



1700 N University Drive
Suite 202 Coral Springs
FL 33071

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 evening
- ☐ Full of energy in the afternoon
- ☐ Full of energy at night
- ☐ Sneezing

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

Sleep

- ☐ Wake up unrefreshed
- ☐ Waking up constantly at night
- ☐ Restless sleep

- ☐ Difficult falling asleep
- ☐ Frequent dreams
- ☐ Other

Thirst

- ☐ Thirsty all the time
- ☐ Prefer cold drinks
- ☐ Thirsty at night

- ☐ Lack of thirst
- ☐ Prefers hot drinks
- ☐ Other

Eyes

- ☐ Blurred Vision
- ☐ Dry eyes
- ☐ Itch eyes
- ☐ Pain in the eyes

- ☐ Watery eyes
- ☐ Vision loss
- ☐ Red eyes
- ☐ Other

Nose

- ☐ Nasal Discharge if yes, color:
- ☐ Dry nose
- ☐ Difficulty Breathing
- ☐ Other

- ☐ Nasal congestion
- ☐ Loss of smells
- ☐ Nose Bleed

Throat, Mouth, Lips, and Head

- ☐ Dry Throat
- ☐ Cough
- ☐ Dry Cough
- ☐ Tastelessness
- ☐ Sour taste in the mouth
- ☐ Mouth ulcers

- ☐ Sore throat
- ☐ Dry Mouth
- ☐ Bitter taste in the mouth
- ☐ Metal taste in the mouth
- ☐ Sweet taste in the mouth
- ☐ Sores on the tip of the tongue

☐ Dry lips

☐ Headache

☐ Cracked Lips

☐ Other

Neck, Ears, and Skin

☐ Stiff neck and shoulders

☐ Low - Pitched Ringing in the Ears

☐ High - Pitched Ringing in the Ears

☐ Pain in the ears

☐ Itchy Skin

☐ Tingling Sensation

☐ Muscle Spasms

☐ Muscle Cramping

☐ Pain in the neck

☐ Left ☐ Right ☐ Both

☐ Left ☐ Right ☐ Both

☐ Dry Skin

☐ Acne

☐ Numbness

☐ Muscle Twitching

☐ Other

Emotions

☐ Stress

☐ Sadness

☐ Restlessness

☐ Mental Confusion

☐ Worry

☐ Mental Sluggishness

☐ Fear

☐ Other

☐ Anxiety

☐ Melancholy

☐ Depression

☐ Over thinking

☐ Anger

☐ Frustration

☐ Irritability

Digestion

☐ Low Appetite

☐ Abrupt Weight Loss

☐ Abdominal Gas

☐ Fatigue after eating

☐ Constipation

☐ Diarrhea

☐ Mucus in the stools

☐ Acid Regurgitation

☐ Abrupt Weight Gain

☐ Abdominal Bloating

☐ Gurgling noise in the stomach

☐ Loose Stool

☐ Incomplete Evacuation

☐ Blood in the stools

☐ Undigested food in the stools

☐ 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 in the 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 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 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 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. 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.

I agree to pay a \$50 fee for any missed or forgotten appointment without 24 hours notice of cancellation. I agree to pay full charges incurred for services rendered, over and above insurance coverage, if applicable.

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:

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: