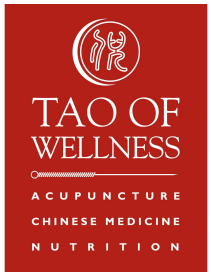

Welcome to the Tao of Wellness!

In an effort to better serve you, below is a reminder checklist of things to prepare before your initial visit. If you have any additional questions, please do not hesitate to call our office at (626) 397-1000 or email us at: officemanager.pasadena@taoofwellness.com

- Please arrive 15 minutes before your appointment
- Please allow approximately 1-½ to 2 hours for your first visit, and 1 hour for subsequent visits.
- Location:
  171 South Los Robles Avenue, Pasadena, CA 91101.
  Our office is located between Cordova Street and El Dorado Street, across the street from the Hilton Pasadena.
- Parking: parking is available behind the building. Please proceed down the driveway (to the right side of the building) and park in our designated parking spots, where you find the red squares. An additional parking option is metered parking on the street (coin only).
- Please complete and sign **ALL** forms enclosed, prior to your appointment.
- Please remember to bring all forms with you when you come in for your appointment. Please note: **ALL** forms need to be completed before any treatment can begin. You may discuss any questions or concerns you might have with our staff or doctors.
- If the forms were emailed or faxed to our office, the following forms will be provided to you upon arrival and must be completed and signed in our office, prior to your appointment: arbitration agreement and informed consent forms.
- Please remember to wear something that is very comfortable and loose fitting.
- If possible, please refrain from using heavily scented products when visiting our office. We have patients and staff with sensitivities. Thank you in advance for your consideration.

Again, welcome to Tao of Wellness and we look forward to serving you!

Sincerely,

- Tao of Wellness

Tao of Wellness

PATIENT INFORMATION:

Name: _____
Last Name First Name

Age: _____ Date of Birth: _____/_____/_____ Driver's License Number: _____ ☐ Male ☐ Female

Home Address: _____ Apt/Ste#:_____

City: _____ State: _____ Zip: _____

Contact Number: ( ) _____-_____☐HOME ☐ CELL ☐ WORK/Alt. Number: ( ) _____-_____ ☐HOME ☐CELL ☐WORK

Employer: _____ Occupation: _____

Work Address: _____City _____ State: ____ Zip: _____

Primary Physician's Name: _____ Phone Number: ( ) _____-_____

E-mail address (to receive Tao of Wellness newsletters) :_____

What is the main reason for your visit today? _____

_____

Please answer the following questions by circling Yes or No

-Do you have a tendency to faint? Yes No
-Do you have a pacemaker? Yes No
-Do you bleed easily and for a considerable length of time? Yes No
-Have you ever had hepatitis? Yes No
-Are you HIV positive? Yes No

-(Females) Are you pregnant? Yes No
-Do you have any allergies? Please list here: _____
_____
-What medications and/or supplements are you currently taking? _____
_____

EMERGENCY CONTACT INFORMATION:

Name: _____Relation: _____ Phone Number: ( ) _____-_____

REFERRED BY:

☐ Individual** ☐ Healthcare Professional** ☐ Tao of Wellness Website ☐ Google ☐ Yelp

☐ Other: _____**If referred by an individual or healthcare professional, please complete below:

Name: _____ Referral Contact Number: ( )_____-_____

Referral's Address: _____

INSURANCE INFORMATION:

(If you require a claim form to submit to your insurance, please complete the section below)

Name of Insurance Co.: _____ Insured's Name: _____

Insured's ID Number: _____ Insured's Date of Birth:_____/_____/_____

Relation to Insured: _____

I have read and agree to the terms above. All of the information is true to the best of my knowledge. Please sign & print your name below.

