3000 N University Drive
Suite A Coral Springs FL
33065

Health History

Please complete this form as thoroughly as possible. All information is strictly confidential.

General Patient Information

Last Name:	.....	First Name:	.....
Address:	.....	City:	.....
State:	.....	Zip Code:	.....
Home Phone:	.....	Work Phone:	.....
Cell Phone:	.....	Email:	.....
SSN:	.....	Age:	.....
Date of Birth:	.....	Gender:	.....
Height:	.....	Weight:	.....
Occupation:	.....		
Employer:	.....		

How do you hear about us? ……

Guardian (if under 18): .....

Guardian Phone Number: .....

Major complaint (s). Please list as simply as possible:

1. .....
2. .....
3. .....

Please list any medications, Vitamins, Herbs, or Supplements that you are taking:

1. .....
2. .....

Please list any surgeries you have had and when:

1. .....
2. .....

How do these conditions interfere with your daily activities?

1. .....
2. .....

What kind of issues do you tend to suffer constantly throughout your life?

1. .....
2. .....
3. .....

Please select what type of pain you have:

- ☐ Sharp
- ☐ Dull
- ☐ Burning
- ☐ Moving
- ☐ Aching
- ☐ Fixed
- ☐ Cramping
- ☐ Other .....

Do the following lessen or worsen the pain?

- ☐ Pressure ☐ L ☐ W
- ☐ Exercise ☐ L ☐ W
- ☐ Cold ☐ L ☐ W
- ☐ Heat ☐ L ☐ W
- ☐ None
- ☐ Other .....

Please Mark the symptoms that you have:

Hot and Cold

- ☐ Chills/Fever
- ☐ Alternated Chills and Fever
- ☐ Heat in the hands, feet, and chest
- ☐ Afternoon hot flushes
- ☐ Hot flashes any time of the day
- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Other .....

Perspiration

- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Night Sweats
- ☐ Profuse sweating

Energy

- ☐ Low energy
- ☐ General weakness

- ☐ Feeling tired in the morning
- ☐ Feeling tired in the afternoon
- ☐ Feeling tired in the evening
- ☐ Full of energy in the morning
- ☐ Full of energy in the afternoon
- ☐ Full of energy in the evening
- ☐ Full of energy at night
- ☐ Easily catch colds
- ☐ Sneezing
- ☐ Other ……

Sleep

- ☐ Wake up unrefreshed
- ☐ Difficult falling asleep
- ☐ Waking up constantly at night
- ☐ Frequent dreams
- ☐ Restless sleep
- ☐ Other .....

Thirst

- ☐ Thirsty all the time
- ☐ Lack of thirst
- ☐ Prefer cold drinks
- ☐ Prefers hot drinks
- ☐ Thirsty at night
- ☐ Other .....

Eyes

- ☐ Blurred Vision
- ☐ Watery eyes
- ☐ Dry eyes
- ☐ Vision loss
- ☐ Itch eyes
- ☐ Red eyes
- ☐ Pain in the eyes
- ☐ Other .....

Nose

- ☐ Nasal Discharge if yes, color: .....
- ☐ Nasal congestion
- ☐ Dry nose
- ☐ Loss of smells
- ☐ Difficulty Breathing
- ☐ Nose Bleed
- ☐ Other .....

Throat, Mouth, Lips, and Head

- ☐ Dry Throat
- ☐ Sore throat
- ☐ Cough
- ☐ Dry Mouth
- ☐ Dry Cough
- ☐ Bitter taste in the mouth
- ☐ Tastelessness
- ☐ Metal taste in the mouth
- ☐ Sour taste in the mouth
- ☐ Sweet taste in the mouth
- ☐ Mouth ulcers
- ☐ Sores on the tip of the tongue

- ☐ Dry lips
- ☐ Cracked Lips
- ☐ Headache
- ☐ Other .....

