Confidential Patient Information Sheet

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____

Would you like to receive a free email newsletter (your email information is held in complete confidence)? ☐ Yes ☐ No

Height _____ Weight _____ Age _____ Sex: ☐ Male ☐ Female Dominant Hand: ☐ Left ☐ Right

Date of birth: _____ Marital Status: _____

Number of children: _____ Ages of children: _____ Number who live with you: _____

Occupation _____ Employer _____

In emergency notify (name): _____ Emergency phone number: _____

Primary Care Doctor _____ Last seen: _____

How did you hear about us: ☐ Social Media ☐ Google Search ☐ Yahoo Search ☐ Email ☐ Other Web

☐ Brochure ☐ Business Card ☐ Other Ad ☐ Referred by: _____

Medical History

Reason for your visit here today: _____

_____

How long have you had this condition? _____

Are you being treated for this condition by anyone else: ☐ Yes ☐ No

If Yes, who? _____ Phone number: _____

Has this condition been diagnosed by a MD? ☐ Yes (Diagnosis: _____) ☐ No

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not much ☐ Not at all

Have you had acupuncture before? ☐ Yes ☐ No Name of Acupuncturist: _____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

If Yes, please identify: _____

Health Inventory

Cardiovascular Conditions:
- ☐ Heart Disease
- ☐ A Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional / Mental:
- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ ADD or ADHD
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Nervousness
- ☐ Anxiety
- ☐ Alzheimer's
- ☐ Dementia

Energy & Immunity:
- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Persistent Cough
- ☐ Pleurisy
- ☐ Tuberculosis
- ☐ Shortness of Breath

Musculo-Skeletal:
- ☐ Neck / Shoulder Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Joint Pain

Head, Eye, Ear, Nose & Throat:
- ☐ Impaired Vision
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Glasses / Contacts
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Ringing
- ☐ Earaches
- ☐ Ear Infections
- ☐ Headaches
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ Frequent Sore Throats
- ☐ TMJ / Jaw Problems
- ☐ Hay Fever

Genito-Urinary Tract:
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Dribbling Urination
- ☐ Frequent UTI
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Discharge
- ☐ Incontinence

Neurological:
- ☐ Vertigo / Dizziness
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy
- ☐ Migraines

Gastrointestinal:
- ☐ Stomach Ulcers
- ☐ Changes in Appetite
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Passing Gas
- ☐ Heart Burn
- ☐ Belching
- ☐ Gall Bladder Disease
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable Bowl Syndrome
- ☐ Leaky Gut Syndrome

Endocrine:
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Feeling Hot or Cold

Other:
- ☐ Cancer Type:_____
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hand / Feet
- ☐ Hemophilia
- ☐ Thin / Graying hair

Liver Conditions:
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Men Only:
- ☐ Impotence
- ☐ Vasectomy Date: _____
- ☐ Prostate problems
- ☐ Testicular Pain / Redness / Swelling
- ☐ Low libido
- ☐ Excessive libido
- ☐ Painful Intercourse
- ☐ Seminal emissions

Women Only:

Are you pregnant right now? ☐ Yes ☐ No ☐ Trying ☐ Maybe Method of Birth Control:_____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____

Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: ☐ Yes ☐ No Date: _____

Check all that apply: ☐ Low libido ☐ Excessive libido ☐ Painful Intercourse ☐ Clotting ☐ Painful Periods ☐ Heavy Flow ☐ Scanty Flow ☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Vaginal Discharge ☐ Breast Lumps / Tenderness ☐ Nipple Discharge ☐ Infertility ☐ Menopausal Symptoms ☐ Premenstrual Problems ☐ Endometriosis ☐ Fibroids ☐ Fibrocystic Breasts ☐ Ovarian Cysts ☐ Abnormal Pap Smear

Medications

Please list the medications and supplements you are currently taking:

Drug / Supplement	Reason for taking	For how long	Dose	Frequency

Known Allergies: _____

_____

I am taking Coumadidn / Warfarin ☐ Yes ☐ No

I have a pacemaker ☐ Yes ☐ No

Lifestyle

Are you vegetarian or vegan? ☐ Yes ☐ No

How would you rate the following areas of your health in the past month:

Energy: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Digestion: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Urination: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Sleep: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Appetite: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Diet: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Exercise: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

Immunity: ☐ Great ☐ Good ☐ Fair ☐ Poor Comments: _____

How do you feel about the following areas of your life in the past month:

Significant Other: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments: _____

Family: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments: _____

Sex Life: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments: _____

Self: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments: _____

Work: ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ N/A Comments: _____

Pain

Please answer the following questions if you have pain.
Indicate on the diagrams below the areas of pain:

Quality of pain: ☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Cramping ☐ Burning ☐ Constant ☐ Fixed ☐ Moves about

On a scale of 1 – 10 (10 being worst) how strong is your pain? _____

Does the pain radiate? ☐ Yes ☐ No Where? _____

What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing

What aggravates the pain?

