HEALTH HISTORY

Theresa Rizzo, A.P., Dipl. OM.

Date: ____ / ____ / ______

Name:			Sex:	Age:
Address:		City:	State:	Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email:		
Date of Birth:	Employer:	Occupation:		
Health Care Providers:	Relationship Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Living w/partner ❒ Other: ___________			
Height:	Usual Blood Pressure:			
Weight:	Weight One Year Ago:	How did you hear of our clinic?		
Are you or may you be currently pregnant?		Have you been treated by Acupuncture or Oriental Medicine Before? ❍ No ❍ Yes: when ____/____/____		

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |――――――|――――――| 10

2 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |――――――|――――――| 10

3 ______________________________

When did this start? ________________ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |――――――|――――――| 10

HEALTH HISTORY

Check the ❒ if you have / had the condition and note the year it started.
Check the ❍ if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer type(s)? ____________	❒	_______	❍
Diabetes	❒	_______	❍
Hepatitis	❒	_______	❍
High Blood Pressure	❒	_______	❍
Heart Disease	❒	_______	❍
Stroke	❒	_______	❍
Seizure Disorder	❒	_______	❍
Thyroid Disease	❒	_______	❍
Asthma	❒	_______	❍
Pacemaker	❒	_______	❍
Arthritis	❒	_______	❍
Chronic Fatigue	❒	_______	❍
Gastritis/Pancreatitis	❒	_______	❍
Hypo/Hyperglycemia	❒	_______	❍
Lyme Disease	❒	_______	❍
Infertility	❒	_______	❍
Elevated Cholesterol	❒	_______	❍

	YOU	Year	FAMILY
Osteoporosis	❒	_______	❍
Herpes	❒	_______	❍
AIDS / HIV	❒	_______	❍
Other STD	❒	_______	❍
Rheumatic Fever	❒	_______	❍
Alcoholism	❒	_______	❍
Allergies type(s)? ____________	❒	_______	❍
Mental Illness	❒	_______	❍
Kidney Disease	❒	_______	❍
Anemia	❒	_______	❍
Chronic Pain	❒	_______	❍
Diverticulitis/IBS	❒	_______	❍
Emphysema	❒	_______	❍
Raynaud's Disease	❒	_______	❍
Venereal Disease	❒	_______	❍
Addiction	❒	_______	❍
Other ______________			

DIET

Low/No Carb, Vegetarian/Vegan, Portion Control, Low Fat, Standard American
Current or past eating disorder?

Typical Breakfast: ______________________________

Typical Lunch: ______________________________

Typical Dinner: ______________________________

Typical Snacks: ______________________________

HABITS

	Amount/Week	If quit, Year?
Coffee/Tea	____________	________
Soda	____________	________
Tobacco	____________	________
Alcohol	____________	________
Drugs	____________	________

EXERCISE

Do you exercise regularly?
If so, what types? What frequency/duration?

____

____

____

____

MEDICATIONS

Please list all Medications, Herbs, and Supplements that you take regularly.

____
____
____
____

INJURIES & TRAUMAS (PHYSICAL/EMOTIONAL)

When What Happened?

_____ ____
_____ ____
_____ ____

SURGERIES

When What Surgery?

_____ ____
_____ ____
_____ ____

CHILDHOOD HEALTH HISTORY

☐ Allergies ☐ Frequent Earaches ☐ Scarlet Fever ☐ Forceps Delivery
☐ Asthma ☐ Frequent Sore Throat ☐ Premature Birth ☐ Other Birth Trauma__________________________
☐ Chicken Pox ☐ Frequent Cold / Flu ☐ Prolonged Labor ☐ Other_______________________________________

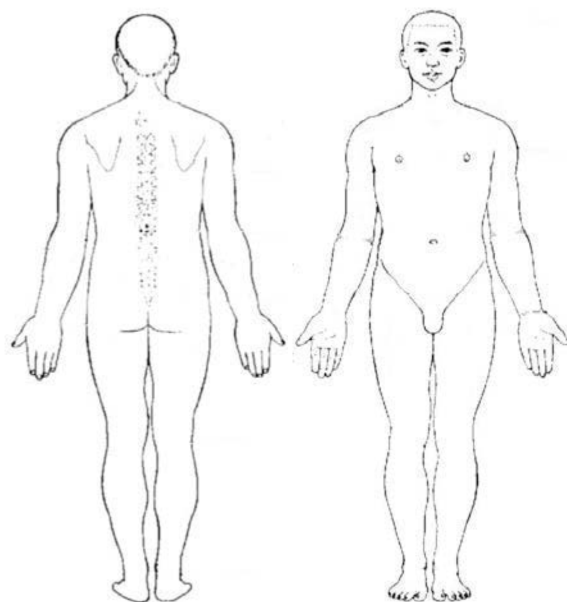
MUSCULOSKELETAL/EXTREMITIES

Pain, Weakness, Numbness in:

☐Head ☐Wrists ☐Legs
☐Neck ☐Hands ☐Knees
☐Shoulders ☐Fingers ☐Ankles
☐Arms ☐Back: U/M/L ☐Feet
☐Elbows ☐Hips ☐Toes