Neck, Ears, and Skin

- ☐ Stiff neck and shoulders
- ☐ Pain in the neck
- ☐ Low - Pitched Ringing in the Ears ☐ Left ☐ Right ☐ Both
- ☐ High - Pitched Ringing in the Ears ☐ Left ☐ Right ☐ Both
- ☐ Pain in the ears
- ☐ Dry Skin
- ☐ Itchy Skin
- ☐ Acne
- ☐ Tingling Sensation
- ☐ Numbness
- ☐ Muscle Spasms
- ☐ Muscle Twitching
- ☐ Muscle Cramping
- ☐ Other .....

Emotions

- ☐ Stress
- ☐ Anxiety
- ☐ Sadness
- ☐ Melancholy
- ☐ Restlessness
- ☐ Depression
- ☐ Mental Confusion
- ☐ Over thinking
- ☐ Worry
- ☐ Anger
- ☐ Mental Sluggishness
- ☐ Frustration
- ☐ Fear
- ☐ Irritability
- ☐ Other .....

Digestion

- ☐ Low Appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas
- ☐ Gurgling noise in the stomach
- ☐ Fatigue after eating
- ☐ Loose Stool
- ☐ Constipation
- ☐ Incomplete Evacuation
- ☐ Diarrhea
- ☐ Blood in the stools
- ☐ Mucus in the stools
- ☐ Undigested food in the stools
- ☐ Acid Regurgitation
- ☐ Bad Breath

☐ Stomach Pain ☐ Heart Burn

☐ Belching ☐ Too much Appetite

☐ Flatulence ☐ Alternate Diarrhea and Constipation

☐ Other ……..

Other Health Related Questionnaires

Do you drink Coffee? ……

How many cups of coffee per day: ……

Do you smoke? ☐ Yes ☐ No

☐ Nicotine ☐ Marijuana

Do you do any recreational drugs? ☐ Yes ☐ No

If yes, what kind? ……

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? ……

Do you drink soda? How many? ……

Urination Color and the amount: ……

How often do you have a bowel movement? ……

Any Pain when urinating? ……

Any Stones? ……

How many times do you eat a day? ……

Do you have a desire to eat? ……

Do you have any craving? ……..

Is there any other health issues? ……..

In general, what kind of food do you eat everyday? Please list them below:

……

……

……

……

For Woman Only

When was your first Menstruation? .....

Menstrual Color: .....

Do you have any pre-menstrual syndrome? ☐ Yes ☐ No

If yes, please list them below:

1. .....

2. .....

Amount of Menstrual Flow: .....

Menstrual Cycle Duration: .....

Vaginal Discharge? ☐ Yes ☐ No

Discharge Color: .....

Discharge Quality: .....

Discharge Amount: .....

Any Smells? .....

Any clots? .....

Any pain? .....

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now, or int he future, treat me while employed by, working with or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smells or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is a generally safe method of treatment but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection in another possible risk, although the clinician uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do no expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be keep confidential and will not be released without my written consent. I understand that any services, consultation, advice, products or treatments that I receive from the acupuncturist are not a substitute or replacement for conventional western medical services or treatments.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Integrated Holistic Medicine, LLC.
Acupuncturists: Su Sandy Aung L.Ac

Patient Signature:

Patient Guardian Signature:

PATIENT CONSENT FORM - PRIVACY

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 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.

Print Name: .....

Signed By: .....

Date: .....

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

INSURANCE VERIFICATION

Date: ……

First name: ……

Last Name: ……

Address: ……..

City, State & Zip(MustHave) ……..

Phone #: ……

Date of Birth: …… ☐ Male ☐ Female

Patient, Subscriber # / ID #: ……

Group #: ……

Insured Name & ID# (if Different from patient) ……..

Relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Co Name: ……

Ins. Co. Phone #: ……..

Chief Complaint or Primary Diagnosis: ……..

Claim # if an accident: ……

Date of Accident/ Injury: ……..

Other Info: ……