

POWER HEALING

Our ability to draw effective conclusions about the present state of your health and how to improve it depends to a large degree, on your ability to respond thoroughly and accurately. Other written questionnaires and questions will be posed by the physicians and staff during your consultation in an effort to correct what's bothering you. Your team at Power Healing will be the only people to review these forms with your consent. Your confidentiality will be strictly maintained.

Your careful consideration of each of the following questions will enhance our efficiency in treating you, and will provide more effective use of your scheduled consultation time. Thank you for your time in advance and we look forward to working with you to help you achieve your health goals with Power Healing.

General Patient Information

Name: ^{Last} _____ ^{First} _____ Today's Date _____

Street Address _____

City _____ State _____ Zip _____ Marital Status: Married / Single

Social Security # _____ Date of Birth _____ Age _____

Gender: Male / Female E-mail address: _____

Phone #: Home _____ Cell _____ Work _____

Place of Employment _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone # _____

How did you hear about us? Referred by (Name) _____

Yellow Pages Internet Drive-by Other _____

Medications (if any): _____

Supplements (if any vitamins, herbs, etc.): _____

Are you on a special Diet? YES / NO, if Yes, please list: _____

What problem(s) are you currently having? And how long do you have it?

1. Major Complaint: _____ Since Month ____ Year _____

2. Secondary Complaint: _____ Since Month ____ Year _____

3. Other Complaint: _____ Since Month ____ Year _____

4. Other Complaint: _____ Since Month ____ Year _____

How do these conditions impair your daily activities? _____

Patient Medical History

Check any you have had in the past:

- Alcoholism
- Allergies
- Arthritis
- Asthma
- Cancer: _____
- Chronic Fatigue Syndrome
- Diabetes
- Drug Addiction
- Emphysema
- Epilepsy/ Seizure
- Fibromyalgia
- Heart Disease
- Hepatitis: _____
- High Blood Pressure
- HIV
- Irritable Bowl Syndrome
- Jaundice
- Kidney Disease
- Lupus (SLE)
- Measles
- Meningitis
- Migraines
- Multiple Sclerosis
- Paralysis
- Pneumonia
- Polio
- Rheumatic Fever
- STDs
- Stroke
- Syphilis
- Thyroid Disorder
- Tuberculosis

Any Others? YES / NO, if Yes, please list below:

Have you ever had to be **HOSPITALIZED**? YES / NO, if Yes, please list below:

Reason 1. _____ Month _____ Year _____

Reason 2. _____ Month _____ Year _____

Reason 3. _____ Month _____ Year _____

Any Others? YES / NO, if Yes, please list on the back of this page.

Have you ever had any **SURGERIES** or **OPERATIONS**? YES /NO, if Yes, please list below:

Surgery 1. _____ Month _____ Year _____

Surgery 2. _____ Month _____ Year _____

Surgery 3. _____ Month _____ Year _____

Any Others? YES / NO, if Yes, please list on the back of this page.

Have you ever had any **INJURIES**? YES / NO (such as automobile accident, serious falls, sports injuries, broken bones, getting knocked unconscious.), if Yes, please list below:

Injury 1: _____ Month _____ Year _____

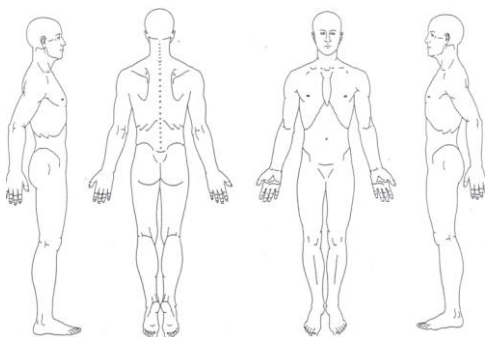
Injury 2: _____ Month _____ Year _____

Injury 3: _____ Month _____ Year _____

Any Others? YES / NO, if Yes, please list on the back of this page.

Patient Profile

Please clearly mark any areas of **PAIN** on the diagram below:



Is the Pain:

- Sharp Burning Aching Cramping Dull
- Moving Fixed

Do any of the following **LESSEN** the pain:

- Pressure Cold Heat Exercise Other: _____

Do any of the following **WORSEN** the pain:

- Pressure Cold Heat Exercise Other: _____

Please check any of the following that pertain to you:

Overall Temperature / Energy:

- Aversion To Cold
- Aversion To Heat
- Chills
- Cold Hands/ Feet
- Easily Catch Colds
- Fevers
- General Weakness
- Hot Flushes
- Lack of Perspiration
- Low Energy/ Fatigue
- Night Sweats
- Perspire Easily
- Preference for Cold Drinks
- Preference for Warm Fluids
- Sweaty Hands/ Feet
- Thirsty

Heart Function:

