ACUPUNCTURE AND INTEGRATIVE HEALTHCARE, LLC
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Patient information: An Introduction to Traditional Chinese Medicine

Traditional Chinese Medicine is a complete medical system which originated in Asia over two thousand years ago. In includes acupuncture, herbal medicine and a number of other natural modalities such as cupping, guasha, electrical stimulation, acupuncture point injection therapy and tuina (Chinese massage).

Acupuncture and Chinese medicine are safe, effective and drug-free therapies that has been cited by WHO (World Health Organization) to treat over 43 conditions including: addiction (alcohol/smoking), allergy, musculoskeletal disorder, back pain, osteoarthritis, chronic fatigue, migraine, emotional problems, stress, infertility and many others (please refer to www.acupuncturecare.biz for a complete list).

In TCM (Traditional Chinese Medicine) there exists a meridian system that runs all throughout the body. There are over 360 specific points on these meridians and they are all connected to the internal organs and body functions. In a healthy body, vital energy (or Qi – pronounced as "chee") in these meridians flows freely resulting in a balanced system. If the flow of energy is interrupted by the stress or injury, that negatively effects the balance in the body causing disease.

By performing acupuncture using the points associated with a particular meridian or organ, the Qi or balance is restored and the diseased condition is relieved. Acupuncture is performed with extremely thin, individually packaged, FDA approved and sterilized stainless steel needles. The process is typically painless and the patient usually experiences slight soreness, numbness, warmth or pressure at the site of insertion.

Each patient's response to acupuncture may vary depending on their health condition, how chronic it is, and overall williness to participate in the treatment process. Most patients usually notice an improvement by the 3rd or 4th treatment. Very often they also notice an improvement in other areas of their health condition since Chinese Medicine is a holistic health system that treats body as a whole. It is important to follow your acupuncture physician's guidelines for herbal, supplement or dietary recommendations as closely as possible. On rare occasions, symptoms may become slightly worse after the treatment which is usually a sign of an underlying conditions being addressed so that the healing can occur. That should get resolved quickly.

Patients are advised not to come to their acupuncture appointment on a too full or empty stomach and it is best not to take hot baths and avoid vigorous physical activity during the rest of the day following the treatment.

PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name M.I. Last Name

Address City State Zip

Home Phone ( ) Cell ( ) Work ( )

SS# Age DOB

Drivers License # Male ☐ Female ☐

Employer Occupation

Married ☐ Single ☐ Divorced ☐ Name of Spouse

Emergency Contact Telephone ( )

Referred by Friend ☐ Relative ☐ Insurance ☐ Other ☐

PRIMARY INSURANCE Cash ☐ Group ☐ Work/Comp ☐ Auto ☐ Other ☐

Name of Insurance Co. ID#. Group#

Name of Insured Relationship to Patient: Self ☐ Spouse☐ Parent ☐

Secondary Insurance Name of Insured

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understand that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (print) Patient Signature Date

24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE

__________takes pride in the quality of care he offers his patients. In order to do this he has a strict cancellation policy. Dr. __________ requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged to the credit card we have on file.

I, ___________________________________ authorize Dr. ________ to charge the credit card given below, for cancellation fees, insurance co-payments and related charges.

V-code _____

____________-_____________-______________-________________ Ex______/_______ Visa ☐ / MC ☐

Patient Name (print) Patient Signature Date

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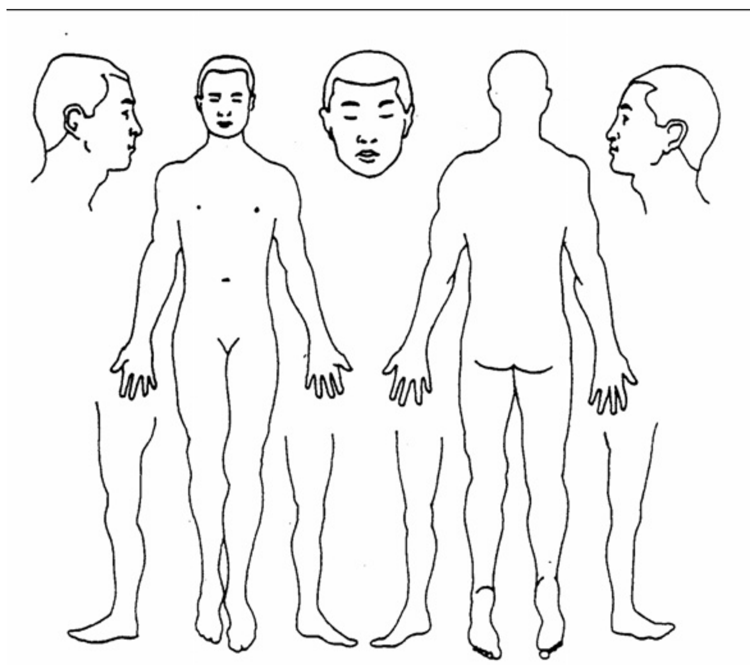
NAME________________________________ DATE__________________________

I. Goals: What would you most like to achieve through your work at the Acupuncture and Integrative Healthcare, LLC?
1. ____
2. ____
3. ____
4. ____
5. ____

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)
1. ____
2. ____
3. ____
4. ____

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? Y / N

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

For Women:
1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

2. Indicate number of occurrences:
Live Births _______ Pregnancies_______ Miscarriages _______ Abortions _______

3. Age: First period _____ Menopause (if applicable) _____

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / ______

5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? ___________________________

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6. Is your menses cycle regular? [ ] Yes [ ] No
a) Average number of days of flow ______
b) The flow is: [ ] Normal [ ] Heavy [ ] Light
c) The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs/symptoms?

