



...dragonflies represent powers of light and transformation..

Dr. Lisa Hollingsworth  
D.C., MAOM, L.Ac.

877.767.6217

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www.beingwellbody.com

# PATIENT INFORMATION INTAKE FORM

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

Name: \_\_\_\_\_  
LAST FIRST M.I.

Address: \_\_\_\_\_  
STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex: (please circle) M/F  
Marital Status: S/M/W/D (please circle) # of children: \_\_\_\_\_

Occupation: \_\_\_\_\_

Primary Reason for Visit: \_\_\_\_\_

Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_  
Mobile ( ) \_\_\_\_\_ Email \_\_\_\_\_

In case of emergency, please contact:  
Name \_\_\_\_\_ Phone number ( ) \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_

## Financial Agreement

*I, the undersigned comply and understand that I am responsible for payment in full at the time services are provided. Payments for Dr. Hollingsworth may be made in the form of cash, check, or credit card. Checks for Dr. Hollingsworth may be made payable to Wellbody Innovations or Dr. Lisa Hollingsworth.*

RESPONSIBLE PARTY SIGNATURE (SIGNATURE OF LEGAL GUARDIAN IF UNDER 18)

PRINT NAME

## 24 hour Cancellation Policy

*I, the undersigned comply and understand that I am responsible for cancelling an appointment 24 hours in advanced. I understand and comply with a charge of \$45 if I cancel my appointment within 4 hours of the appointment time or do not show up. I permit Wellbody Innovations to charge my card on file.*

RESPONSIBLE PARTY SIGNATURE (SIGNATURE OF LEGAL GUARDIAN IF UNDER 18)

PRINT NAME

The doctor of the future will give no medicine but will interest his patients in the care of the human frame, in diet and in the cause and the prevention of disease.

-Thomas Alva Edison



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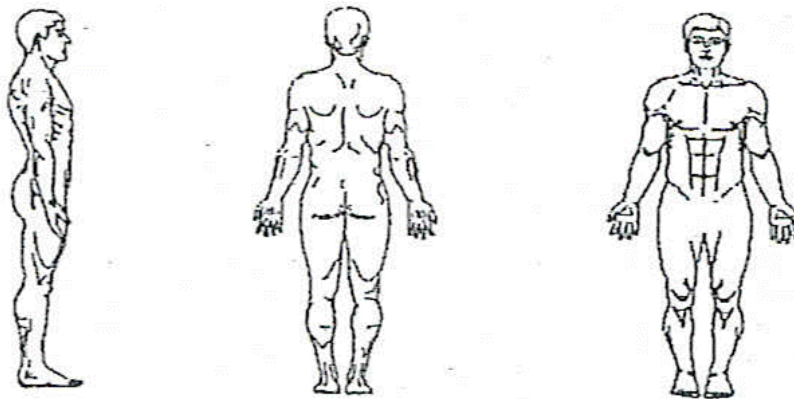
## PHYSICAL INFORMATION

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

### HOW IT BEGAN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mark an X on the picture where you have pain, numbness, tingling, or other symptoms. Please number multiple areas of discomfort with "#1, 2" and so on.



Please rate your pain or discomfort on a scale of 0 to 10. Please circle.

1    2    3    4    5    6    7    8    9    10

No Pain(0) \_\_\_\_\_ Unbearable (10)

Please check mark all that apply.

How often are your symptoms present?

Constantly  Frequently  Occasionally

Since it began, is your problem:

Improving  Worsening  No change

Describe your current symptom (s)?

Sharp/Stabbing  Throbbing  Aches  Dull  Soreness

Weakness  Numbness  Shooting  Burning  Tingling

Other (please describe) \_\_\_\_\_

What makes the problem better?

Nothing  Lying down  Walking  Standing  Sitting

Movement  Exercise  Inactivity/Rest

Other (please describe) \_\_\_\_\_

What makes the problem worse?

Nothing  Lying down  Walking  Standing  Sitting  Movement

Exercise  Inactivity  Other (please describe) \_\_\_\_\_

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# HEALTH HISTORY

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

**Past/Current Medical Conditions:** \_\_\_\_\_

**What treatment (s) have you received for your condition?**

\_\_\_ Medications \_\_\_ Surgery \_\_\_ Physical Therapy \_\_\_ Chiropractic  
\_\_\_ None \_\_\_ Other (please describe) \_\_\_\_\_

**Name & address of doctor (s) that have treated you for this condition:**

\_\_\_\_\_

**Date of Last:**

Physical Exam \_\_\_\_\_ Spinal X-Ray \_\_\_\_\_ Blood Test \_\_\_\_\_  
Spinal Exam \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ Urine Test \_\_\_\_\_  
Acupuncture Exam \_\_\_\_\_ MRI, CT, Bone Scan \_\_\_\_\_

