WU'S
WELLNESS CENTER

**Last Name:** _____ **First Name:** _____
**Gender: (circle one): M F** **Date of Birth:** _____ **Age:**_____
**Address:**_____ **City/State/Zip:** _____
**Home Phone:** _____ **Work:** _____ **Mobile:** _____
**E-mail:** _____
**Occupation:** _____ **Sports/Activities:** _____
**How did you hear about us?**_____
**Your Dr's Name:** _____ **Your Dr's Phone #:** _____
**Diagnosis By Your Dr:** _____
**Please describe occurrence and symptoms (required):** _____
_____
**Onset Date:** _____ **Treatment Received:** _____
**Emergency Contact Name & Number:** _____

**Please answer the following questions yes or no:**

| | | | |
|---|---|---|---|
| Have you ever received acupuncture before? | ____ | Do you have a tendency to faint? | ____ |
| | | Are you taking any medications? | ____ |
| Do you bruise or discolor easily? | ____ | (Please list all medication on back) | |
| Do you bleed for a long time? | ____ | Are you hungry at this present time? | ____ |
| Do you have hepatitis? | ____ | Are you exhausted at this time? | ____ |
| Have you ever had hepatitis? | ____ | Are you nervous at this time? | ____ |
| Do you have high blood pressure? | ____ | Are you pregnant at this time? | ____ |
| Do you have low blood pressure? | ____ | Do you have a compensation claim or lawsuit pending your complaint? | ____ |
| Do you or have you ever had any heart problem? | ____ | How does your body respond to soft tissue manual therapy? Circle all that apply: | |
| Do you have any respiratory problems? | ____ | Improvement, Neutral, Sore, Very Sore, | |
| Have you had any surgery before? | ____ | Unknown, Other _____ | |

I, the undersigned, realize that acupuncture/ acupressure may be considered an investigative procedure in the United States of America. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment. Every attempt will be made to protect me from harm, but there may be the possibility of unfavorable skin reaction, unforeseen nerve damage, possible infection, unexpected bleeding and/ or other complications not anticipated. I realize that I may withdraw from the program at any time. I agree to pay for all services at the time they are received.

**Patient's Signature:** _____ **Date:** _____

Wu's Wellness Center
1014 Clement Street, San Francisco, CA 94118 (415) 750-5050

Dear Clients:

In order to provide quality care to all of our clients, we have established the following policies:

**Cancellation fee is charged $110 per session, unless given <u>ONE FULL BUSINESS DAY</u> 24 hours notice. Please cancel BY PHONE ONLY.** The clinic is open Monday through Friday. When scheduling appointments, please keep in mind that cancellations made during weekends and holidays (when the clinic may be closed) will be subject to the cancellation fee if adequate notice is not provided.

**No refund on any herbs, books, supplies, or equipment.**

Credit for herbs is available at our discretion for any herb formula that is:
1.) Non-expired 2) Unopened 3) Bottled

Wu's Wellness Center reserves the right to disqualify ourselves from treating a patient.

Thank you for your support and cooperation. We hope that these policies help us create a positive and beneficial experience for you each time that you visit our office.

**Client Signature: _____**

**Date: _____**

**Office Signature: _____**


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**(Client's copy)**