[ ] Difficulty with Orgasm
[ ] Cramps
[ ] PMS
[ ] Heavy Vaginal discharge between periods
[ ] Pain with Intercourse
[ ] Nausea
[ ] Bleeding between Periods
[ ] Blood Clots
[ ] Breast Distention
[ ] Vaginal Discharge

For Men:
1. Do you have any bothersome urinary symptoms? [ ] Yes [ ] No

Describe:____

2. Check all that apply:

[ ] Erectile dysfunction
[ ] Difficulty with orgasm
[ ] Pain or swelling of the testicles
[ ] Frequent need to urinate at night
[ ] Impotence/erectile dysfunction
[ ] Premature ejaculation
[ ] Feeling of coldness or numbness in genitalia
[ ] Pain/Subtly of testicles

3. Do you get up at night to urinate? [ ] Yes [ ] No How often? ______________________

4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?
____

5. Have you sought Medical intervention for these problems? If so, when? ______________________

____

6. What treatments have you tried for these problems and how successful have they been?
____

III. Medical History

Please check all that apply	*Date Diagnosed*		*Date Diagnosed*
Diabetes	___ / ___ / ___	High Cholesterol	___ / ___ / ___
High Blood Pressure	___ / ___ / ___	High Blood Pressure	___ / ___ / ___
Thyroid Disease	___ / ___ / ___	Seizures	___ / ___ / ___
Cancer	___ / ___ / ___	Hepatitis	___ / ___ / ___
HIV	___ / ___ / ___	Others	___ / ___ / ___

IV. Surgical History

____ Date ______________
____ Date ______________
____ Date ______________

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V. Family History
Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements
Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Allergies (to medications, chemicals or foods):

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)

____

2. What do you eat on a "typical" day? ______________________________
a) Breakfast ____
b) Lunch ____
c) Dinner ____
d) Snacks ____
e) Foods you tend to crave: ____________________________________
f) Foods you dislike: ____

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IX. Social History
1. How much per day do you use of the following?
a) Coffee, tea, soft drinks: ____________________
b) Alcohol: ____________________
c) Cigarettes, cigars, other tobacco: ____________________
d) Other drugs: ____________________

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?
____

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?
____
____

7. In the past year, how many days have been significantly affected by your health? __________

8. How many days did you feel generally poor? ______

9. How many times were you in the hospital? ______

10. Please describe your current exercise regimen:
Hours per week: ____ Activities: ____________________ [ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? ________

12. Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

13. Who would you describe as your source of primary social support? (relationship to you)

X. Other Information
Please list and briefly describe the most significant events in your life:
1. ____________________
2. ____________________
3. ____________________
4. ____________________

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:
____
____
____
____
____
____

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HEALTH: CHECK ALL THAT APPLY

GENERAL

Past	*Current*	*Condition*
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _______________

SKIN & HAIR

Past	*Current*	*Condition*
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HECK & NECK

Past	*Current*	*Condition*
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _______________

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _______________

EYES

Past	*Current*	*Condition*
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _______________

NOSE, THROAT, MOUTH

Past	*Current*	*Condition*
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	*Current*	*Condition*
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____________

RESPIRATORY

Past	*Current*	*Condition*
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: ______________

GASTRO-INTESTINAL

Past	*Current*	*Condition*
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: ______________

GENITO-URINARY

Past	*Current*	*Condition*
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: ______________

MALE

Past	*Current*	*Condition*
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: ______________

FEMALE

Past	*Current*	*Condition*
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____________

NEUROLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: __________________

PSYCHOLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: __________________

INFECTION SCREENING

Past	*Current*	*Condition*
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	*Current*	*Condition*
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain

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OUR CLINIC PROTECTS YOUR HEALTH INFORMATION AND PRIVACY

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company and with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners. We will obtain your authorization before disclosing any information.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, worker's comp and your employer, and other third party administrators (*e.g.* requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you -*e.g.* your name, address, Social Security number, etc.).

We value our relationship with you, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (941)773-1899

Yours sincerely,

Olga V. Ways, L.Ac,

Your Office

Acknowledgement of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practices for the office of Olga V. Ways, DOM, AP, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: ____ **Date:** _____________

If not signed by patient, please indicate relationship to patient (e.g., mother) and patient's name.

Patient:_______________________________________

Relationship: _________________________________