Meridian Wellness

CONFIDENTIAL

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 _____ Age _____ Date of Birth _____

Email_____ Occupation

(current or previous) _____ Retired: ☐ YES ☐ NO

Emergency Contact _____ Relation _____ Phone _____

How did you hear about us? _____

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

In order of importance, list the health concerns you are most interested in correcting:

1. _____
2. _____
3. _____

Approximately how long have you been noticing each of those issues?

1. _____
2. _____
3. _____

Is there a certain time of day when any of these problems are better? Worse?

_____

_____

Have you used any of the following to treat these concerns?

☐ Aleve	☐ Tylenol	☐ Motrin	☐ Ibuprofen
☐ Physical Therapy	☐ Acupuncture	☐ Chiropractic	☐ Massage Therapy
☐ Injections	☐ Topical Creams	☐ Herbal Medicine	☐ Other: _____
☐ Gabapentin / Neurontin	☐ Lyrica	☐ Cymbalta	_____

Is your balance / walking ability affected? ☐ YES ☐ NO

What do **you** think is causing your symptoms?

_____

Since they first started, have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the Same

List anything that makes your symptoms worse: _____ Better: _____

Is this condition interfering with any daily activities? List or check all that apply: _____

☐ Sleep ☐ Work ☐ Housework ☐ Exercise ☐ Walking ☐ Shopping ☐Standing

PAIN

-Disregard this section if you are not experiencing pain-

How would you describe your symptoms? Please check all that apply:

☐ Aching	☐ Numbness	☐ Hot sensation	☐ Cold sensation	☐ Burning
☐ Cramping	☐ Sharp /Stabbing	☐ Tingling	☐ Nagging	☐ Shooting
☐ Swelling	☐ Pins and Needles	☐ Stiff	☐ Heavy / "dead"	☐ Electric Shocks

☐ Other: _____

How would you rate your pain RIGHT NOW?

No Pain — Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

What is your **typical** or **average** pain level?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its **best**?

0 1 2 3 4 5 6 7 8 9 10

What is your pain level at its **worst**?

0 1 2 3 4 5 6 7 8 9 10

IF you *had* to accept some level of pain after the completion of treatment, what would be an acceptable level?

0 1 2 3 4 5 6 7 8 9 10

How motivated are you in getting this condition resolved?

Not Motivated — Somewhat — Extremely motivated

0 1 2 3 4 5 6 7 8 9 10

Is there anything else you would like the doctor to know?

_____

_____

_____

HEALTH HISTORY

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	☐ GERD
☐ Infertility	☐ Diverticulitis/IBS	☐ Lyme Disease	☐ Liver/Gallbladder Disease	☐ Ulcer
☐ Impotence	☐ Gastritis/ Pancreatitis	☐ Heart Disease	☐ Nervous Disorders	☐ Blood Clots
☐ Stroke	☐ Food Allergies	☐ Kidney Disease	☐ Joint Replacements	☐ Hepatitis

☐ Other_____

Are you taking Coumadin, Warfarin, or any other blood thinning medication? ☐ 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 (medicines, foods, scents, latex, or other items):

_____

_____

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

NAME	DOSAGE	REASON FOR TAKING	DURATION

Please describe the use of any drugs for non-medical purposes

_____

Do you smoke/vape? ☐ YES ☐ NO ☐ FORMERLY If yes, how many cigars/cigarettes/pods 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 you have had any of the following symptoms, particularly in the past 3 months:

Constitutional	☐ weight loss ☐ fatigue	☐ fevers ☐ weight gain	☐ chills ☐ insomnia	☐ poor appetite ☐ night sweats	
Head / Eyes	☐ headaches ☐ blurry vision	☐ eye pain ☐ eye discharge	☐ red eyes ☐ dry/ itchy eyes	☐ decrease in vision	
Ear/Nose/Throat	☐ ringing in ears ☐ hearing loss	☐ ear pain ☐ sore throat	☐ dry mouth ☐ dry throat	☐ nosebleeds ☐ sinus issues	☐ swollen glands ☐ difficulty swallowing
Skin/Hair	☐ rash ☐ varicose veins	☐ dry skin ☐ skin thickening	☐ itchy skin ☐ loss of hair	☐ pimples / acne ☐ sores / ulcers	☐ changes in finger or toenails
Cardiovascular	☐ chest pain	☐ palpitations	☐ rapid heartbeat	☐ poor circulation	☐ swelling in legs/feet
Respiratory	☐ shortness of breath ☐ chronic cough	☐ coughing w/ blood ☐ excess sputum	☐ wheezing ☐ sleep apnea	☐ difficulty inhaling ☐ difficulty exhaling	
Gastrointestinal	☐ nausea	☐ vomiting	☐ diarrhea	☐ constipation	☐ hemorrhoids ☐ frequent heartburn
Genitourinary	☐ increased frequency ☐ blood in urine	☐ incontinence ☐ painful urination	☐ urinary retention ☐ cloudy urine	☐ frequent UTI ☐ kidney stones	
Musculoskeletal	☐ joint pain ☐ muscle aches	☐ frequent leg cramps ☐ muscle weakness	☐ bone pain ☐ joint swelling	☐ tendonitis ☐ bursitis	
Psychiatric	☐ anxiety	☐ depression	☐ panic attacks	☐ alcohol/ drug dependence	
Endocrine	☐ goiter	☐ heat intolerance	☐ cold intolerance	☐ increased thirst	☐ excess sweating
Neurological	☐ seizures ☐ slurred speech	☐ tremors ☐ concussion	☐ migraines ☐ poor memory	☐ dizziness/vertigo ☐ loss of balance	
Blood/Lymphatic	☐ low blood count	☐ bruise easily	☐ transfusions	☐ clotting disorder	
Allergic/Immune	☐ allergic reactions	☐ hay fever	☐ frequent infections	☐ hepatitis	☐ HIV positive
Men's Health	☐ enlarged prostate ☐ premature ejaculation	☐ impotence ☐ low libido	☐ excessive libido ☐ testicular pain	☐ nocturnal emissions ☐ dribbling urination	

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? _____

Please check any and all that apply:

☐ Difficult / Painful Intercourse	☐ Vaginal Dryness/ Itching	☐ Vaginal Discharge (Color:_____)		
☐ Polycystic Ovarian Syndrome	☐ Vaginal Sores	☐ Ovarian Cysts		
☐ Uterine Fibroids	☐ Infertility	☐ Painful Menstruation		
☐ Fibrocystic Breast Tissue	☐ Endometriosis	☐ Irregular Menstruation		
☐ Spotting Between Periods	☐ Breast Lumps	☐ Uterine Prolapse		
☐ Yeast Infections	☐ Low Libido	☐ Peri-menopausal	☐ Menopausal	
☐ Cramps	☐ PMS Cramps	☐PMS Bloating	☐ PMS Breast Tenderness	☐ Light/Scanty Flow
☐ PMS Insomnia	☐ PMS Emotional Changes	☐ Clots	☐ Spotting	☐Heavy Flow

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To the best of my knowledge, the questions on this health history 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, Tiu-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: _____ **Date** _____

Meridian Wellness

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: _____

CREDIT CARD AUTHORIZATION AGREEMENT

Please complete all fields. You may cancel this authorization at any time by contacting us in writing.
This authorization will remain in effect until cancelled.

Card Type: ☐ Mastercard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____ **Expiration Date:** _____ **CVV:** _____

Billing Address Zip Code: _____

I, _____, authorize Meridian Wellness to charge my credit card above for agreed upon purchases. I understand that my information will be saved on file for future transactions on my account.

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