

BAREFOOT HOLISTIC HEALTH CLINIC



CONFIDENTIAL PATIENT INFORMATION

We do not share any of your information with anyone without your specific consent.

Please print the following information:

Name _____ Date _____

Street _____ City _____

State _____ Zip _____ E-mail _____

Home Phone _____ Business phone _____

Birth date _____ Place of Birth _____

Occupation _____ Employer _____

Emergency contact _____ Phone _____

Family Physician _____

Referred to us by _____

Would like to receive an invitation to receive our electronic Barefoot Acupunctur newsletter?
__ Yes, send the invitation to the newsletter to my e-mail above. __ No, thanks.

MEDICAL HISTORY

Have you had acupuncture before? Yes / No Herbal medicine? Y / N

Do you currently have any infectious disease? Y / N If yes, please identify: __HIV+
__ Hepatits B __Hepatitis C __Mononucleosis __Tuberculosis __Streptococcus

Reason(s) for this visit _____

When did this begin? _____

Rate the severity of the main complaint (1=mild, 10=severe) 1 2 3 4 5 6 7 8 9 10

Do you receive treatments for this/these conditions from other practitioners? Y / N

If yes, who? _____ Phone: _____

Known or suspected allergies: _____

**BAREFOOT HOLISTIC HEALTH CLINIC
HEALTH INVENTORY**

<u>Cardiovascular</u> __ Heart disease __ Pacemaker __ High blood pressure __ Low blood pressure __ Chest pain __ Palpitations __ Stroke __ Varicose veins __ Edema __ Hemophilia	<u>Psychological</u> __ Clinical depression __ Mild depression __ ADD or ADHD __ Schizophrenia __ Mood swings __ Panic attacks __ Nervousness __ Anxiety __ Alzheimer's __ Dementia __ Substance abuse	<u>Energy & Immunity</u> __ Chronic fatigue synd. __ General fatigue __ Slow wound healing __ Easy bruising __ Chronic infections __ Frequent allergies __ Anemia	<u>Respiratory</u> __ Pneumonia __ Asthma __ Frequent infections __ Difficulty breathing __ Emphysema __ Persistent cough __ Pleurisy __ Tuberculosis __ Breath shortness __ Hoarse voice __ Weak voice
<u>Musculoskeletal</u> __ Neck pain __ Shoulder pain __ Upper back pain __ Midback pain __ Lumbar pain __ Leg pain __ Muscle pain __ Muscle cramps __ Muscle twitches or spasms __ Osteoporosis __ Arthritis __ Other joint pain	<u>Head and EENT</u> __ Impaired vision __ Eye pain/strain __ Glaucoma __ Glasses/contacts __ Excess tears __ Eyes dry __ Hearing impaired __ Ears ringing __ Earaches __ Ear infections __ Headaches __ Sinus problems __ Nose bleeds __ Teeth grinding __ Frequent sore throat __ TMJ / jaw problems __ Hay fever	<u>Urinary</u> __ Kidney disease __ Kidney stones __ Painful urination __ Dribbling urination __ Frequent UTI __ Frequent urination __ Blood in urine __ Discharge __ Incontinence __ Night-time urination How many times?__	<u>Gastrointestinal</u> __ Stomach ulcers __ Appetite low __ Constant hunger __ Nausea / vomiting __ Epigastric /abdominal pain __ Passing gas __ Acid reflux __ Belching __ Gall bladder disease __ Gall bladder stones __ Hemorrhoids __ BM < once daily __ Hard stools __ Diarrhea __ Inflamed bowel __ Irritable bowel
<u>Endocrine</u> __ Hypothyroid __ Hyperthyroid __ Diabetes type I __ Diabetes type II Other_____	<u>Neurological</u> __ Vertigo/ dizziness __ Paralysis __ Numbness/tingling __ Loss of balance __ Seizures	<u>Skin</u> __ Eczema __ Psoriasis __ Acne __ Dry skin	<u>Other</u> __ Cancer Type:_____ __ Autoimmune Type:_____
<u>Female</u> __ Perimenopause __ Post menopause Pregnant__now__trying__maybe Birth control method_____ Age of first menses_____ Date of last menses_____ Cycle length (days)_____ Average length of menses (days)_____ No. of: Pregnancies__ Births__ Abortions__ Miscarriages__ Hysterectomy Y / N Date:_____ Check all that apply: __ Clots __ Painful periods __ Heavy flow __ Scanty flow __ Painful intercourse __ Unexpected bleeding __ Irregular cycles __ Vaginal discharge __ Breast tenderness or lumps __ Nipple discharge __ Infertility __ PMS			<u>Male</u> __ Impotence __ Vasectomy __ Prostate problems __ Painful intercourse __ Seminal emissions __ Testicular pain

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PAIN

Please answer the following questions if you have pain. Indicate location of pain on diagram.

