**Lavender Retreat, Inc**

**1236 Pennsylvania Ave SE**

**Washington DC, 20003**

**Acknowledgement of receipt of statement of HIPAA Notice of Privacy Practices**

I acknowledge that I have received a copy of the statement of HIPAA notice of privacy practices for the offices of Lavender Retreat, Inc. The statement of HIPAA notice of privacy practices describes the types of uses and disclosures of my protected health information that might occur in my treatment payment for services, or in the performance of office healthcare operations. The statement of HIPAA notice of privacy practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The statement of HIPAA notice of privacy practices is also posted in the facility.

Lavender Retreat reserves the right to change the HIPAA Notice of privacy practices that are described in the statement of HIPAA Notice of privacy practices. If HIPAA Notice of privacy practices changes, I will be offered a copy of the revised statement of HIPAA Notice of privacy practices at the time of my first visit after the revision become effective. I may also obtain a revised statement of privacy practices by requesting that one be mailed to me.

**Additional Disclosure Authority**

In addition to the allowable disclosures described in the statement of HIPAA notice of privacy practices. I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any Member of my immediate family Yes No

Spouse only Yes No

Other Yes No

Name of Patient of Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lavender Retreat, Inc**

**1236 Pennsylvania Ave SE**

**Washington DC, 20003**

**Telephone: 202.450.2329**

**Financial Information / and Cancellation Policy**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Information Authorization:

I understand that I am financially responsible for all charges incurred during my course of treatment. All returned checks will be subjected to a $55.00 returned check fee. All fees and co-payments are due at the time of service unless special arrangements have been made.

I authorize the release of information needed for the processing of my insurance claims. I certify that the information reported with regard to my insurance policy is accurate and up to date.

**Cancellation Policy**

We charge a cancellation fee for patients who fail to come to their appointments with less than 24 hours’ notice. We attempt to practice at the highest level and if a patient does not arrive for their appointment, there is a significant inconvenience for other patients. If you must change your appointment, we ask that you contact our office 24 hours prior to your scheduled appointment. During the weekend or a holiday leave a message on our voicemail or email us. The date and time will be automatically recorded. You will be charged $60.00 for your appointment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/ Responsible Party Date



**Patient Consent for Use and Disclosure Information**

Note: *Please Read the Following Statements Carefully*

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_hereby voluntarily consent to be treated by Frances Lutz, L.Ac, DACM, MSTOM, with oriental medical procedures, which may include acupuncture, moxibustion, cupping, gua sha, acupressure, massage, Chinese herbal medicine, or nutrition and lifestyle counseling. Frances Lutz, L.Ac is a licensed acupuncturist in the state of District of Columbia.

I understand that acupuncture is performed by the insertion of sterile needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat body dysfunctions or disease and to normalize the body’s physiological functions. These can include some local bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, dizziness and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I acknowledge that due to the relaxation of certain muscles in the body it is possible for the acupuncture needles to fall out during the acupuncture treatment and that this has no negative effect on the treatment outcome.

I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, or if a new ailment or condition appears that I should consult my personal physician or any other licensed physician.

I accept the fact no guarantee is made concerning the use and effects of acupuncture or Chinese Herb. I understand that I am free to stop treatment at any time. I understand that I should inform my acupuncturist prior to being treated if I believe I might be pregnant.

I understand that the evaluation given me is an energetic assessment of the traditional Chinese medicine meridian network and in no way purports to be or replaces a western medical examination and diagnosis. In the course of the evaluation, there may be reference to that state of various “organs, “such as heart, liver, spleen, kidneys, etc., which actually refers to energetic channels of the same name.

I have carefully read all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

YOU ACKNOWLEDGE THAT YOU HAVE READ THE **CONSENT FORM** BEFORE SIGNING.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Patient’s or guardian) (Date)

Witnessed By:

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner Name (Print & Sign) (Date)



**Welcome to Lavender Retreat Wellness Destination**

1236 Pennsylvania Ave SE, Washington DC, 20003

Acupuncture

New Patient Intake Form

intake

All written records are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client (you) or the client’s legal guardian — unless legally required by local, state or federal subpoena, summons, or other court order.

