

Health History Form

Name _____ Home# _____ Work # _____ Cell # _____
Street _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ M_F_Ht _____ Wt _____ Occupation _____
Email _____ How did you hear about us _____
Primary Reason for your visit today _____
Other concurrent therapies _____
Name of Doctor _____ Phone # _____ Fax # _____
Address _____ City _____ St _____ Zip _____
Doctors Diagnosis _____
How are you responding to your present course of treatment? () Better () Same () Worse
Date of last appointment with regular Physician _____
Reason for that appointment _____

***YOUR* PAST MEDICAL HISTORY (include dates)**

- () Cancer () Diabetes () Heart Disease () Stroke () Sexually Transmitted Disease
- () Seizure () Hepatitis () Thyroid Disease () Alcoholism () High Blood Pressure
- () Other (explain) _____

***FAMILY* PAST MEDICAL HISTORY**

- () Cancer () Diabetes () Heart Disease () Stroke () Sexually Transmitted Disease
- () Seizure () Hepatitis () Thyroid Disease () Alcoholism () High Blood Pressure
- () Other (explain) _____

Surgeries _____

Significant Trauma _____

Birth History _____

Allergies (drug, food, chemical, environmental) _____

Medicine taken in the past 2 months (medications, vitamins, and food supplements)

Name _____	Dosage _____
_____	Dosage _____
_____	Dosage _____
_____	Dosage _____
_____	Dosage _____
_____	Dosage _____
_____	Dosage _____
_____	Dosage _____

Occupational Stresses (chemical, physical, psychological, etc) _____

Exercise (type duration, frequency) _____

Habits () Cigarettes () Coffee () Soda () Tea () Alcohol () Drugs () Sugar

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Avg Daily Diet _____
General _____

- Poor Appetite Fevers Poor Sleep Heavy Sleep Insomnia Fatigue
 Sweat Easily Tremors Cold Hands Cold Feet Cold Back Heavy Appetite
 Cold Abdomen Chills Vertigo Night Sweats Localized Weakness
 Poor Coordination Cravings _____ Sudden Energy Drop At _____ (time)
 Peculiar Tastes or Smells _____ Strong Thirst (cold/hot drinks) _____
 Bleeds/ Bruises Easily (where) _____ Varicose/Spider Veins

SKIN/HAIR

- Rashes Pimples Ulcerations Dandruff Loss of Hair Change in Texture
 Hives Itching Purpura Eczema Other Problem

HEAD, EYES, EARS, NOSE AND THROAT

- Dizziness Eye Pain Sinus Problems Poor Hearing Jaw Clicks Ringing in Ears
 Concussion Mucus Poor Vision Copious Saliva Earaches Nose Bleeds
 Eye Strain Floaters Facial Pain Color Blindness Glasses Night Blindness
 Migraines Cataracts Dry Mouth Grinding Teeth Dry Throat Teeth Problems
 Headaches

CARDIOVASCULAR

- High Blood Pressure Chest Pain Fainting Irregular Heart Beat Cold Hands/Feet
 Low Blood Pressure Blood Clots Dizziness Swollen Hands/Feet Difficulty Breathing

RESPIRATORY

- Coughing Blood Cough Asthma Bronchitis Pneumonia Tight Chest
 Production of Phlegm Difficulty Breathing When Lying Down

GASTROINTESTINAL

- Nausea Vomiting Diarrhea Hemorrhoids Belching Black Stools Gas
 Bad Breath Rectal Pain Pain/Cramps Constipation Bloody Stool Sensitive Abdomen
Bowel Movement Frequency _____ Color _____

GENITO-URINARY

- Pain on Urination Wake up to Urinate Kidney Stones Urgency to Urinate Impotency
 Incontinence Frequent Urination Blood in Urine Venereal Disease Other _____

PREGNANCY & GYNECOLOGY

- Irregular Periods Clots Discharge Sores Breast Lumps Menopause
of pregnancies ___ #of Births _____ # Premature ___ # Miscarriages ___ Age at first Menses ___
Period Duration _____ Last Menses _____ Birth Control _____

MUSCULOSKELETAL

- Neck Pain (where) _____ Muscle Pain (where) _____
 Back Pain (where) _____ Joint Pain (where) _____

