NATURAL HEALING & ACUPUNCTURE INC.

PATIENT RECORD

NAME :_____ BIRTHDATE :_____/_____/_____
[LAST] [FIRST]

SOCIAL SECURITY NUMBER: _____ - _____ - _____ DRIVER'S LICENSE NUMBER: _____

HOME ADDRESS: _____CITY:_____

STATE/ZIP:_____ SEX: ☐ M / ☐ F AGE:_____ REFERRED BY: _____

HOME PHONE : (_____)_____ WORK PHONE : (____)_____CELL PHONE (_____)_____

[☐] CHECK TO RECEIVE NEWSLETTER E-MAIL:_____

OCCUPATION:_____ EMPLOYER:_____

SPOUSE/PARTNER/EMERGENCY CONTACT INFO:

NAME :_____ BEST PHONE: (_____)_____

YOUR DOCTOR'S NAME:_____ SPECIALTY:_____

DOCTOR'S PHONE NUMBER:(_____)_____ DOCTOR'S CITY & STATE: _____

IS YOUR CONDITION DUE TO: ☐ ACCIDENT ☐ JOB INJURY ☐ OTHER

FOR ACUPUNCTURE PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS			
1.	Do you have a tendency to faint?	☐ Yes	☐ No
2.	Do you have a pacemaker	☐ Yes	☐ No
3.	Do you bleed for a long time?	☐ Yes	☐ No
4.	Have you ever had hepatitis?	☐ Yes	☐ No
5.	Are you HIV +?	☐ Yes	☐ No
6.	Are you hungry now?	☐ Yes	☐ No
7.	Are you exhausted now?	☐ Yes	☐ No
8.	[Women] Are you pregnant?	☐ Yes	☐ No

For patients without insurance:
We will collect in full at the time of the visit.

For patients with insurance:
As a courtesy, we will accept your insurance assignment whenever possible once your coverage is verified. We will file your claim forms & assist you in every way we can. It may be necessary for us to charge a co-pay for services rendered if your insurance policy does not cover the full cost of the treatment

If you need to cancel an appointment, please inform the office at least 24 hours in advance to avoid a full charge of service. A missed appointment without 24-hour cancellation will also be charged a full fee.

Patient's Signature **Date**

Initial Evaluation Form

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released without your authorization

Name:_____ Date:_____

Birthdate:_____ Age:_____ Height:_____ Weight:_____

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Based upon the chief complaint when did the problem start?

_____

If pain, rate on a scale of 1-10 Circle one

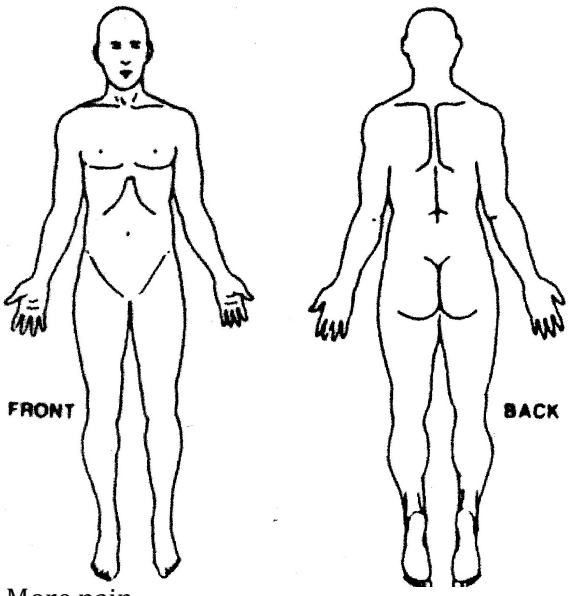
Less pain

0 1 2 3 4 5 6 7 8 9 10

More pain

Minimal Slight Moderate Severe

PLEASE MARK YOUR AREAS OF PAIN



How long have you had this condition? _____ Have you had this condition in the past?_____

What makes it better?_____

What makes it worse?_____

Is your condition: (circle one) Getting worse ☐ Constant ☐ Comes and goes ☐

Medications you are currently taking:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Other medications:_____

Herbs/Supplements you are currently taking:_____

List surgeries/Operations you have had and when? _____

Date of your last physical examination:_____ By whom?_____

Medical History (Do you have or have you ever had?)