- Anxiety
- Blood Pressure Problem
- Chest Pain/Compression
- Forgetfulness/Poor Memory
- Insomnia/Sleep Problem
- Mental Confusion/Fogginess
- Pacemaker
- Palpitations
- Poor Circulation
- Mental Restlessness
- Sores on Tongue
- Swelling of Ankles

Lung Function:

- Asthma
- Body Aches
- Cough
- Difficult Breathing
- Dry Mouth/ Throat
- Dry Nose
- Melancholy
- Nose Bleeds
- Phlegm Production
- Short of Breath
- Sinus Congestion
- Skin Problem
- Smoke Cigarettes: # _____ per Day
- Sneezing
- Sore Throat
- Wheezing

Nasal Discharge: Color: Clear / Yellow / Green / Others: _____

Are you allergic to any Medications/ Food/ Pollens/ Others: _____

The EFFECTS on you: _____

Headache: Dull/ Sharp, Location: Top/ Temple/ Occipital/ Front/ Whole Head, How often: _____

SP/ ST Function:

- Abrupt Weight Change
- Abdominal Distention
- Bad Breathe
- Belching
- Black Stools
- Bleeding or Swollen Gums
- Bloating
- Blood in Stools
- Canker Sores
- Constipation
- Diarrhea
- Easily Bruise
- Excess Hunger
- Fatigue after Eating
- Gas
- Gurgling Stomach
- Heartburn/Acid Reflux
- Heaviness Sensation
- Hemorrhoids
- Hiccups
- Incomplete Stools
- Loose Stools
- Mucous in Stools
- Nausea
- Organ Prolapsed
- Over-Thinking
- Poor Appetite
- Stomach Pain
- Ulcer
- Undigested Food in Stools
- Vomiting
- Worry

LIV/GB Function:

- Anger Easily
- Bitter taste
- Blurry Vision
- Depression
- Dizziness/ Vertigo
- Alternating Diarrhea and Constipation
- Frequent Headaches
- Frustration
- Gall-Stones
- Hypochondriac Pain
- Irritability
- Lump in Throat
- Muscle Tension
- Muscles Spasms
- Nervousness
- Numbness/Tingling
- Red Face or Eyes
- Ringing in Ears
- Seizures/ Convulsions
- Sexual Disease
- Stiff Neck

KID/UB Function:

- Easily Broken Bones
- Excessive Hair Loss
- Leg Edema
- Fearful
- Kidney Stones
- Lack of Bladder Control
- Low Back Pain
- Low Libido
- Memory Problems
- Night Sweats
- Sore/ Weak Knees
- Tinnitus

Urination:

- Blood or Pus in Urine
- Burning
- Cloudy
- Dark Yellow Color
- Difficult
- Frequent
- Incontinence
- Painful
- Profuse
- Scanty
- Strong Odor
- Urgent

Men only:

Last DRE (digital rectal examination, prostate examination): Month _____ Year _____

Were the results Normal? YES / NO

Last PSA (prostate specific antigen): Month _____ Year _____

Were the results Normal? YES / NO

- Genital Pain
- Swollen Testes
- Penile Discharge
- Premature Ejaculation
- Impotence

Women only:

Are you *Pregnant* now? YES / NO

If Not, the first day of *Last Menstrual Period*: Month _____ Day _____ Year _____

Age of first menses: _____ Y/O

Number of living children: _____

Age of menopause: _____ Y/O

Number of miscarriages: _____

Number of pregnancies: _____

Number of abortions: _____

Last *Breast Examination* by a physician: Month _____ Year _____. Were the results normal? YES / NO

Last *Pelvic Examination* by a physician: Month _____ Year _____. Were the results normal? YES / NO

Last *Papinicolao Smear*: Month _____ Year _____. Were the results normal? YES / NO

Last *Mammography*: Month _____ Year _____. Were the results normal? YES / NO

Last *CA-125* ovarian cancer screen (a blood test): Month ____ Year _____. Were the results normal? YES / NO

Do you have any *Vaginal Discharge* between cycles? YES / NO, if Yes:

When: _____, Color: _____, Thin / Thick, Strong odor: YES / NO

Do you experience any of the following pre-menstrual syndromes (PMS):

- Anxiety Depression Headaches Nausea
- Breast Tenderness Emotional Irritability Vomiting
- Cramps Food Cravings Migraines Water Retention

Do you have *Regular* menstrual cycle? YES / NO

Days in *Menstrual Cycle*: _____ Days

Any *Abnormal Bleeding* between cycles? YES / NO

Average number *Days of Flow*: _____ Days

Menstrual Chart:

	<u>Day 1</u>	<u>Day 2</u>	<u>Day 3</u>	<u>Day 4</u>	<u>Day 5</u>	<u>Day 6</u>	<u>Day 7</u>
Color (bright red, pale, dark)							
Amount of flow (heavy, light)							
Cramps (dull, sharp)							
Clots (large, small, purple, red)							

Recent Tests, Results and Dates:

- Blood Sugar: Month _____ Year _____ Result: Normal / Abnormal
- Cholesterol: Month _____ Year _____ Result: Normal / Abnormal
- HIV: Month _____ Year _____ Result: Normal / Abnormal
- Physical: Month _____ Year _____ Result: Normal / Abnormal

Any Others? YES / NO, if Yes, please list below:

Family Medical History

Check the following that have occurred in your blood relatives:

- Alcoholism Diabetes High Blood Pressure
- Allergies Drug Mental Illness
- Arthritis Epilepsy/ Seizure Obesity
- Cancer Heart Disease Stroke

Any Others? YES / NO, if Yes, please list on the back of this page.

