HEATHER'S HOLISTIC HEALTH, LLC INFORMATION FORM

Name _____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Date of Birth _____

Medications _____ Occupation _____

1. Have you ever had massage therapy? Yes or No _____
1a. **Do you prefer quiet massage or to engage in conversation** ? Quiet Talking (circle one)
2. Have you ever had surgery? (back, knee, etc.) Yes or No _____
3. Are you under a doctor's care? Yes or No _____
4. Do you see a Chiropractor? Yes or No _____
5. Do you have headaches? Yes or No _____
6. Do you grind your teeth at night? Yes or No _____
7. Do you suffer from allergies? Yes or No _____
8. Do you take medications? Yes or No _____
9. Do you have any open sores, rashes? Yes or No _____
10. Do you have chronic back pain? Yes or No _____
11. Do you have varicose veins? Yes or No _____
12. Are you pregnant? Yes or No _____
13. Do you have arthritis? Yes or No _____
14. Do you have blood clots? Yes or No _____
15. Do you have heart problems? Yes or No _____
16. 17. Do you have diabetes? Yes or No _____
18. Do you have HIV or AIDS? Yes or No _____
19. Have you ever broken any bones? Yes or No _____
20. Have you suffered any sprains or strained muscles? Yes or No _____
21. Do you smoke? Yes or No _____
22. Do you have asthma? Yes or No _____
23. Do you suffer from TMJ (jaw pain) Yes or No _____
24. Do you have any long-term illness? Yes or No _____
25. Are you sensitive to any oils or scents? Yes or No _____
26. Are there any areas that should be avoided? _____
27. What specific areas would you like to have worked on? _____
28. How did you find out about us? Women's Journal _____ Local Book _____ Friend _____
Internet _____ Newspaper _____ Newsletter _____ Other _____ Sign _____
In case of emergency, please notify _____ Phone _____

I have completed this information form to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care. Information exchanged during any massage session is educational in nature and is intended to help me to become more familiar and conscious of your health status. All information is private and confidential.

Name _____ Date _____

PATIENT QUESTIONNAIRE AND INFORMED CONSENT FORM

		YES	NO
1.	Are you now, or have you recently been, on any medication(s)? If yes, please list medication:_____	____	____
2.	Are you now, or have you ever been, on blood thinners or anticoagulants?	____	____
3.	Do you bleed easily?	____	____
4.	Have you ever been told that you have a heart problem?	____	____
5.	Do you have a pacemaker, or any other device that has been surgically implanted in your body?	____	____
6.	Have you ever had hepatitis, or has your skin ever turned yellow?	____	____
7.	Do you faint easily?	____	____
8.	Are you pregnant, or are your periods delayed?	____	____

Acupuncture is an Oriental medical procedure that has been practiced for over 3,000 years. In the USA, it is considered therapeutic treatment by the National Institute of Health.

1. I the undersigned hereby authorize and direct any licensed acupuncturist in this office to administer acupuncture, which involves the insertion of needles at one or more points in the body or the application of other forms or adaptations of Oriental medicine.

2. I understand that the acupuncturist prior to my receiving the initial treatment will answer any and all questions posed by me regarding the procedures of acupuncture to be used.

3. I understand that health insurance may not cover this treatment. A physician referral may be necessary for coverage by HMO's.

4. There are almost never side effects from this treatment, however upon occasion, symptoms, which have been experienced in the past, may recur. These symptoms should abate within 72 hours. Sometimes a drop of blood may exit when the needles are removed and slight bruising may be seen. Success of the treatments will also vary among individuals; however studies have proven acupuncture to be effective in a variety of both acute and chronic illness, and it is especially helpful for pain management and control.

**A Note About Appointments: We ask that you give us 24 hours notice to cancel an appointment. We reserve the right to charge a cancellation fee for appointments cancelled in less than 24 hours.*

I have read and understood the above statements, and fully consent to the use of acupuncture as a treatment modality.

Date_____ Patient Signature_____

Parent/Guardian_____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held **absolutely** confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you.

Have you tried Acupuncture or Chinese traditional herbal medicine before?_____
Main concern(s) you would like us to help you with._____
_____
To what extent does this problem affect your daily activities(work, sleep, eating, etc.)?_____
How long has it been since you first noticed your symptoms?_____
_____
Have you been given a diagnosis for the problem? If so, what?_____

What kinds of treatment have you tried?_____
_____

ast medical history (please include dates):
ignificant Illnesses: ☐Cancer ☐Diabetes ☐Hepatitis ☐High Blood Pressure
☐Heart Disease ☐Seizures ☐Rheumatic Fever ☐Thyroid Disease
☐Venereal Disease Other_____
Surgeries:_____
_____
gnificant Trauma:
_____
_____
ith History (prolonged labor, forceps delivery, etc): _____
llergies:_____
ther relevant medical history: _____
_____
_____