- ☐ Arthritis
- ☐ Asthma
- ☐ Anemia
- ☐ Heart Trouble
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Stroke
- ☐ Kidney or Bladder Trouble
- ☐ Gallstones
- ☐ Ulcers
- ☐ Fatigue/Fibromyalgia
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Sudden Weight Loss
- ☐ Sudden Weight Gain
- ☐ HIV +

Other:_____

Family History: (Has any member of your family had any of the above?) YES ☐ NO ☐ (Circle one)

If yes, which member & what did they have?_____

Energy Level: Please rank your overall energy level on a scale from 1(low) to 10 (high):

0 1 2 3 4 5 6 7 8 9 10

Do you experience an energy slump (circle if applies): After Meals ☐ After Lunch ☐

Stress: What causes it? _____

☐ None ☐ Moderate ☐ Severe

Sweating: ☐ Night Sweats ☐ Excessive Sweating ☐ Sweating with Slight Exertion ☐ Rarely Sweats

Circulation: Feelings of…

- ☐ Hot areas?_____
- ☐ Cold areas?_____
- ☐ Cold limbs
- ☐ Bruises easily
- ☐ Bleeds easily

Other :_____

Skin: (check all that apply)

- ☐ Dry itchy
- ☐ Moist/Clammy
- ☐ Frequent rashes
- ☐ Burning
- ☐ Hair thinning
- ☐ Acne
- ☐ Dry scalp
- ☐ Bruises easily
- ☐ Hives

Other :_____

Scars: (list all scars from accidents and surgeries)_____

Sleep: (Circle all that apply) Falling asleep ☐ Staying asleep ☐ Excessive dreaming ☐

Other: _____ How many hours do you sleep per night?_____

Head: Headaches/Migraines (what area?) _____

☐ Dizzy ☐ Memory loss ☐ Loss of balance

Other :_____

Eyes: ☐ Eye pain ☐ Blurred vision ☐ Dry eyes ☐ Darkness under eyes

Other: _____

Ears: ☐ Poor hearing ☐ Earaches ☐ Ear infections ☐ Ear ringing

Other: _____

Nose: ☐ Frequent nose bleeds ☐ Sinus issues ☐ Frequent colds

Other:_____

Throat: ☐ Sore Throat ☐ Difficulty swallowing ☐ Swollen tongue ☐ Hoarseness ☐ Jaw Problems

Other: _____

Chest: ☐ Hard to breathe ☐ Wheezing ☐ Shortness of breath ☐ Pain/pressure in chest

☐ Issues breathing at night ☐ Palpitations ☐ Persistent cough ☐ Coughing blood

☐ Coughing phlegm Other:_____

Bowels: ☐ Diarrhea ☐ Constipation ☐ Bloody stools ☐ Black stools ☐ Mucus in stools

☐ Hemorrhoids ☐ Lower bowel gas ☐ Stools have foul odor ☐ Colon problems

Number of bowel movements a day?_____

Urine: Color:_____ Amount:_____

☐ Frequent Urination ☐ Hard to urinate ☐ Pain or burning on urination ☐ Frequent infection

☐ Daytime ☐ Water retention ☐ Strong smelling urine ☐ Blood in urine

☐ At night

Musculoskeletal: Pain in:

☐ Neck	☐ Upper Back	☐ Muscle spasm/cramps
☐ Shoulder	☐ Weak Ankles	☐ Loss of grip
☐ Between Shoulders	☐ Mid Back	☐ Loss of feeling in Hands/Feet
☐ Arms/Wrists	☐ Stiff all over	☐ Swollen Knees/Elbows
☐ Hands/Fingers	☐ Lower Back	☐ Leg cramps at night
☐ Hip	☐ Sciatica	☐ Painful Joints
☐ Knee	☐ Tingling in Feet	☐ Weakness in Legs
☐ Big Toe	☐ Bones sore/painful	☐ Bursitis

Neurological:

☐ Nervousness	☐ Mood swings	☐ Suicidal
☐ Depressed	☐ Poor coordination	☐ Seizures
☐ Easily angered	☐ Memory confusion	☐ Tremors
☐ Easily irritated	☐ Muscle weakness	☐ Nerve pain
☐ Frequent crying	☐ Poor concentration	☐ Numbness/tingling in limbs
☐ Worry/anxiety	☐ Feel weak and shaky	☐ Shingles

Other: _____

Females:

Last monthly period? _____ Last PAP test?_____ Form of birth control?_____

Age started menses?_____ Age stopped? _____ Color:_____

No. Pregnancies?_____ No. Deliveries?_____ No. Miscarriages?_____ No. Abortions?_____

Females [Cont.]:

☐ Water retention ☐ Low or no sex drive ☐ Hot flashes ☐ Food cravings
☐ Mood changes ☐ Miss periods ☐ Painful Breasts

Discharge:

☐ Yellow ☐ White ☐ Itching ☐ Thick ☐ Odor

Males:

☐ Low sex drive ☐ Lack of sex drive ☐ Impotence ☐ Ejaculation causes pain ☐ Discharges
☐ Premature ejaculation ☐ Pain or burning while urinating ☐ Prostate trouble