Power Healing

407-373-3700

www.powerhealing4u.com

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this Consent.

Patient's Name (Please Print): _____ Date: _____

Patient or Representative Signature: _____ Date: _____

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Patient Consent to Treatment

Please read the following and confirm that you agree to and clearly understand them by signing below.

- (1) The Practitioner performing the procedures is a Licensed Acupuncture Physician and a Doctor of Oriental Medicine. In the State of Florida, such a practitioner is a *Primary Health Care Provider* (Florida Statutes 457.102) with limited Prescriptive Rights. However, this practitioner is NOT a Medical Doctor (MD).
- (2) Because the Practitioner is not your primary care medical physician, it is important that you consult with your primary care medical physician regarding the procedure and the medical problems you have prior to care.
- (3) The Practitioner has been certified by the Board of Acupuncture to perform Acu-point Injection Therapy, which means that he/she is allowed to administer the injection of *herbs, homeopathics*, and other *nutritional supplements* in the form of sterile substances. (FS Law 64B1-4.012). In other words, the Practitioner **ONLY** uses natural substances and does NOT use any synthetic drugs or medications.
- (4) The Practitioner is licensed to use Adjunctive Therapies (such as Laser Acupuncture, Homeopathy, Thermal Therapy, Therapeutic Exercises, Lifestyle Counseling, and other) and Herbal or Nutritional Therapies into his/her practice. (FS Law 64B1-4.008 and 64B1-4.004).
- (5) Treatment: Any and all health care treatment, which may include Acupuncture, Herbal Formulas, Tui-Na, Cupping Therapy, Moxibustion, Therapeutic Exercises and/or Nutritional Counseling. I understand that Needling and Cupping Therapy may cause *bruising* in some cases, & that **ALL treatments are outside of the standard of care & are therefore considered unproven & experimental, with unknown & possibly dangerous &/or deadly outcome.**
- (6) Financial Information: All fees are due in full at the time services are rendered, unless prior arrangements have been made with POWER HEALING. I hereby acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to POWER HEALING or it's affiliates for the amount due, as stated above. Payment can be made by major credit cards, cash, or check.
- (7) Authorization to Use and Disclose Health Information: I authorize the release of any of my medical information to my insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care.
- (8) The cost of the "Customized Herbal Prescriptions;" are NOT included in the pricing of any and all treatment(s) and/or any and all variations of the Health Care Plan(s) as these prescriptions are based on each individual need. Payment for any and all personalized Prescriptions IS ADDITIONAL and such payment will be due the day the formula is received. **Personalized Prescriptions CANNOT be refunded.**
- (9) This agreement assumes full cooperation on part of the patient. This cooperation includes and is not limited too Patient's agreement to remain active in the recommended program. Hence, compliance to recommended schedules is equally important and the patient agrees to **keep appointments** to the best of their ability. Patient understands that *additional treatments may be necessary due to lack of cooperation*, failure to keep appointments, failure to follow diet or lifestyle recommendations, engaging in activities outlined to be injurious or which may cause additional trauma to the body and/or any unforeseen and therefore unpredictable problems and contingencies. Cost of any and all additional treatments, if required, would be over and above the cost of any and all treatments provided for in any and all previous agreement(s).
- (10) If the need arises to change Patient's treatment plan from the initial agreement, it is necessary for the Patient to schedule an additional consultation with the doctor before any changes in treatment plans occur.
- (11) Refunds will be provided by check and paid within 7 business days of the receipt of a written termination request from the patient.
- (12) The refunded amount will be based in this Agreement for less the total number of individual services offered. The refunded amount for individual services will be calculated at the Regular Price for each service minus any incentive treatments.
- (13) Patient recognizes that this Agreement is NOT a warrantee or guarantee of results, and that it deals solely with financial and time obligations. Any balance due for services is *regardless of results & treatment outcome*. Refunds will NOT be provided on the basis of treatment outcome.

I fully understand that by signing below, I am indicating that I have read and understood the information in this Consent Form; that I have been verbally advised and that I have had an adequate and reasonable opportunity to ask questions, that I have received all of the information I desire about the Practitioner and any and all Procedures, and that all of this information is mentally and physically clear to me, and that I authorize the Practitioners of POWER HEALING to perform the Procedures.

Patient/Client Name: _____

Signature: _____ Date: _____