



Patient Information & Medical History

Please take the time to fill out this questionnaire completely and carefully to help us provide you with a complete health evaluation. We realize that some questions may seem irrelevant to your main problem, but they are significant in helping us to make an accurate diagnosis and formulate an appropriate treatment plan. All your answers are absolutely confidential. If you have any questions, please do not hesitate to ask. Thank you. **If you need more room, please use the other side of these sheets.**

Name _____ Date _____

Street _____ City _____ State/Zip _____

Phone _____ Email _____

Age _____ Date of Birth _____ Gender _____ Height _____ Weight _____

Occupation _____ Referred by _____

Physician _____ Physician Phone _____

Emergency Contact _____ Relation _____ Phone _____

How did you hear about us? _____

Have you ever been treated with Acupuncture or Oriental Medicine before? YES NO

Main problem(s) you would like us to help with (symptoms, diagnosis, duration, etc):

What other medical treatment(s) or therapies have you tried for this problem?

Please check all illnesses or conditions which you currently have, or have had in the past:

- Arthritis Thyroid Imbalance Chronic Fatigue Bleeding Tendency Anemia
- Asthma High/Low Blood Pressure Alcoholism High Cholesterol Migraines
- Cancer Hyper/Hypoglycemia Meningitis Autoimmune Disease Seizures
- Diabetes Respiratory Allergies Raynaud's Chronic Pain Condition Emphysema
- Infertility Diverticulitis/IBS Lyme Disease Liver/Gallbladder Disease Ulcer
- Impotence Gastritis/ Pancreatitis Heart Disease Nervous Disorders HIV/AIDS
- Stroke Food Allergies/Intolerance Kidney Disease STD _____ Hepatitis
- Other _____

Are you taking Coumadin or Warfarin? YES NO

Do you have a Pacemaker? YES NO Do you have Seizures? YES NO

Do you currently have any infections disease? YES NO Possibly

If Yes, please identify: _____

Hospitalizations/Surgeries/Significant Trauma (include dates):

Known or suspected allergies:

Please check illnesses which have occurred in any of your blood relatives:

- Cancer Heart Disease Seizures Epilepsy High Blood Pressure
- Diabetes Stroke Asthma Kidney Disease Other _____

Please list any medications or supplements you are currently taking (continue on back of page if necessary):

NAME	DOSAGE	REASON FOR TAKING	DURATION

Please describe any use of drugs for non-medical purposes

Do you smoke? YES NO If yes, how many cigarettes per day? _____

Do you drink alcohol? YES NO If yes, how many alcoholic beverages per week? _____

Caffeinated beverages? YES NO If yes, how many per week? _____

Please check if have had any of the following symptoms, particularly in the last 3 months:

Temperature

- Feel warmer than others Night Sweats Spontaneous Sweating Flushed/ warm face or cheeks
- Feel cooler than others Cold Nose Cold Hands & Feet Warm in afternoon/ evening

Head, Eyes, Ear, Nose, and Throat

- Headaches Migraines Light sensitivity Poor Vision Night Blindness
- Eye Pain / Strain Floaters Dry Eyes Itchy Eyes Watery Eyes
- Twitching Eyelids Poor Hearing Ringing in Ears Earaches/Infections Dizziness
- Sinusitis Rhinitis Nasal Congestion Nosebleeds Facial Pain
- Mouth/ Lip Sores Dental Problems TMJ/ Jaw pain Dry Mouth/ Throat Sore Throats
- Poor Memory Swollen Glands Foggy Headed Difficulty Swallowing Seizures

Skin / Hair

- Rashes Eczema/ Psoriasis Dermatitis Itching Pimples/ Acne
- Spider Veins Varicose Veins Recent Moles Warts Fungal Infection
- Ulcerations Loss of Hair Dry/ Brittle Hair Dandruff Weak/ Brittle Nails

Cardiovascular / Respiratory

- Chest Pain/Pressure Irregular Heartbeat Blood Clots Dizziness
- Shortness of Breath Palpitations at Rest Fainting Bruising Easily
- Low Blood Pressure High Blood Pressure Phlebitis Swelling of Hands/Feet
- Recurrent Bronchitis Difficulty Inhaling Dry Cough Cough with Phlegm (color _____)
- Asthma Difficulty Exhaling Snoring Cough with Blood
- Wheezing Chest Tightness Sleep Apnea Difficulty breathing While Laying Down

Digestive System

- Nausea Indigestion Bloating Belching
- Vomiting Difficulty Swallowing Heartburn Reflux / GERD
- Bad Breath Bitter Taste in Mouth Gas Gallstones
- Significant Thirst Abdominal Pain/Cramps Hernia Excessive Hunger

Bowel Habits

How often do you have a bowel movement? _____

- IBS / Crohn's Loose Stool Diarrhea Hard/Dry Stool Constipation
- Mucus in Stool Blood In Stool Pain/Cramps Straining Hemorrhoids
- Incontinence of Stool Frequent Laxative Use Rectal Pain

Genito-Urinary

- Pain on Urination Incontinence Frequent Urination Urgency to Urinate Kidney Stones
- Blood in Urine Scanty Flow Copious Flow Burning Urination Frequent UTIs
- Cloudy Urine Sore Genitals Herpes Dribbling After Urination

Men's Health

- Prostate Problems Impotence Painful Urination Low Libido Excessive Libido
- Testicular Pain Prostatitis Dribbling Urination Premature Ejaculation Nocturnal Emission