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I\_\_\_\_\_\_\_\_\_\_\_\_Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH INSURANCE INFORMATION**

**Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Group ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Card Holder relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Deductible Met: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Co-Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your goals of treatment?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY**

Do you smoke? \_\_\_\_\_\_\_\_\_\_\_Have you ever smoked:\_\_\_\_\_\_\_\_\_\_\_\_\_How Often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If you are, How many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Pacemaker? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List the main health problems for which you are seeking treatment:**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of onset of symptom (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Severity of Symptoms 1-10 (1 mild/10 severe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of onset of symptom (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Severity of Symptoms 1-10 (1 mild/10 severe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of onset of symptom (s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Severity of Symptoms 1-10 (1 mild/10 severe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What other forms of treatment have you sought?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What are your goals of treatment?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all past Hospitalizations, Surgeries or Accidents (car accident, fall etc, include Date):** (if extensive, provide list)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies, Food Sensitivities:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescription drugs you are currently taking:** (if more than 4 provide list)

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vitamins, Supplements, Over-the-Counter Medication you are currently taking:** (if more than 4 provide list)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

(Check the following conditions that have occurred in your blood relatives- grandparents, parents or siblings)

□ Allergies (list) □ Alcoholism □ Depression □ High Blood Pressure □ Tuberculosis □ Arteriosclerosis □ Cancer (type) □ Diabetes □ Seizures □ Obesity □ Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Heart Diseases □ Stroke

**YOUR PAST MEDICAL HISTORY**

(Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.)

□ AIDS/HIV □ Cancer: \_\_\_\_\_\_\_\_\_\_\_\_ □ Measles □ Seizures □ Herpes (Type: \_\_\_\_\_\_\_) □ Alcoholism □ Chicken Pox □ Multiple Sclerosis □ Stroke □ High Blood Pressure □ Allergies

□ Diabetes (Type: \_\_\_\_\_) □ Mumps □ Thyroid Disorders □ Venereal disease □ Appendicitis □ Emphysema □ Pacemaker □ Tuberculosis □ Rheumatic Fever □ Arteriosclerosis □ Gout □ Pleurisy

□ Typhoid Fever □ Scarlet Fever □ Asthma □ Heart Disease □ Pneumonia □ Ulcers □ Epilepsy □ Birth Trauma □ Hepatitis (Type: \_\_\_\_\_) □ Psychological Disorder □ Whooping Cough □ Goiter

Other significant Past Medical problems/medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL LIFESTYLE HABITS**

Cigarettes (packs) \_\_\_\_\_\_\_\_\_\_\_\_ Coffee/Tea (cups per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol (drinks per week) \_\_\_\_\_\_\_\_\_\_\_ Recreational drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food cravings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daily Water intake (cups/day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dairy Diet that you might eat on a typical day?

• Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What non-work activities do you Enjoy doing?** (reading, hiking, TV, meditation, music, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Life Stresses: \_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP BEHAVIOR**

What time do you go to bed at night: \_\_\_\_\_\_\_\_\_\_\_What time do you wake in the morning: \_\_\_\_\_\_\_\_\_\_

Do you fall asleep easily? □ Yes □ No if no, how long does it take you to fall asleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you stay asleep throughout the night? □ Yes □ No if no, how often do you wake throughout the night?

Do you wake rested? □ Yes □ No / Do you have vivid dreaming? □ Yes □ No / Sweat at night? □ Yes □ No

Do you wake to urinate in the middle of the night? □ Yes □ No

if yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OVERALL TEMPERATURE**

(Check all the following that apply to you.)

□ Cold Hands □ Sweaty Hands □ Usually feel Hot □ Sweat Easily □ Hot flashes any time

□ Cold Feet □ Sweaty Feet □ Usually feel Cold □ Afternoon Flushes □ Heat/Warmth in Face

**MEDICAL REVIEW OF SYSTEMS**

Please Fill this out Carefully. **One Check** = Symptom you have experienced **Two Checks** = Frequently occurring symptom

**GENERAL SYMPTOMS**

□ Poor appetite □ Large appetite □ Being overweight □ Strongly like cold drinks □ Strongly like hot drinks □ Recent weight Loss/Gain □ Fatigue □ Excessive sleeping □ Difficulty sleeping □ Lack of strength □ Bodily heaviness □ Easily catch colds □ Vague Flu-like symptoms □ Excessively thirsty □ Poor circulation □ Shortness of breath □ Fever □ Chills □ Vertigo or dizziness □ Bleed or bruise easily □ Peculiar taste in mouth □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**RESPIRATORY**

□ Difficulty breathing when lying down □ Shortness of breath □ Tight chest □ Asthma/wheezing

□ Difficult inhalation? exhalation? □ Cough Wet or Dry? \_\_\_\_\_\_\_\_\_\_\_ Thick or Thin? \_\_\_\_\_\_\_\_\_ Color of phlegm \_\_\_\_\_\_\_\_ □ Coughing up blood □ Pneumonia.

