

# Acupuncture & Natural Healing Center, Inc.

## PATIENT REGISTRATION

Date \_\_\_\_\_

Patient's Name (First, Middle, Last) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State/Zip \_\_\_\_\_

Is this the address you wish any medical correspondence to be mailed? Yes/No

If no, list address \_\_\_\_\_

Email address \_\_\_\_\_ Would you like to receive our newsletter? Yes/No

Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

May we contact you and/or leave a message on your answering machine about appointments and/or health care information? Yes/No

If no, what number(s) may we reach you at? \_\_\_\_\_

Are you employed? Yes/No Occupation \_\_\_\_\_ Business Phone # \_\_\_\_\_

Employer or Business Name \_\_\_\_\_

Business Address \_\_\_\_\_

Spouse Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed By \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone# \_\_\_\_\_

Please list to whom we may contact in an emergency if someone other than your spouse?

Name \_\_\_\_\_ Number \_\_\_\_\_

Name \_\_\_\_\_ Number \_\_\_\_\_

Can these people discuss your medical diagnosis, history, etc. with the health care provider? Yes/No

Can this person discuss your medical history in case of an emergency? Yes/No

How did you hear about us? \_\_\_\_\_

Acupuncture & Natural Healing Center, Inc.  
921 E. Ocean Blvd. #2  
Stuart, FL 34994 (772) 781-5353

PATIENT QUESTIONNAIRE

- I. Please list the family members or other persons, if any who we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

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- II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name\_\_\_\_\_ Number\_\_\_\_\_

Name\_\_\_\_\_ Number\_\_\_\_\_

- III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home address:

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- IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL" Yes\_\_\_\_\_ No\_\_\_\_\_

- V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information IF other than your home number:\_\_\_\_\_

- VI. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voice mail? Yes\_\_\_\_\_ No\_\_\_\_\_

PATIENT NAME:\_\_\_\_\_

SIGNATURE:\_\_\_\_\_ DATE:\_\_\_\_\_

NAME \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Account No. \_\_\_\_\_

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Major Complaint/s \_\_\_\_\_

\_\_\_\_\_

Other Complaints \_\_\_\_\_

Date of onset (when problem was first noticed)? \_\_\_\_\_

Pain is:  Minimal  Slight  Moderate  Severe

How long have you had this condition? \_\_\_\_\_

Have you had this in the past?  Yes  No When? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Is your condition:  Getting worse  Constant  Comes and goes

Medications/Drugs/Herbs you are currently taking:

\_\_\_\_\_

\_\_\_\_\_

List Surgeries/Operations you have had and the dates: \_\_\_\_\_

\_\_\_\_\_

Date of your last physical examination \_\_\_\_\_ By whom? \_\_\_\_\_

**MEDICAL HISTORY:** (Do you have or have you ever had):  Arthritis  Asthma  Anemia  Heart trouble

Cancer  Diabetes  Epilepsy  Stroke  Kidney or bladder trouble  Gallstones  Ulcers

High Blood Pressure  Chronic fatigue  Hepatitis  Jaundice  Sudden weight loss  Sudden weight gain