Women's Health

Are you pregnant? YES NO

Is it possible that you are pregnant? YES NO

Do you practice birth control? YES No If yes, what type and for how long? _____

- | | | | |
|--|---|--|-------------------------------------|
| <input type="checkbox"/> Difficult / Painful Intercourse | <input type="checkbox"/> Vaginal Dryness/ Itching | <input type="checkbox"/> Vaginal Discharge (Color:_____) | |
| <input type="checkbox"/> Polycystic Ovarian Syndrome | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Infertility | <input type="checkbox"/> Painful Menstruation | |
| <input type="checkbox"/> Fibrocystic Breast Tissue | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Irregular Menstruation | |
| <input type="checkbox"/> Spotting Between Periods | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Uterine Prolapse | |
| <input type="checkbox"/> Yeast Infections | <input type="checkbox"/> Low Libido | <input type="checkbox"/> Peri-menopausal | <input type="checkbox"/> Menopausal |

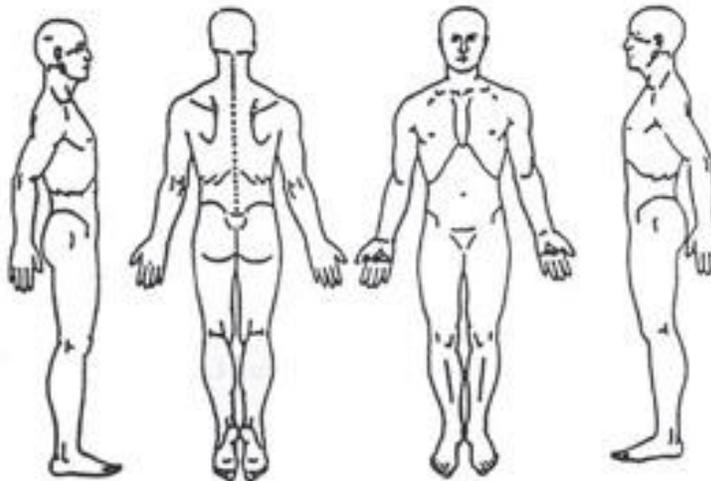
Do You Experience:

- | | | | | |
|--|--|---------------------------------------|--|--|
| <input type="checkbox"/> Cramps During | <input type="checkbox"/> PMS Cramps | <input type="checkbox"/> PMS Bloating | <input type="checkbox"/> PMS Breast Tenderness | <input type="checkbox"/> Light/Scanty Flow |
| <input type="checkbox"/> PMS Insomnia | <input type="checkbox"/> PMS Emotional Changes | <input type="checkbox"/> Clots | <input type="checkbox"/> Spotting | <input type="checkbox"/> Heavy Flow |

Musculoskeletal

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Sprains / Strains | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Worse with Cold Weather | <input type="checkbox"/> Better with Heat | |
| <input type="checkbox"/> Better with Pressure | <input type="checkbox"/> Worse with Pressure | <input type="checkbox"/> Better with Rest | <input type="checkbox"/> Better with Movement | |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tics / Tremors | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Neuropathy | |
- Soreness/ Weakness in Lower Body (back, knee, hip, ankle, foot)

Please circle or shade any areas where you experience pain/ numbness/ tension:



Neurological

- Seizures
- Loss of Balance
- Vertigo
- Dizziness
- Areas of Numbness
- Poor Memory
- Concussion
- Lack of Coordination

Emotional

- Often Angry
- Depressed
- Difficult to Express Emotions
- Fearful
- Often Worried
- Easily Irritated
- Tendency to Over-Think Everything
- Nervous
- Cry Easily
- Anxious
- Easily Susceptible to Stress
- Restless
- Indecisive
- Hyper
- Seasonal Affective Disorder
- Sad/ Grieving

Have you ever been treated for emotional problems? Yes No

Have you ever considered or attempted suicide? Yes No

Have you ever been treated for substance abuse? Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient Signature: _____

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 *Laura Pilitsis, L.A.c.*

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)



PAYMENT AND CANCELLATION POLICY

Payment is due at time of treatment. Cash, checks and credit cards are accepted.

In respect and consideration of others who also need appointments, we ask for 24 hours notice in advance of any appointment cancellation or rescheduling. Please call the clinic or email us as soon as possible if you need to cancel and/or reschedule (whether or not it is 24 hours in advance).

ALL APPOINTMENTS THAT ARE CANCELLED WITH LESS THAN 24 HOURS NOTICE, RESCHEDULED TO A LATER DATE WITH LESS THAN 24 HOURS NOTICE AND THOSE MISSED WITH OR WITHOUT NOTICE, WILL REQUIRE PAYMENT OF THE FULL COST OF MISSED APPOINTMENT AT YOUR NEXT VISIT.

If appointments have been purchased in a package, then the missed or cancelled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding!

I agree to the above policy:

Print Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Meridian Wellness

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

PATIENT RIGHTS

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

Access: You have the right to inspect and copy your protected health information.

Restriction: You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Alternative Communication: You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Disclosure Accounting You have the right to receive an accounting of disclosures of protected health information.

Electronic Notice: If you receive this Notice on our website or by electronic mail, you are entitled to obtain a paper copy of this Notice upon request.

Questions and Complaints

If you want more information about our privacy practices, please contact us.

You have recourse if you feel that we have violated your privacy rights. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

I have read and understand the HIPAA privacy policies of Meridian Wellness and Laura Pilitsis, L.Ac., M.A., Dipl.OM.

Signature

Printed name

Date

Relationship to patient (if applicable)