Acupuncture & Natural Healing Center
921 SE Ocean Blvd. Suite 2, Stuart, FL 34994 Phone (772) 781-5353

Barbara Thurman, A.P.
Ronald M. Mullen, A.P.

NAME _____ Date _____ Time _____ Account No. _____

Birth Date _____ Height _____ Weight _____

Major Complaint/s _____

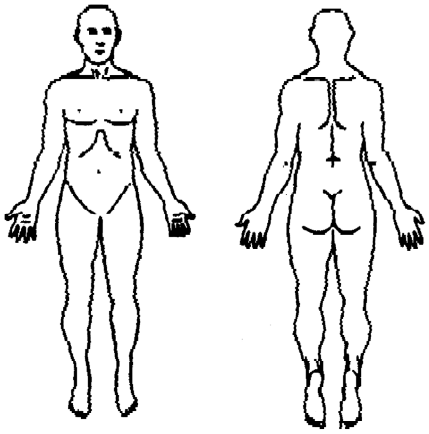
_____

_____

Other Complaints _____

_____

Please mark areas of pain



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 (And why?): _____

_____

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 □Pulmonary Fibrosis
□ Cancer Diabetes □ Epilepsy □ Stroke Kidney or bladder trouble □ Gallstones □ Ulcers □ COPD □Fibromyalgia Prostatitis
□ High Blood Pressure □ Chronic Fatigue □ Hepatitis □ Jaundice □ Sudden Weight Loss □ Sudden Weight Gain □ UTI □Migraines
□ 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) _____ Body Heaviness

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 □ Chills □ 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 □ Eczema □ Loss of pigment
□ 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 □ Facial pain
□ Other: _____

EYES: □ Eye pain Dry eyes □ Blurred vision □ Darkness under eyes □ Watery / itchy eyes □ Glaucoma □ Cataracts
□ Spots in eye Other:_____

EARS: □ Poor hearing □ Ear aches Ear discharge/infections □ Ringing/buzzing in ears □ Hearing loss □ Other: _____

NOSE: □Frequent nose bleeds Sinus trouble □Frequent colds □Stuffy nose □Dryness in nose □Excessive mucous □Hay fever

□ Other: _____

THROAT: □ Sore throat Hoarseness □ Voice loss □ Canker Sores □ Dry mouth □ 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 □ Lack of bowel control Constipation □ Bloody stools □ Black stools □ Mucus in stools □ Hemorrhoids

□ Lower bowel gas Stools have foul odor □ Colon problems □ Laxative use 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 Bedwetting □ Lack of bladder control □ Kidney Stones □ 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 □ Ribs □ Sciatic pain □ Joint pain □ Spinal problems: _____

□ Other: _____

NEUROLOGICAL: □ Nervousness Depressed □ Easily angered □ Easily irritated □ Frequent crying □ Worry/Anxiety Fearful

□ Mood swings Memory confusion □ Poor concentration □ Suicidal Tremors □ Poor attention span □ Difficulty with decisions

□ Numbness/tingling in limbs Poor coordination □ Muscle weakness □ Feel week and shaky □ Seizures □ Underachiever

□ Neuralgia (nerve pain) Shingles □ Difficulty completing projects Other: _____

FEMALES: □ Pregnant? Yes No Last monthly period _____ Last PAP test _____

Form of birth control: □ None Pill □ IUD Other: _____

Age started menstrual cycle _____ Age stopped _____ □ Menstrual pain □ Menopause Symptoms

□ Low backache Irregular □ Clotting □ Heavy bleeding □ Light scanty bleeding □ Vaginal dryness Color _____

□ Water retention Mood changes □ Miss periods □ Low or no sex drive □ Painful breasts □ Vaginal odor □ 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 □ Prostate 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? _____

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.

PATIENT REGISTRATION

Date_____

Patient's Name (First, Middle, last)_____

Date of Birth_____ Age_____

Address_____City:_____State/Zip_____

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

If no, list address _____

***Email address*_____**

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

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

INFORMED CONSENT TO TREAT

I, _____the undersigned, hereby voluntarily consent to participate in Acupuncture treatments and other procedures within the scope of the practice of acupuncture by the acupuncturist(s) named above and/or other licensed acupuncturist who now or in the future may treat me while employed by, working or associated with or serving as back-up for the acupuncturists named above, including working at the clinic or office listed above or any other office or clinic.

I fully understand that Acupuncture and Chinese Herbal therapy are not treatments for medical emergencies.

I understand that methods of treatment may include, but are not limited to, acupuncture, electrical stimulation, cupping, moxibustion, thermography scan, Chinese herbal medicine, Tui-Na (Chinese massage), vitamins, thermography, nutritional products, nutritional counseling, laboratory testing, and/or homeopathic formulas (either orally or by injection).

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 35 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 will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with my treatment.

I have read and understood the above mentioned statements and I release Acupuncture Physicians Barbara Thurman, Ronald Mullen, and the Acupuncture & Natural Healing Center, Inc., from all and any claims incurred by me as a result of treatment. I voluntarily consent and choose to have Acupuncture and/or other procedures. 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.

I am in good health with the following exceptions:

_____

_____

_____

_____

Date: _____

Patient's Name:_____(please print)

Patient's Signature _____

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:_____

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PATIENT QUESTIONAIRE

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):

_____

_____

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:

_____

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 inforamation 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:_____

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, Discover, Visa and Master Card.

Regarding Insurance

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:_____