'amily Medical History:
☐Diabetes ☐Cancer ☐High Blood Pressure ☐Heart Disease ☐Stroke ☐Seizures
☐Asthma ☐Allergies_____
_____
Medicines taken within the last two months (vitamins, drugs, herbs, etc.):_____
_____

Occupation:_____

Occupational Stress Factors (physical, psychological, chemical):_____

Do you follow a regular exercise program?_____ If so, please describe._____

_____

Have you ever been on a restricted diet?_____ What kind?_____

Please describe-your average daily diet:_____

Morning Afternoon Evening

_____

_____

Do you smoke?_____ How many packs per day?_____

How much coffee, tea or cola do you drink per week_____

How much alcohol do you drink per week?_____

Please describe any use of drugs for non-medical purposes._____

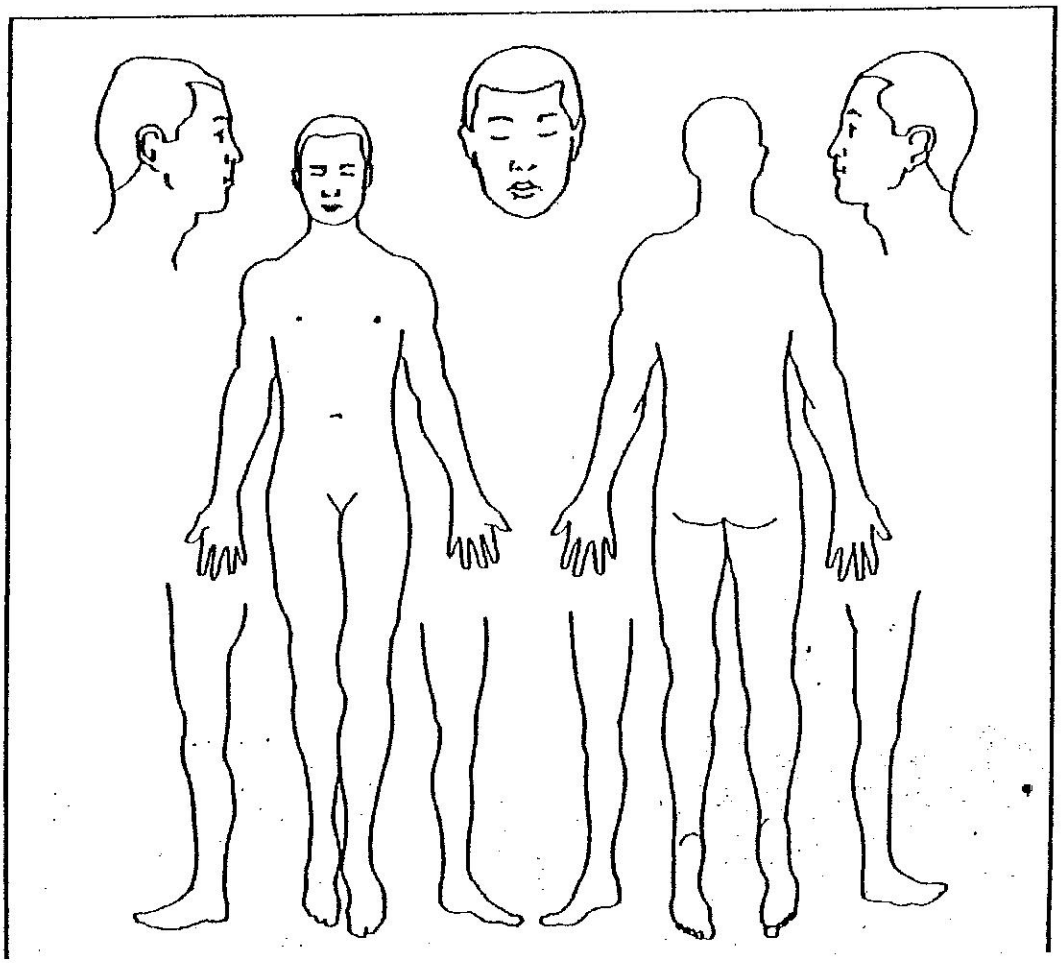
_____

_____

_____

Indicate painful or distressed areas:

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
	normal
#	tense
Spontaneous pain	
!	slight
!!	moderate
!!!	severe
Pulsing	
∞	slight
∞∞	moderate
∞∞∞	strong
Temperature	
-	colder
	normal
+	hotter
Physical	
O	sores
!!	rashes
><	spasms



Please check if you have had any of these symptoms in the last 3 months:

GENERAL

___ Poor appetite
___ General weakness
___ Sudden energy drop
___ Sweat easily
___ Bleed or bruise easily
___ Dizziness
___ Poor sleeping
___ Strong thirst
___ Weight loss
___ Weight gain
___ Change in appetite
___ Poor balance
___ Night sweats
___ Fever daytime
___ Cravings
___ Chills