Other: \_\_\_\_\_

**FAMILY HISTORY:** (Has any member of your family had any of the above)?  Yes  No If yes; which member and

what did they have? \_\_\_\_\_

**ENERGY LEVEL:**  High (Time of day) \_\_\_\_\_  Low (Time of day) \_\_\_\_\_

**STRESS:**  None  Moderate  Severe What causes it? \_\_\_\_\_

**SWEATING:**  Night sweats  Rarely sweat  Excess sweating \_\_\_\_\_

**CIRCULATION:** Feelings of  Hot  Cold What area? \_\_\_\_\_

Bleed easily  Cold limbs  Other: \_\_\_\_\_

**SKIN:**  Dry  Itchy  Moist/clammy  Burning  Changing moles or lumps (cysts/tumors)  Boils

Frequent skin rashes  Acne  Hair loss/thinning  Dry scalp  Skin puffy/wrinkled

Bruises easily (black and blue spots)  Hives  Other: \_\_\_\_\_

**SCARS:** (List ALL scars from accidents or surgeries) \_\_\_\_\_

\_\_\_\_\_

**SLEEP PROBLEMS:**  Trouble falling asleep  Trouble staying asleep  Restful  Excess dreaming

Other: \_\_\_\_\_ How many hours do you sleep a night? \_\_\_\_\_

**HEAD:**  Headaches (what area?) \_\_\_\_\_  Dizziness  Memory loss  Loss of balance

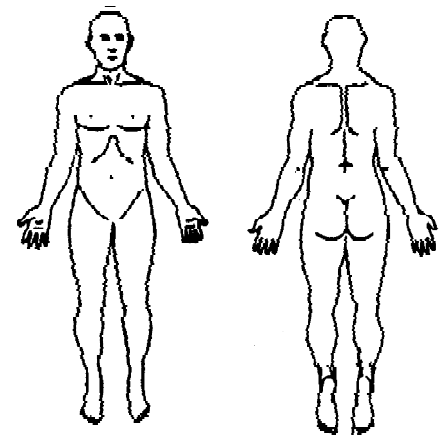
Other: \_\_\_\_\_

**EYES:**  Eye pain  Dry eyes  Blurred vision  Darkness under eyes  Other: \_\_\_\_\_

**EARS:**  Poor hearing  Earaches  Ear discharge/infections  Ringing/buzzing in ears  Other: \_\_\_\_\_

**NOSE:**  Frequent nose bleeds  Sinus trouble  Frequent colds  Other: \_\_\_\_\_

Please mark areas of pain



**THROAT:**  Sore throat  Hoarseness  Difficulty swallowing  Jaw problems  Teeth/gum problems  Swollen tongue  Other: \_\_\_\_\_

**CHEST:**  Hard to breathe  Wheezing  Shortness of breath  Mucus rattles when breathing  Trouble breathing at night

Pain/pressure in chest  Palpitations  Persistent cough  Coughing blood  Coughing phlegm  
Sputum color \_\_\_\_\_ Consistency \_\_\_\_\_  Other: \_\_\_\_\_

**BLOOD PRESSURE:**  High  Low  Do not know \_\_\_\_\_

**BOWELS:**  Diarrhea  Constipation  Bloody stools  Black stools  Mucus in stools  Hemorrhoids

Lower bowel gas  Stools have foul odor  Colon problems  Number bowel movements a day \_\_\_\_\_  
 Other: \_\_\_\_\_

**URINE:**  Color \_\_\_\_\_ Amount \_\_\_\_\_ Frequent urination  Daytime  At night

Strong smelling urine  Hard to urinate  Pain or burning on urinating  Blood in urine  Frequent Infections  Water retention  Other: \_\_\_\_\_

**MUSCULOSKELETAL:** Pain in:  Neck  Shoulder  Between shoulders  Arms/hands  Hip  Knee

Fingers  Big toe  Upper back  Mid back  Lower back  Bones sore/painful  Loss of grip  
 Swollen knees/elbows  Leg cramps at night  Weakness in legs  Weak ankles  Stiff all over  
 Tingling in feet  Muscle spasm/cramps  Loss of feeling in hands/feet  Painful joints  Bursitis  
 Other: \_\_\_\_\_

**NEUROLOGICAL:**  Nervousness  Depressed  Easily angered  Easily irritated  Frequent crying

Worry/Anxiety  Mood swings  Memory confusion  Poor concentration  Suicidal  Tremors  
 Numbness/tingling in limbs  Poor coordination  Muscle weakness  Feel weak and shaky  
 Seizures  Neuralgia (nerve pain)  Shingles  Other: \_\_\_\_\_

**FEMALES:**  Pregnant?  Yes  No Last monthly period \_\_\_\_\_ Last PAP test \_\_\_\_\_

Form of birth control:  None  Pill  Other: \_\_\_\_\_

Age started menstrual cycle \_\_\_\_\_ Age stopped \_\_\_\_\_  Menstrual pain

Low backache  Irregular  Clotting  Heavy bleeding  Light scanty bleeding  Color \_\_\_\_\_

Water retention  Mood changes  Miss periods  Low or no sex drive  Painful breasts  Hot

flashes  Food cravings  Other: \_\_\_\_\_

Discharges:  Yellow  Thick  White  Odor  Itching  Liquid  Other: \_\_\_\_\_

#Pregnancies \_\_\_\_ #Deliveries \_\_\_\_ #Miscarriages \_\_\_\_ #Abortions \_\_\_\_ #Cesareans \_\_\_\_

Operations:  Cervix  Uterus  Ovaries  Other: \_\_\_\_\_

**MALES:**  Low sexual drive  Lack of sexual drive  Impotence  Ejaculation causes pain  Discharges

Pain or burning while urinating  Premature ejaculation  Prostrate trouble  Other: \_\_\_\_\_