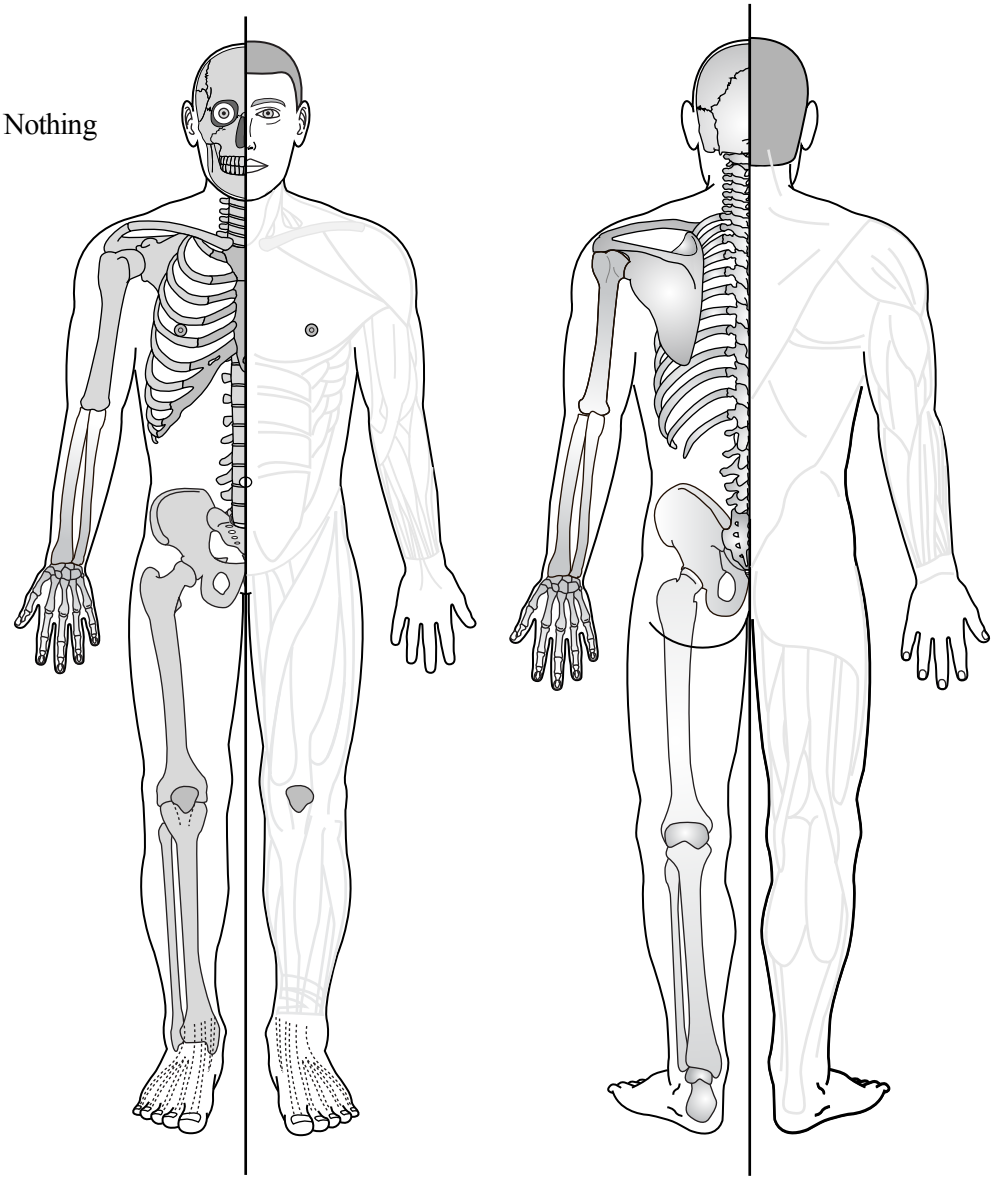
☐ Ice ☐ Heat ☐ Rest ☐ Movement

☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing

When is the pain the worst?