**Please place a check mark in the box if you once had or currently have the following:**

	Y	N		Y	N		Y	N
AIDS/HIV			Glaucoma			Pacemaker		
ALCOHOLISM			Goiter			Parkinson's Disease		
Allergy shots			Headaches			Polio		
Anemia			Heart Disease			Prostate Problem		
Anorexia			Hepatitis			Prosthesis		
Appendicitis			Herniated Disc			Psychiatric Care		
Arthritis			Hernia			Rheumatoid Arthritis		
Asthma			Herpes			Rheumatic Fever		
Bleeding Disorders			High Blood Pressure			Scarlet Fever		
Breast Lumps			High Cholesterol			Stroke		
Bronchitis			Kidney Disease			Suicide Attempt		
Bulimia			Liver Disease			Thyroid Imbalance		
Cancer			Measles			Tonsillitis		
Cataracts			Meningitis			Tuberculosis		
Chemical Dependency			Migraine			Tumors/Growths		
Chicken Pox			Miscarriage			Typhoid Fever		
Diabetes			Mononucleosis			Ulcers		
Emphysema			Multiple Sclerosis			Vaginal Infections		
Fibroids (Uterine)			Mumps			Whooping Cough		
Fractures			Osteoporosis					

<u>Family Medical History</u> Please check if a family member has had: ___ Cancer ___ Heart Disease ___ Diabetes ___ Stroke ___ High Blood Pressure ___ Obesity	<u>Please describe injuries/surgeries/accidents/falls/broken bones/dislocations:</u> _____ _____ _____ _____
	<u>Please list medications/vitamins/supplements:</u> _____ _____ _____

<u>Exercise</u> ___ None ___ Daily ___ Moderate ___ Heavy
---

<u>Sleep Position</u> ___ Back ___ Stomach ___ Lft/Rt Side
---

<u>Work Activity</u> ___ Sitting ___ Standing ___ Light Labor ___ Heavy Labor
--

<u>Dominant Hand</u> ___ Right ___ Left ___ Ambidextrous
--

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## Credit Card Authorization

Credit Card: \_\_\_\_\_

CC#: \_\_\_\_\_

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

Code (last 3 digits at signature strip for MC or Visa/4 digits  
on front of AMEX): \_\_\_\_\_

Name (as it appears on credit card):  
\_\_\_\_\_

Billing Address for Credit Card:

STREET \_\_\_\_\_  
\_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

Email address: \_\_\_\_\_  
  
\_\_\_\_\_

### Credit Card Authorization:

I, the undersigned comply and understand that my credit card will be charged with my consent for a pre-negotiated amount for products and/or services rendered by Dr. Lisa Hollingsworth of Holistic Wellbody Innovations. Payment for Dr. Lisa Hollingsworth will be processed via PayPal and receipt will be made available by request.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

## **Acupuncture Informed Consent Form**

Please read this information carefully and ask your practitioner if there is anything that you do not understand.

### **What is Acupuncture?**

Acupuncture is a form of therapy in which fine needles are inserted in specific points on the body.

### **Is Acupuncture Safe?**

Acupuncture is generally very safe. Serious side effects are very rare- less than one per 10,000 treatments.

### **Does Acupuncture Have Side Effects?**

You need to be aware that:

- Drowsiness occurs after treatments in a small number of patients. If affected, you are advised not to drive
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments
- Pain during treatments occur in about 1% of treatments
- Symptoms can get worse after treatments (less than 3% of patients)
- Fainting can occur in certain patients, particularly at the first treatment.

**Single-use, sterile, disposable needles are used.**

### **Is There Anything Your Practitioner Needs to Know?**

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced fainting
- If you have a pacemaker or any other electrical implant
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medications
- If you have damaged heart valves or have any other particular risk of infection

### **Heat Treatment with a TDP Lamp**

This is used to warm an area of the body. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exist.

### **Cupping**

This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight burn blister may appear due to heat.

### **Gua Sha**

Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. It often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

### **Electro-Acupuncture**

A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

**Traditional Chinese Herbal Supplements**

Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs.

If I experience any discomfort related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing Dr. Lisa Hollingsworth of my symptoms.

\_\_\_\_\_ (Please initial)

Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother. \_\_\_\_\_ (Please initial)

**Statement of Consent**

By signing below, I show that:

- I have read, or have had read to me, the information on this consent form
- I understand the possible risks and complications involved. I understand that I can request more information at any time if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue any treatments at any time. I understand that this refusal may affect the expected results.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Print Name in full\_\_\_\_\_

Print Name if Guardian has signed\_\_\_\_\_

## Chiropractic Informed Consent Form

### Chiropractic

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

### Analysis

A doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VCS). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission through the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the recuperative powers of the body.

### Diagnosis

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

### Informed Consent for Chiropractic Care

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment and other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a chiropractic adjustment, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known of to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

### Results

The purpose of chiropractic service is to promote natural health via reduction of the VSS and VSC.

Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual yet satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to failures find quick relief through chiropractic. In turn, we must admit that conditions which do not respond to chiropractic care may come under control or be helped through medical science. The fact is that science of chiropractic and medicine may never be so exact as to provide definite solutions to all problems. Both have made great strides in alleviating pain and controlling disease.

### TO THE PATIENT

Please discuss any questions or problems with the doctor **before** signing this statement of policy.

I have read, and understand the foregoing.

Date \_\_\_\_\_ Signature \_\_\_\_\_