☐Joint Swelling ☐Edema ☐Carpal Tunnel
☐Broken Bones ☐Tendonitis ☐Sprains/Strains
☐Bone Deformities ☐Muscle Pain ☐Rotator Cuff
☐Paralysis ☐Bursitis ☐Poor Balance
☐Whole Body Pain ☐Sciatica ☐Restricted Movement
☐Other________________________

Please Mark All Places on the Body Where You Have Any Concern →



HEAD, EYES, EARS, NOSE, THROAT

☐Migraines ☐Eye Strain ☐Poor Hearing ☐Sinus Problems ☐DryLips/Mouth
☐Poor Vision ☐Dizziness ☐Earaches ☐Sore Throats ☐Dry Throat
☐Blurry Vision ☐Eye Pain ☐Ear Ringing ☐Lip/Mouth Sores ☐Difficulty Swallowing
☐Night Blindness ☐Cataracts ☐Excess Ear Wax ☐Tongue Sores ☐Headaches
☐Glasses ☐Red/Itchy Eyes ☐Nose Bleeds ☐Grinding Teeth ☐Heavy-headed
☐Spots in Eyes ☐Color Blindness ☐Poor Smell ☐Jaw locks/clicks ☐Light-headed

CARDIOVASCULAR

☐Shortness of Breath ☐Irregular Heart Beats ☐ Blood Clots ☐Bleed/Bruise Easily ☐Phlebitis
☐Slow Heart Rate ☐Palpitations ☐Spontaneous Sweating ☐Chest Pain/Pressure ☐High Blood Pressure
☐Fast Heart Rate ☐Varicose/Spider Veins ☐Fainting ☐Hands/Feet Swelling ☐Low Blood Pressure

RESPIRATORY

☐Cough/Wheezing ☐Pneumonia ☐Difficult Inhale/Exhale ☐Bronchitis
☐Frequent Colds ☐Coughing Blood ☐Pain on Deep Inhalation ☐Phlegm (color:__________)
☐Frequent Fevers ☐Asthma ☐Chest Tightness ☐Difficulty Breathing when lying down

GASTROINTESTINAL

BM: How Often? __x/__day(s) | Stools keep shape? Y/N

☐Indigestion ☐Nausea/Vomiting ☐Peculiar Tastes/Smells

☐Black Stools ☐Bloating ☐Belching ☐Bad Breath ☐Excess Saliva

☐Hemmorhoids ☐Bowel Incontinence ☐Poor Appetite ☐Excessive Hunger ☐Feel a "lump in throat"

☐Hiatal Hernia ☐IBS/Crohn's Disease ☐Blood in Stool ☐Heartburn/Reflux ☐Stomachaches

☐Dry Stools ☐Difficult to Pass ☐Tired after BM ☐Cramps w/ BM ☐Unsatisfying BM

☐Gas ☐Rectal Pain ☐Abdominal Pain

DIARRHEA |——|——| CONSTIPATION

GENITO-URINARY

☐Clear Urine ☐Dark Urine ☐Cloudy Urine ☐Burning Urine

☐Scanty Urine ☐Profuse Urine ☐Frequent Urine ☐Urgent Urine

☐Blood in Urine ☐Painful Urine ☐Incontinence ☐Kidney Stones

☐Frequent UTI ☐Erectile Dysfunction ☐Difficult Start/Stop ☐Fluid in = Fluid out

☐Prostate Disease ☐Decreased Libido ☐Premature Ejaculation ☐Nocturnal Emission

☐Testical Pain ☐Herpes ☐Genital Pain ☐Genital Sores

☐Jock Itch ☐Vasectomy ☐Hernia ☐Excess Libido

GYNECOLOGICAL

☐Vaginal Dryness ☐Vaginal Sores ☐Vaginal Discharge ☐Infertility ☐Irregular Periods ☐Ovarian Cysts

☐Endometriosis ☐Fibroids ☐PMS ☐Painful Periods ☐Heavy Periods ☐Light Periods

☐Cramps ☐Clots ☐Breasts Tender ☐Mood Changes ☐Period Fatigue ☐Spotting

☐Digestive changes w/Period ☐Fibrocystic Breast Tissue ☐Polycystic Ovarian Disease ☐Difficult/Painful Intercourse ☐Age at First Menses_______ ☐Date of Last Menses_______

☐Length of Cycle:_________days ☐Length of Menses:_______days ☐Menopause: Age________________ ☐Number of Pregnancies:__________ ☐Number of Births:______________ ☐# of Abortions/Miscarriages:______

NEURO – PSYCHO – EMOTIONAL

☐Seizures ☐Loss of Balance ☐Vertigo/Dizziness ☐Areas of Numbness ☐Lack of Coordination

☐Nervousness ☐Anxiety ☐Panic Attacks ☐Irritable ☐Depression

☐Bi-Polar ☐Poor Memory ☐Forgetful ☐ADD/ADHD ☐Fearful

☐Angry ☐Sad ☐Grief ☐Joy ☐Indecision

☐Concussion ☐Poor Concentration ☐Overthinking ☐Tremors ☐Easily Stressed

☐Seasonal Affective Disorder ☐Difficulty Expressing Emotions ☐Frequently Sigh/Yawn ☐Other______________