NEUROPSYCHOLOGICAL

- Poor Memory Seizures Areas of Numbness Concussion Depression
 Anxiety Anger Easily Easily Stressed Considered/Attempted Suicide
 Other Neurological or Emotional (specify) _____

MOST & LEAST FAVORITE Climate _____
Season _____ Taste _____
Time of Day _____ Temperature _____

Patient Agreement and Consent Form

VOLUNTARY TREATMENT

I voluntarily consent to receive acupuncture treatment. The procedures involved in treatment have been explained to me and I have felt free to ask questions. I understand that I may be treated with the insertion of needles and/or with the application of heat to the skin.

I have not been guaranteed any success concerning the uses and effects of acupuncture. I understand that I am free to discontinue treatment at any time.

POSSIBLE SIDE EFFECTS AND HEALING REACTIONS

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, dizziness, temporary pain or discomfort, and temporary aggravation of symptoms existing prior to treatment.

MEDICAL REFERRAL

I understand that if there is a worsening of my ailment or condition, or if a new ailment or condition arises that I should consult my medical doctor.

Acupuncture treatment is a complement to and not a substitute for Western medical care. Certain conditions may best be addressed in partnership with my medical doctor or other health care provider.

INFECTIOUS DISEASE AND CLEAN NEEDLE PROCEDURES

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that my acupuncture practitioner follows universally prescribed precautions to guard against the spread of infection. My practitioner uses only sterilized, prepackaged, disposable needles. Needles that are used for my treatment are used only on me and are inserted according to clean procedures based on nationally prescribed standards.

PAYMENT AND CANCELLATIONS

I understand that payment is due at the time of treatment. In order to prevent being charged a \$60 cancellation fee I agree to give at least 24hrs notice of cancellation.

Patient Name (Print)

Date

Patient Signature

Witness Signature

Patient Questionnaire

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment and payment)

2. Please list the family members or significant others, if any, whom we may inform about your medical condition IN AN EMERGENCY

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent in other than your home.

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"

YES ___ NO ___

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number

6. Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?

YES ___ NO ___

PATIENT NAME _____

Patient Signature _____ Date _____

HIPAA Consent Form

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 not affect any disclosures 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 Name (Print)

Date

Patient Signature

Witness Signature

JoAnne Lehrfeld, Acupuncture Physician
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As you begin your journey with acupuncture there are a few things important to know. Please give these thoughts your careful attention.

When coming in for treatment please, don't over use products that obscure your natural odor or color. Such products include cologne, fragrant soaps, shampoos, conditioner and lotions. These products can interfere with the diagnostic process. Deodorant, however, can be worn as usual.

When you arrive for treatment it is best to have a little something in your stomach, but please do not eat a large meal just prior to treatment as it can skew pulse readings.

On the day of treatment and for 24 hours after, I recommend you reduce your intake of caffeine and abstain from alcohol. This will help to maximize the effects of your treatment. It is always wise to drink lots of water. This is especially true immediately after treatment as this will aid in flushing your system of toxins. For 24 hours after your session it is best not to have a massage or any other bodywork, not to partake in strenuous exercise or have a sauna, hot tub (or even a very hot shower). These can diminish the effect of energy work.

If you have any questions please do not hesitate to call me.

Important facts about water:

1. 75% of Americans are chronically dehydrated.
(Likely applies to half the world population)
2. In 37% of Americans, the thirst Mechanism is so weak that it is often mistaken for hunger.
3. Even MILD dehydration will slow down one's metabolism as much as 3%.
4. A University of Washington study found that one glass of water shuts down midnight hunger pains for almost 100% of dieters.
5. Lack of water is the #1 trigger of daytime fatigue.
6. Preliminary research indicates that 8-10 glasses of water a day could significantly ease back and joint pain for up to 80% of sufferers.
7. A 2% drop in body water can trigger fuzzy short term memory, trouble with basic math, and difficulty focusing on the computer screen or a printed page.
8. Drinking 5 glasses-of water daily decreases the risk of colon cancer by 45%, plus it can slash the risk of breast cancer by 79%, and one is 50% less likely to develop bladder cancer.