**CARDIOVASCULAR**

□ High blood pressure □ Blood clots □ Low blood pressure □ Fainting □ Chest pain □ Difficulty breathing □ Tachycardia □ Heart palpitations □ Irregular heartbeat □ Ankle swelling/edema

**PSYCHOLOGICAL**

□ Depression □ Anxiety □ Irritability □ Easily stressed □ Tendency to become Obsessive

□ Seeing a therapist

**GASTROINTESTINAL**

□ Nausea □ Vomiting □ Acid reflux □ Gassy □ Abdominal bloating □ Abdominal pain □ Bad breath □ Diarrhea □ Constipation □ Black stools □ Blood in stools □ Mucous in stools □ Hemorrhoids

□ Itchy or burning anus □ Intestinal pain or cramping □ Rectal pain □ Colitis/Diverticulitis □ Laxative use

What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Daily Bowel Movements \_\_\_\_\_\_\_

**MUSCULOSKELETAL**

□ Neck/Shoulder pain □ Muscle cramps or pain □ Upper back pain □ Low back pain □ Joint pain or stiffness □ Rib side pain □ Leg pain □ Radiating pain

**GENITOURINARY**

□ Pain on urination □ Frequent urination □ Urgent urination □ Blood in urine □ Unable to hold urine

□ Incomplete urination □ Wake to urinate □ Bed wetting □ Excessive Libido □ Low Libido □ Kidney Stone

□ Impotence □ Premature Ejaculation □ Nocturnal emission □ Pain with Intercourse

**MALES**

□ Inability to ejaculate or orgasm □ Scrotal pain □ Abnormal penis discharge □ Retention of urine

□ Post Void dribbling □ BPH, Prostatitis Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEAD, EYES, EARS, NOSE & THROAT**

□ Headaches □ Migraines □ Head injury □ Neck pain or stiffness □ Facial pain

□ Glasses (What age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

□ Eye strain □ Eye pain □ Red eyes □ Itchy eyes □ Eyes Sensitive to light □ Poor vision □ Blurred vision

□ See spots/shadows □ Double vision □ Glaucoma □ Cataracts □ Teeth problems □ Grinding teeth

□ TMJ □ Gum problems □ Sores on lips or tongue □ Dry mouth □ Excessive Saliva□ Excessive phlegm Color: \_\_\_\_\_\_\_\_\_\_\_ □ Sinus problems □ Recurrent sore throat □ Lumps in throat □ Enlarged Thyroid

□ Nosebleeds □ Ringing in ears (High or Low?) □ Poor hearing □ Earaches

**NEUROLOGICAL**

□ Dizziness □ Drowsiness □ Muscle spasms or tremors □ Poor memory □ “Tics” □ Numbness

□ Convulsions/Seizures □ Slurred speech □ Speech problems (other) □ Weakness in muscles

**SKIN, HAIR**

□ Dry hair or Skin □ Itchy skin or Scalp □ Hair loss □ Eczema or Psoriasis □ Recurrent fungal infections □ Changing moles □ Increased perspiration

**GYNECOLOGY**

Are you currently pregnant? □ Yes □ No

Age of first menses: \_\_\_\_\_\_\_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of flow \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood clots: □ Yes □ No if yes, what color are they? \_\_\_\_\_\_\_\_\_\_\_\_ Length of cycle (i.e. 28 days) \_\_\_\_\_\_\_\_\_\_

Color of Menstrual blood: □ Pale Red □ Bright Red □ Red □ Dark Red □ Brown

Texture of menstrual blood: □ Thick □ Thin □ Watery □ Normal

Amount of menstrual blood: □ Light flow □ Heavy flow □ Spotting □ Normal

Pain: □ Yes □ No if yes when? (before, during or after menses) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the Pain: □ Sharp □ Cramping □ Bloating □ Burning □ Bearing down sensation

Irregular periods(describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PMS (irritability, breast tenderness etc., please describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current method of contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past method of contraception: \_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of live births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any premature births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast (lumps, cysts, tenderness, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Urinary tract infections: □ Yes □ No How frequent? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaginal discharge (describe color): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain/itching of genitalia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap smear: □ Normal / □ Abnormal \_\_\_\_\_

Have you been diagnosed with: □ Fibroids □ Fibrocystic Breasts □ Endometriosis □ Ovarian Cysts

□ PID □ Interstitial Cystitis □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Symptoms related to Menses:

□ Swollen Breasts □ Nausea □ Poor appetite □ Vaginal dryness □ Headache □ Diarrhea □ Constipation

□ Mood Swings □ Ravenous appetite □ Hot flashes □ Night sweats □ Increased libido □ Decreased libido □ Insomnia

Menopause (date of onset): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any bleeding since Menopause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on Hormone Replacement Therapy (HRT)? □ Yes □ No if yes, Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you been on HRT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any side effects? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bone Density Scan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_