☐ Morning ☐ Afternoon ☐ Evening

Anything you wish to add?



The above information is true to the best of my knowledge.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

TO OUR PATIENTS:

Thank you for choosing South Florida Acupuncture Associates for your health care needs. We are committed to your optimal health and strive to insure that your treatments are successful and your visits here positive. To help achieve this, it is important that you follow all instructions carefully.

When you come for your visits please remember the following:

1. Briefly tell the doctor your present symptoms (or bring a list).
2. Listen carefully to all instructions. Take notes if necessary.
3. Ask all questions while the doctor is seeing you; once he leaves your room, he must give his full attention to other patients who are waiting. Make yourself a list of questions before your visit, if you wish. Also, ask the doctor when you need to see him again to schedule your next appointment at the front desk while paying for treatment.
4. Please extend the same courtesies to other patients that you expect them to show you. Please be on time for your appointments. If something unexpected comes up, please call immediately to see if we can work you in later or re-schedule for another day. And remember to ask all your questions during your time with the doctor.

The following explains our office policies:

PAYMENTS Payments are due at the time of service. We accept cash, checks, MasterCard, Visa, Discover, and American Express.

INSURANCE We do accept assignment, if you don't have coverage, payments are due at time of service. We will file insurance for your reimbursement only if you have verified that acupuncture is covered. Please present your insurance card for us to photocopy.

MISSEDAPPOINTMENTS Unless cancelled 24 hours in advance, our policy is to charge the usual fee for an office visit missed. Your treatments will be more effective if you follow your treatment schedule and the doctor's instructions. Problems do arise and we will work with you as much as possible. However, we must have the courtesy of a call from you well in advance if you need to miss or re-schedule an appointment.

I have read and agree to the policies stated above.

_____ _____

Patient's signature Date

CONSENT FOR ACUPUNCTURE TREATMENT

I, _____, do consent for treatment in the office(s) of South Florida Acupuncture Associates. I understand that acupuncture, acupressure, injections and cupping treatments may occasionally cause minor, temporary discomforts. I also understand that there are no guarantees regarding the above treatments or any remedies and herbal medicines prescribed.

I further understand that it is my responsibility to immediately report any reactions or discomforts related to the treatment to the health care attendant (if any should occur) and follow the instructions given.

I also state that I speak, read, and write English, or that the contents of this form have been explained to me in my native tongue.

I have read and understand the above paragraphs and request that these procedures be used for my treatment as deemed necessary by my health care provider.

_____ _____

PATIENT'S (OR LEGAL GUARDIAN) SIGNATURE DATE

AUTHORIZATION FOR USE OF SIGNATURE ON FILE

FOR CLAIM AUTHORIZATION AND PAYMENT RESPONSIBILITY

Patient Name: _____

I,_____ , do hereby authorize Matthew Enright, AP

Landon Agoado, AP, Andrew Agoado, AP and Cheryl Yelverton, MD to mark the section "ENROLLEES OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE." This section authorizes:

1. The release of any medical information necessary to process insurance claims on my behalf.

2. The release of medical information from outside sources which may assist in my diagnosis and treatment plan.

3. **Matthew Enright, AP, Landon Agoado, AP, Andrew Agoado, AP and Cheryl Yelverton, MD** to file insurance claims on my behalf for services rendered.

4. Payment of medical benefits to be paid directly to **Matthew Enright, AP, Landon Agoado, AP, Andrew Agoado, AP and Cheryl Yelverton, MD** the provider(s).

I hereby agree to be responsible for payment of services rendered by **Matthew Enright, AP, Landon Agoado, AP, Andrew Agoado, AP and Cheryl Yelverton, MD** in the event I have no medical insurance coverage, or in the event my insurance carrier shall deny payment due to a deductible, non-authorized visit, treatment deemed not medically necessary or other reason. I understand that my coverage may not cover routine maintenance, preventative or wellness visits. Additionally, I shall be resonsible for any co-payments mandated by my insurance carrier.

This authorization has been explained to my full satisfaction. I understand its nature and effect, and it will remain in force until terminated by me in writing.

_____ _____

Patient's signature Date