X_____ Date: _____
Signature of Patient or Parent/Legal Guardian (if under 18 years of age)

X_____ Relation: _____
Printed Name of Patient or Parent/Legal Guardian (if under 18 years of age)

Symptom Checklist

Patient Name: _____

The following is a list of symptoms you may or may not have experienced, mark them as you see fit:
No Mark= Never or Rarely Experienced
√ = Occasionally Experienced
√ √ = Frequently Experienced
√ √ √ = Constantly Experienced

Cardiovascular		**Respiratory**		**Male Only**	
Shortness of Breath		Cough		Prostate Inflammation	
High Blood Pressure		Coughing Blood		Prostate Enlargement	
Low Blood Pressure		Sore Throat		Elevated PSA	
Irregular Heart Beat		Nasal Congestions		Testicular Pain	
Palpitation		Nose Bleed		Erectile Discomfort/Weakness	
Dizziness		Asthma or Wheezing			
Chest Pain/Pressure		Pneumonia		**Female Only**	
Leg Cramps		Hay Fever		Premenstrual Pain	
		Bronchitis		Menstrual Pain	
Gastrointestinal				Breast Pain/Condition	
Indigestion		**Genitourinary**		Irregular Menstruation	
Heartburn/Acid Reflux		Frequent Urination		Hot Flashes/Night Sweats	
Gall Stones		Painful Urination			
Constipation		Night Urination		**Miscellaneous**	
Diarrhea		Hesitated Urination		Jaundice	
Blood in Stool		Urinary Incontinence		Hepatitis	
Excessive Appetite		Blood in the Urine		Memory Loss	
Decreased Appetite		Venereal Disease		Hearing Loss	
Excessive Thirst		Genital Area Pains		Tinnitus	
Nausea		Decreased Libido		Headaches	
Vomiting				Insomnia	
Belching/Burping		**Musculoskeletal**		Fever	
Colitis/Diverticulitis		Back Pain		Chills	
Hernias		Neck/Shoulder Pains		Kidney Stones	
Difficulty Swallowing		Muscle Pain/Cramps		Intolerance to Weather Changes	
Skin		Painful Joints		Eye Discomfort/Pain	
Ulcerations		Numbness/Tingling in Hands/Feet		Fatigue	
Rash/Hives		Broken Bones		Depression/Anxiety	
Edema		Arthritis		Hemorrhoids	

TAO OF WELLNESS
ACUPUNCTURE
CHINESE MEDICINE
NUTRITION

Office Policy

Last Name: _____ First Name: _____

Please read through our office policy below, and acknowledge that you will adhere to the following Tao of Wellness policies:

1. Payment is expected at the time services are rendered. Accepted forms of payment are cash, checks, Visa, Mastercard & Discover card. There is a service charge of $15.00 for every returned check from the bank.

2. We do not bill insurance companies or accept assignments. We are not responsible for collecting from your insurance company, negotiating a settlement, or disputing a claim.

3. If you need to cancel or reschedule your appointment(s), please inform us **at least 24 hours prior** to your appointment time to avoid a cancellation fee. If you miss your appointment(s) or cancel within the 24 hours prior to your appointment(s), you will be charged for the missed appointment(s).

4. If you arrive late to your appointment(s), we will do our best to accommodate you. We cannot guarantee that you will be seen by your scheduled practitioner. Additionally, your treatment time may be shortened due to time constraints. If you have booked multiple services and the practitioner is unable to complete all services, you will still be charged for all scheduled services.

5. Herbal supplements are not returnable, nor refundable; however, some exceptions may be made in certain circumstances.

6. The Tao of Wellness is required by law to follow HIPAA guidelines, to maintain the privacy and confidentiality of your protected Health Information. The policy is available for you to read in our waiting room or you can request a written copy from our staff.

   Please Initial here X_____ to acknowledge that you have been advised of our HIPAA guidelines and offered the policy for review or provided a written copy, upon request.

I have read and agree to the above terms and conditions.

X_____ Date: _____
Signature of Patient/Parent/ Legal Guardian (if under 18 years of age)

X_____ Relation: _____
Printed Name of Patient/Parent/ Legal Guardian (if under 18 years of age)

X_____ Date: _____
Office Signature