required no more than approximately 35 minutes 3-4 times/week. If you're honest with yourself, you recognize it really is based on what you judge as a valuable use of your time. Hum? TV, or a thriving, abundant life.

## 3. My family won't be on board with the changes I will need to make.

- a. I recognize this sounds like a silly thought, but also realize it is a real concern for some. You would certainly think that all family members would be on board, however, in infrequent situations a spouse or family member may be negative toward your new enthusiasm. This usually comes down to a lack of understanding of what your lifestyle program entails, as well as some distrust of whether this approach will really work. It may help to steer these family members to our site, [www.evergreenacu.com](http://www.evergreenacu.com) and view some of the incredible testimonials from our patients. Without taking the time to learn about our programs and proven success it is only human nature to be cautious. Once familiarizing themselves, you will not only get support, but an accountability partner to help ensure your success.

## 4. Eating right is too hard and expensive.

- a. If you have not been eating right, you should already understand how expensive eating wrong can be. Health deteriorates and medical bills escalate with each year that these poor choices are made. Like any habits, there are good and bad. Once you develop a habit it can be a challenge to change or alter. Once the good or correct habit is developed it will be hard to break. I would challenge anyone to compare grocery bills of a cart full of healthy food compared to one full of junk. And speaking of expense, this is not just a financial term. Losing out on the joys and experience in life because you're not feeding your body nutritious foods is terrible, unnecessary expense.



## **5. I can't afford a lifestyle program or hire a health coach.**

- a. Most people recognize the importance of an education, whether this is a high-school, college, or even an online education. It's widely accepted that this is an investment that must be made in order to have the best insurance of meeting our financial needs. The return on this financial investment can materialize into a very secure and abundant life. Although there are situations in life where funding higher education can seem impossible, we witness people every day finding solutions to "get it done". These individuals simply think differently. They do not accept anything less than their God given potential. I am suggesting that your health should be viewed as at least as valuable as your financial situation. What value is wealth if you do not have the health and vitality to enjoy it? At Imagine Wellness, we work with each individual to overcome any financial obstacles. We have solutions to allow those on fixed budgets and tired to easily move forward.

## **6. I'm afraid that proper lifestyle changes might isolate me from my friends and family.**

- a. It is true that not all of your friends will share your newly found optimism toward taking control of your health. Friends who do not place high priority on their health often play down healthy lifestyle choices. Although they may not mean any negative intent, this behavior is sabotaging. In one of my patient member video's I discuss this as being all too common and some tips to disarm this behavior in a non-confronting manner. The bottom line is those who truly care for you will support your decision to place your health as a priority.

## **7. My doctor may not approve.**

- a. I will always be open and willing to work with any doctor or health professional you currently have. They also, should be open and willing to do the same if the goal is to optimize health and improve lifestyle choices. This includes reducing and/or eliminating unnecessary medications. A doctor's main concern and intent should always to aid in the optimization of health in his/her patients. This begins with "Do No Harm". I am always cautious of a physician that dismisses any holistic and natural approach to health. In summary, you are ultimately responsible for your health and therefore, the final decision and direction you wish to pursue.

## **8. I don't have the self-discipline to make permanent changes.**

- a. Self-discipline is not a trait that we are born with, but one that is developed over time through life experience. Discipline coincides with positive experience. In other words, as your actions result in positive changes you will be inclined to continue these actions. One could look at this as positive habits or simply, discipline. Self-discipline is also strengthened through accountability held by loved ones, a friend, or a mentor.

## **9. What happens if I commit to a lifestyle program and then hate the experience and give up?**

- a. Life is series of ups and downs. We do not always enjoy the duties required for the end result we are seeking. It's funny how these duties or actions can initially seem to be difficult or "no fun", but later take on an uplifting emotion. This is because we come to recognize the most meaningful successes we have in life cam from such actions. Having a successful marriage; raising children; optimizing our health and becoming financially independent all require discipline and actions that sometimes have us

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wanting to “give up and quit”. Those of us who continue to play the game are allowed the pleasures of earned rewards.

**10. I don't have the personal confidence to take action.**

- b. Very few of us have a natural born instinct of confidence. This comes from continually taking action even when we are fearful. The actual definition for this is courage. As we continue to develop skills from taking these bold steps, we become less fearless or confident. We are here to mentor and support you. We do not judge or chastise. We offer an environment that anyone at any level can feel comfortable and genuinely cared for. As you become a veteran in the art of wellness, you too will become very confident.