

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: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> 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? <input type="radio"/> No <input type="radio"/> 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 | | YOU | Year | FAMILY |
|------------------------|--------------------------|-------|-----------------------|--------------------|--------------------------|-------|-----------------------|
| Cancer type(s)? | <input type="checkbox"/> | _____ | <input type="radio"/> | Osteoporosis | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Diabetes | <input type="checkbox"/> | _____ | <input type="radio"/> | Herpes | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Hepatitis | <input type="checkbox"/> | _____ | <input type="radio"/> | AIDS / HIV | <input type="checkbox"/> | _____ | <input type="radio"/> |
| High Blood Pressure | <input type="checkbox"/> | _____ | <input type="radio"/> | Other STD | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Heart Disease | <input type="checkbox"/> | _____ | <input type="radio"/> | Rheumatic Fever | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Stroke | <input type="checkbox"/> | _____ | <input type="radio"/> | Alcoholism | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Seizure Disorder | <input type="checkbox"/> | _____ | <input type="radio"/> | Allergies type(s)? | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Thyroid Disease | <input type="checkbox"/> | _____ | <input type="radio"/> | Mental Illness | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Asthma | <input type="checkbox"/> | _____ | <input type="radio"/> | Kidney Disease | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Pacemaker | <input type="checkbox"/> | _____ | <input type="radio"/> | Anemia | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Arthritis | <input type="checkbox"/> | _____ | <input type="radio"/> | Chronic Pain | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Chronic Fatigue | <input type="checkbox"/> | _____ | <input type="radio"/> | Diverticulitis/IBS | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Gastritis/Pancreatitis | <input type="checkbox"/> | _____ | <input type="radio"/> | Emphysema | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Hypo/Hyperglycemia | <input type="checkbox"/> | _____ | <input type="radio"/> | Raynaud's Disease | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Lyme Disease | <input type="checkbox"/> | _____ | <input type="radio"/> | Venereal Disease | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Infertility | <input type="checkbox"/> | _____ | <input type="radio"/> | Addiction | <input type="checkbox"/> | _____ | <input type="radio"/> |
| Elevated Cholesterol | <input type="checkbox"/> | _____ | <input type="radio"/> | 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

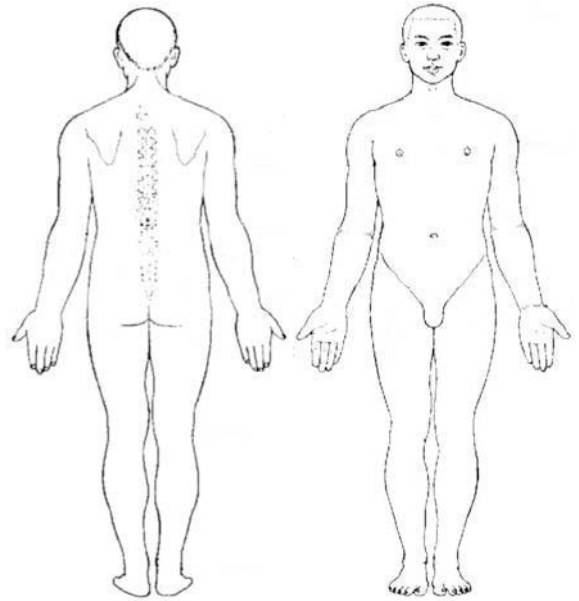
- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent Earaches | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Forceps Delivery |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Other Birth Trauma _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent Cold / Flu | <input type="checkbox"/> Prolonged Labor | <input type="checkbox"/> Other _____ |

MUSCULOSKELETAL/EXTREMITIES

Pain, Weakness, Numbness in:

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Head | <input type="checkbox"/> Wrists | <input type="checkbox"/> Legs |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Hands | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Fingers | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Back: U/M/L | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Elbows | <input type="checkbox"/> Hips | <input type="checkbox"/> Toes |
| | | |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Edema | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Bone Deformities | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Poor Balance |
| <input type="checkbox"/> Whole Body Pain | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Restricted Movement |
| <input type="checkbox"/> Other _____ | | |

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



HEAD, EYES, EARS, NOSE, THROAT

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

CARDIOVASCULAR

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Bleed/Bruise Easily | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Slow Heart Rate | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Spontaneous Sweating | <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fast Heart Rate | <input type="checkbox"/> Varicose/Spider Veins | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hands/Feet Swelling | <input type="checkbox"/> Low Blood Pressure |

RESPIRATORY

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficult Inhale/Exhale | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain on Deep Inhalation | <input type="checkbox"/> Phlegm (color: _____) |
| <input type="checkbox"/> Frequent Fevers | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest Tightness | <input type="checkbox"/> Difficulty Breathing when lying down |

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, Tui-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 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 is another possible risk, although the clinic 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 effect 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 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 if 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 in 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 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 _____