

POWER HEALING

At Steve Acupuncture Center

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

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.

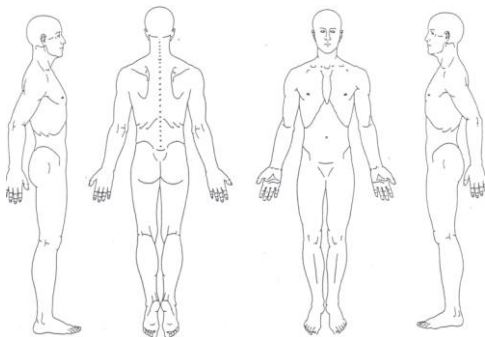
Have you ever had any **INJURIES**? YES / NO (such as automobile accident, serious falls, sports injuries, broken bones, getting knocked unconscious.), if Yes, please list below:

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

Heart Function:

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

Lung Function:

- Asthma Dry Mouth/ Throat Phlegm Production Smoke Cigarettes: # ____ per Day
- Body Aches Dry Nose Short of Breath Sneezing
- Cough Melancholy Sinus Congestion Sore Throat
- Difficult Breathing Nose Bleeds Skin Problem 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 Canker Sores Heartburn/Acid Reflux Organ Prolapsed
- Abdominal Distention Constipation Heaviness Sensation Over-Thinking
- Bad Breathe Diarrhea Hemorrhoids Poor Appetite
- Belching Easily Bruise Hiccups Stomach Pain
- Black Stools Excess Hunger Incomplete Stools Ulcer
- Bleeding or Swollen Gums Fatigue after Eating Loose Stools Undigested Food in Stools
- Bloating Gas Mucous in Stools Vomiting
- Blood in Stools Gurgling Stomach Nausea Worry

LIV/GB Function:

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

KID/UB Function:

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

Urination:

- Blood or Pus in Urine Dark Yellow Color Incontinence Scanty
- Burning Difficult Painful Strong Odor
- Cloudy Frequent Profuse 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
- Breast Tenderness
- Cramps
- Depression
- Emotional
- Food Cravings
- Headaches
- Irritability
- Migraines
- Nausea
- Vomiting
- 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
- Allergies
- Arthritis
- Cancer
- Diabetes
- Drug
- Epilepsy/ Seizure
- Heart Disease
- High Blood Pressure
- Mental Illness
- Obesity
- 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.
- (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 Customized Herbal Prescriptions are NOT included in the pricing of the Health Care Plan as these prescriptions are based on each individual need. Payment for personalized Prescriptions will be due the day the formula is received. **Personalized Prescriptions CANNOT be refunded.**
- (9) This agreement assumes full cooperation. This cooperation includes 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 & decrease treatment results. Additional treatments would be in addition to the treatments provided for by this agreement.
- (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 the last two 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.

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: _____