**APPETITE:**  Excessive appetite  Poor appetite  Appetite keeps changing  Feel tired or weak if a meal is missed  Excessive thirst  Never thirsty  Other: \_\_\_\_\_

Specific food cravings?  Yes  No If yes, what? \_\_\_\_\_  Other: \_\_\_\_\_

**DIGESTION:**  Stomach gas  Lower bowel gas  Heartburn  Burning/belching  Stomach pain

Stomach cramps  Nausea  Vomiting  Bad breath  Sores in mouth  Weight gain  Weight loss

Bitter/sour taste in mouth  Abdominal bloating How long after eating? \_\_\_\_\_

Food allergies?  Yes  No If yes, to what? \_\_\_\_\_

**NUTRITION:** List some of your favorite foods \_\_\_\_\_

Do you:  Skip breakfast  Eat a snack  Eat a hearty breakfast

How many meals a day do you eat? \_\_\_\_\_ When is your biggest meal? \_\_\_\_\_

Do you eat when you are worried or rushed?  Yes  No How often? \_\_\_\_\_

Do you plan your meals according a dietary plan?  Yes  No Explain \_\_\_\_\_

How many glasses of water do you drink per day? \_\_\_\_\_  Filtered  Bottled

# Acupuncture & Natural Healing Center, Inc.

## PAYMENT INFORMATION

We would like to thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Payment Policy in which we require all patients to read and sign below before any treatment.

Full payment is due at time of service. We accept cash, personal and business checks, Visa and Master Card.

We will be happy to supply you with a receipt upon your request. This receipt is the paperwork you will need to file with your insurance company for reimbursement.

### Regarding Insurance

Our office is not set up to file your insurance for you unless you have been in an accident. We will be glad to supply you with all the necessary forms to file with your insurance company. You are responsible for payment of each treatment at the time of treatment.

By signing this document, you are authorizing the release of any information requested by any insurance company, adjuster or attorney that will assist in the payment of a claim.

### Usual and Customary Rates (UCR)

Our practice is committed to providing the best possible treatment to our patients. We charge what is 'usual and customary' for our area. Please be aware that some and at times perhaps all of the services provided may be 'non-covered' services and not considered reasonable and necessary by insurance companies. You will be responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

### Missed Appointments

Unless you cancel your appointment within 24 hours of your scheduled time, it is our policy that you will be responsible for full payment for that time slot. Please help us to serve you better by keeping your scheduled appointments or giving us a call to cancel within the 24 hour time period.

Thank you for taking the time to read our Payment Information Policy letter. Please let us know if you have any questions.

By signing below, you are stating that you understand and agree to our Payment Information document.

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

# Acupuncture & Natural Healing Center, Inc.

## NOTICE OF PRIVACY PRACTICES PATIENT CONSENT FORM

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:

- Protect 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 not 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

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

This Consent was signed by: \_\_\_\_\_  
(Print Name of Patient)

If patient is a minor, please print and sign name of guardian authorizing this treatment:

Print name \_\_\_\_\_ Date: \_\_\_\_\_

Sign name: \_\_\_\_\_

**ACUPUNCTURE & NATURAL HEALING CENTER**

Barbara Thurman, A.P. ♦ Ronald M. Mullen, A.P.  
NCCA Diplomate, Florida Licensed Acupuncture Physicians  
921 SE Ocean Blvd. #2  
Stuart, Florida 34994  
(772) 781-5353

**INFORMED CONSENT TO TREAT**

I, \_\_\_\_\_ the undersigned, hereby voluntarily consent to participate in Acupuncture treatment. I fully understand that Acupuncture and Chinese Herbal therapy are not treatments for medical emergencies.

I understand that I will undergo treatment of Acupuncture and Chinese Herbs. I am aware that Acupuncture means the insertion of disposable fileform needles into the body. These needles will remain in my body for a period of approximately 20 to 30 minutes.

I have been informed that Acupuncture can be contraindicated under the following conditions: after three months of pregnancy, during a period of extreme emotional stress, or when exhausted, weak or famished. I further understand that when performed under the above mentioned conditions fainting or vomiting or other reactions may occur.

I have read and understood the above mentioned statements and I release Acupuncture Physicians Barbara Thurman and Ronald Mullen from all and any claims incurred by me as a result of treatment. I voluntarily consent and choose to have Acupuncture and Chinese Herbal therapy.

I am in good health with the following exceptions:

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

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

Patient's Name: \_\_\_\_\_(please print)

Patient's Signature \_\_\_\_\_