Please explain any of the above or list anything not listed above: _____

_____

_____

SKIN AND HAIR

___ Rashes
___ Itching
___ Dandruff
___ Ulcerations
___ Eczema
___ Change in moles
___ Hives
___ Pimples
___ Boils

Please explain any of the above or list anything not listed: _____

_____

_____

HEAD, EYES, EARS, NOSE, THROAT

___ Dizziness
___ Change in vision
___ Ringing in ears
___ Sinus problems
___ Grinding/clenching teeth
___ Spots in front of eyes
___ Poor hearing
___ Recurrent sore throats
___ Mouth sores
___ Tension headaches
___ Migraine headaches
___ Sinus headaches
___ Earaches
___ Eye pain
___ Nosebleeds
___ Facial pain
___ Chronic colds

Please explain any of the above or list any condition not mentioned: _____

_____

CARDIOVASCULAR/CIRCULATION

___ High blood pressure
___ Low blood pressure
___ Irregular heart beat
___ Cold hands or feet
___ Blood clots
___ Swelling of hands
___ Chest pain
___ Fainting
___ Swelling of feet
___ Other heart problems

Any other heart or blood vessel problems: _____

_____

RESPIRATORY

___ Cough
___ Chronic cough
___ Phlegm/mucous
___ Shortness of breath
___ Bronchitis
___ Asthma
___ Pressure in chest

what color? _____

Any other lung problems? _____

_____

GASTROINTESTINAL

___ Nausea
___ Constipation
___ Indigestion
___ Rectal pain
___ Vomiting
___ Gas
___ Bad breath
___ Hemorrhoids
___ Diarrhea
___ Belching
___ Abdominal pain or cramps
___ Diverticulitis
___ Colitis

Any other problem with stomach or intestines? _____

_____

GASTROINTESTINAL

☐Nausea ☐Vomiting ☐Diarrhea
☐Constipation ☐Gas ☐Belching
☐Black stools ☐Blood in stools ☐Indigestion
☐Bad breath ☐Rectal pain ☐Hemorrhoids
☐Abdominal pain or cramps ☐Chronic laxative use

Any other problems with your stomach or intestines?_____

GENITO-URINARY

☐Pain on urination ☐Frequent urination ☐Blood in urine
☐Urgency to urinate ☐Unable to hold urine ☐Kidney stones
☐Decrease in flow ☐Impotency ☐Sores on genitals

Do you wake up at night to urinate?_____How often?_____

Any particular color to your urine?_____

Any other problems with your genital or urinary systems?_____

REPRODUCTIVE AND GYNECOLOGIC

_____Number of pregnancies _____Number of births _____Premature births
_____Miscarriages _____Age at first menses _____Abortion
_____Length of time between menses _____First date of last menses _____Duration
☐Unusual character (heavy or light) ☐Clots ☐Painful periods
☐Irregular periods ☐Last PAP ☐Vaginal discharge
☐Vaginal sores ☐Breast lumps ☐Menopause (age___)

☐Changes in body/psyche prior to menstruation_____

Do you practice birth control?_____ What type?_____ For how long?_____

MUSCULOSKELETAL

☐Neck pain ☐Muscle pains ☐Knee pain
☐Back pain ☐Muscle weakness ☐Foot/ankle pains
☐Hand/wrist pains ☐Shoulder pains ☐Hip pain

Any other joint or bone problems?_____

NEUROPSYCHOLOGICAL

☐Seizures ☐Dizziness ☐Loss of balance
☐Areas of numbness ☐Lack of coordination ☐Poor memory
☐Concussion ☐Depression ☐Anxiety
☐Bad temper ☐Easily susceptible to stress

Have you ever been treated for emotional problems?_____

Have you ever considered or attempted suicide?_____

Any other neurological or psychological problems?_____

COMMENTS

Please tell us of any other problems you would like to discuss:

_____

_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding your health record

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examintaion and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used willl help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our web site that provides information about our customer service and/or benefits.

Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem

For further explanation of this notice you may contact-the Secretary of U. S. Department of Health and Human Services at-The Hubert Humphrey Bldg.- 200 Independence Ave. SW, Washington, DC 20201.

If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human Services with no fear of retaliation by this office.

Your health information will be used for treatment, payment, and health care operations.

Treatment-Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician/Acupuncturist recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment- Your health care infromation will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentatioan that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations-The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your infromation may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Client Signature_____

Effective Date_____Date of Care_____

Worker's Compensation- This office will release information to the extent authorized by law in matters of worker's compensation.

Public Health- This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correctional Facilities- This office will release medical information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for r the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement- (1) Your health information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. (2) Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of their office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more patients, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posted where registration occurs. All individuals receiving care will be given a hard copy.

CLIENT COMMENTS

_____

_____

_____

_____

_____

_____

_____