ENERGY

☐Wired ☐Dependence on Caffeine ☐Energy Drop after Eating ☐Sudden Energy Drop: Time of Day:______

☐Fatigue ☐Body feels Heavy ☐Body feels Weak

LOW |——|——| HIGH

SLEEP

☐Difficulty Falling Asleep ☐Difficulty Staying Asleep ☐Excessive Sleep ☐Not Enough Sleep

☐Sleep Walk/Talk ☐Disturbing Dreams ☐Wake to Urinate ☐Restless Sleep

☐Not Rested Upon Waking ☐Wake ____x / night ☐Sleep:____hrs./night

Too Little (Insomnia) |——|——| Too Much (Hypersomnia)

SKIN, HAIR, & NAILS

☐Rashes ☐Acne ☐Dandruff ☐Itching ☐Warts

☐Eczema ☐Psoriasis ☐Dermatitis ☐Face Flushing ☐Hives

☐Thick Skin ☐Scaly Skin ☐Thin Skin ☐Thin Nails ☐Dry Skin

☐Dry Nails ☐Discolored Skin ☐Dark under eyes ☐Nail Fungus ☐Abscesses/Infections

☐Hair Loss ☐Dry/Brittle Hair ☐Premature Greying ☐Recent Moles ☐Lumps

☐Ulcerations ☐Weak Nails ☐Ridged Nails ☐Change in Skin/Hair Texture ☐Other__________________

DRY |——|——| OILY

TEMPERATURE & THIRST

☐Cold Hands/Feet ☐Cold "in the bones" ☐Areas of Numbness ☐Chills

☐Thirst for Cold Drinks ☐Thirst for Hot Drinks ☐Thirst, No desire to Drink ☐Absence of thirst

☐Excessive Thirst ☐Hot Hands ☐Hot Feet ☐Hot Chest

☐Hot Flashes ☐Hot in Afternoon ☐Hot at Night ☐Night Sweats

☐Unusual Sweats: Where on Body:___________ What Time:_______am/pm

COLD |——|——| HOT

Theresa Rizzo, A.P., Dipl. OM.
1330 NW 6th St., Suite A
Gainesville, FL. 32601
(352) 371-0012

HIPAA CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and Physician certifications.

I have been informed by you; of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 in the future treat me while employed by, working 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, Tiu-Na (Chinese massage), Chinese 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 be an unpleasant smell 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 i 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 eec o cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Bums 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 effect and risks may ocur. 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 Chinese 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 i I am or become pregnant.

I do not 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 kept confidential and will not be released without my written consent.

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.

PATIENT SIGNATURE **X**	(Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

Financial Policy

In respect for our intention to offer high quality healthcare at affordable prices, we ask for 24 hour notice in advance if it is necessary to cancel or reschedule an appointment. All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged $40 for that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments n that package.

Late policy

We will do our best to accommodate you if you arrive late for your appointment. However, if you arrive more than than 10 minutes late and we are unable to accommodate you, we will consider it a missed appointment and enforce our financial policy.

Returned checks

There will be a $20 charge for any returned checks.

Thank you for your understanding.

Theresa Rizzo A.P., Dip. O.M.

Signature____ Date:________________

Printed name____

Theresa Rizzo, A.P., Dipl. O.M.(NCCAOM),
1330 NW 6th St Suite A
Gainesville, Florida 32601
(352) 432-1693

Patient Billing Information/Insured Information			
Patient Name:		**DOB:**	**Sex:**
Address:			
Other Insured/Spouse Information			
Name:	**Relationship:**	**DOB:**	**Notes**
Employer:			

Primary Insurance Information			
Carrier:		**Plan:**	
Send copy of card front and back to: Rizzoacupuntcure@beehivemedicalsolutions.com			
Policy #:		**Claims Phone #:**	
Group ID:		**Claims Address:**	

Secondary Insurance Information			
Carrier:		**Plan:**	
Send copy of card front and back to: Rizzoacupuntcure@beehivemedicalsolutions.com			
Policy #:		**Claims Phone #:**	
Group ID:		**Claims Address:**	

A copy of the card can be sent as an attachment Via Phone :)

I have read and understand the office HIPAA policy and understand that I can request a paper copy of the HIPAA policy.

All professional services rendered are charged to the patient. It is customary to pay for services rendered unless arrangements have been made prior to any appointments.

If I have insurance coverage, I hereby authorize my physician to furnish to that insurance carrier my illness and treatment. My information to Beehive Medical Solutions for the billing process of my medical claims.
Print Name: ______________________________

Sign____ Date: ____

Theresa Rizzo, A.P., Dipl. O.M.(NCCAOM),
1330 NW 6th St Suite A
Gainesville, Florida 32601
(352) 432-1693

Group ID:		**Claims Address:**	

Primary Insurance Information			
In Network	Deductible	Met	Remaining
Out of Network			
Secondary Insurance Information			
In Network	Deductible	Met	Remaining
Out of Network			