Appetite:

☐ Excessive appetite ☐ Tired/weak if meal is missed ☐ Excessive thirsty
☐ Poor appetite ☐ Appetite keeps changing ☐ Never thirsty

Specific food cravings:_____

Digestion:

☐ Stomach gas ☐ Stomach pain ☐ Bad breath
☐ Lower bowel gas ☐ Stomach cramps ☐ Sores in mouth
☐ Heartburn ☐ Nausea ☐ Weight gain
☐ Burning/belching ☐ Vomiting ☐ Weight loss
☐ Bitter/sour taste in mouth ☐ Abdominal bloating… How long after eating?_____
☐ Food Allergies

Nutrition: List some of your favorite foods: _____

_____

Do You?

☐ Skip breakfast ☐ Eat a snack ☐ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal?_____

How many glasses of water do you drink?_____

Do you use?

☐ Alcohol Glasses per week: _____ Type: _____

☐ Tobacco No. of packs per day: _____ How many years?_____

Do you:

☐ Eat raw fruits and vegetables at least 2x/day?
☐ Eat green or yellow vegetables at least 2x/day?
☐ Eat frequently between meals?
☐ Chew your food thoroughly before swallowing it?
☐ Drink juice, milk or other drinks instead of water when thirsty?
☐ Always add salt?
☐ Eat meat or dairy products 2 or more times a day?
☐ Eat the same foods almost every day?
☐ Eat when you are not hungry?
☐ Eat until you feel full?
☐ Occasionally go on a crash diet?

Patient Signature _____

Informed Consent to Telehealth

To better serve the needs of patients, our services may be available by telehealth (two-way interactive video communication and electronic transmission). This consent explains telehealth care. If you have any questions, please ask your provider.

I understand that I may be evaluated and treated via telehealth and agree to the following:

1. Telehealth Services: Telehealth involves transmission of video or digital photographs of me, and/or details of my health ("Transmitted Data"). All Transmitted Data is sent via electronic means to my provider(s) to facilitate health care services. I understand that:

a) Telehealth is different from traditional care in that the patient and provider do not meet physically in-person;

b) Patients will be informed of any additional personnel that are to be present, seen or unseen, during the encounter. Patients must inform their Provider of any person other than the patient who is present. Patients have the right to exclude anyone from either location;

c) Patients have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment, however, equivalent in-person services might not be available at the same location or time as telehealth services. A refusal to participate in telehealth will not affect rights to future care or benefits to which a patient may otherwise be entitled;

d) Patients have the right to follow-up with their provider as necessary with questions or concerns;

e) Benefits of telehealth include that the patients and providers can continue health care services when an in-person appointment is not possible or is inconvenient. The provider can also visualize some of the client's environment. Telehealth may also minimize exposure to illness;

f) There are also risks involved in telehealth including, without limit, losing the ability to; a) perform aspects of a physical examination (for example listening to the patient's heart and lungs or verifying vital signs); b) read physical or vocal cues/tones, and facial expressions; and c) provide immediate emergency physical services/care;

g) Additionally, technical issues may disrupt the visit. There are also risks to preserving confidentiality including the risk that communications may be overheard; and that communications may be accessed by unknown third-parties; 8) Patients shall have to access to all medical information resulting from the telehealth services as provided by applicable law for patient access to medical records.

2. Confidentiality: All confidentiality protections required by law or regulation will apply to my care. Although confidentiality extends to communications by text, email, telephone, videoconference and other electronic means, providers cannot guarantee that those communications will be kept confidential and/or that a third-party may not gain access to such communications. With electronic communication, there is always a risk that communications may be compromised, unsecured, and/or accessed by a third-party. To help maintain confidentiality when engaging in electronic health services, it is important that all sessions be conducted in a confidential place. This means that clients agree to participate in telehealth only while in a room or area where other people are not present and cannot overhear the conversation. Do not have sessions in public places. Sessions may not be recorded and patients must seek written permission before recording any portion of the session and/or posting any portion of sessions.

3. Emergencies: Telehealth is not appropriate if I am experiencing an emergent health care situation. If am experiencing an emergency, I understand that it is my responsibility to immediately call 911. If an emergency develops during telehealth services, I understand that it is my responsibility to immediately inform my telehealth provider, call 911 and stay connected with my telehealth provider (if possible) until help arrives.

I have read and agree to the terms in the Telehealth Consent. I understand that telehealth is not a substitute for in person health care services. I understand that telehealth is not appropriate if I am experiencing a crisis or having suicidal or homicidal thoughts. In case of emergency situations, I will contact 911.

Patient Name: _____ Signature: _____ Date: _____