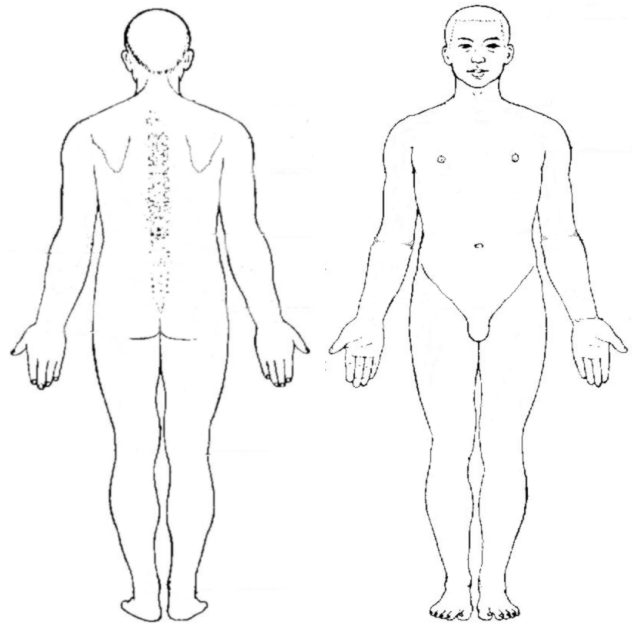
Quality of pain: Dull Sharp Stabbing Sore Cramping Burning Fixed Moves
 Constant Comes and goes Rate on scale of 1-10 (10=worst) _____

Does the pain radiate? Y / N

Where? _____

What reduces the pain? cold heat rest
 movement pressure / massage moisture
 nothing

What increases the pain? cold heat rest
 movement pressure / massage moisture
 nothing



OTHER

<p>Thermal <input type="checkbox"/> Feel hotter than others <input type="checkbox"/> Feel colder than others <input type="checkbox"/> Hot flashes <input type="checkbox"/> Cold hands <input type="checkbox"/> Cold feet <input type="checkbox"/> prefer cold or cool beverages <input type="checkbox"/> prefer neutral beverages <input type="checkbox"/> prefer warm or hot beverages</p>	<p>Sweating <input type="checkbox"/> Spontaneous sweating <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Night sweating <input type="checkbox"/> Insufficient sweating</p>	<p>Thirst <input type="checkbox"/> 0-4 cups of fluid daily <input type="checkbox"/> 4-8 cups of fluid daily <input type="checkbox"/> about 8 cups daily <input type="checkbox"/> 8-12 cups daily <input type="checkbox"/> 12-16 cups daily <input type="checkbox"/> drink in sips <input type="checkbox"/> drink in gulps</p>
<p>Appetite <input type="checkbox"/> Good appetite <input type="checkbox"/> Weak appetite <input type="checkbox"/> Cravings for <input type="checkbox"/> Sweet <input type="checkbox"/> Salty <input type="checkbox"/> Sour <input type="checkbox"/> Spicy <input type="checkbox"/> Bitter <input type="checkbox"/> Other _____</p>	<p>Bowel movements <input type="checkbox"/> Soft or loose stool <input type="checkbox"/> Hard stool <input type="checkbox"/> Alternating stool consistency <input type="checkbox"/> BM < 3 times weekly <input type="checkbox"/> BM 3-5 times weekly <input type="checkbox"/> BM 6-7 times weekly <input type="checkbox"/> BM 2-3 times daily <input type="checkbox"/> BM > 3 times daily</p>	<p>Emotions I frequently feel <input type="checkbox"/> Angry <input type="checkbox"/> Joy <input type="checkbox"/> Irritable <input type="checkbox"/> Fear <input type="checkbox"/> Impatient <input type="checkbox"/> Timid/shy <input type="checkbox"/> Anxiety <input type="checkbox"/> Indecisive <input type="checkbox"/> Worry <input type="checkbox"/> Obsessive <input type="checkbox"/> Sadness <input type="checkbox"/> Grief <input type="checkbox"/> Depression</p>

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MEDICATIONS

Please list the medications and supplements you currently take:

Drug or supplement	Reason for use	For how long	Dose	Frequency
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Do you take Coumadin / Warfarin? Y / N

LIFESTYLE

Daily amount used within the last 2 months

___ Tobacco Amount: _____ Alcohol Amount: _____

___ Coffee Amount: _____ Recreational drugs Amt: _____

___ Soda Amount: _____ Sugar / sweets Amount: _____

___ TV Amount: _____

Hours of sleep per night: _____

Please provide any information you wish to share that might not have been covered by the above questions.

Signature _____ Date _____

BAREFOOT HOLISTIC HEALTH CLINIC

REQUEST FOR ACUPUNCTURE OR ORIENTAL MEDICINE TREATMENT

Please read the following and sign below:

Barefoot Acupuncture Clinic provides Chinese traditional therapies including acupuncture, herbal medicines, tuina medical body therapy, reflexology, moxibustion or other heat therapy, spooning, cupping, diet therapy, hypnotherapy, and Reiki. The therapist on staff will determine which of these therapies may improve your health. You have the right to informed consent and to refuse any therapy at your discretion.

Due to variations in human constitution and response, no one can guarantee that any of the above mentioned therapies will produce any specific effect.

By signing this form, you hereby expressly release Barefoot Acupuncture Clinic from any duty to refer you to any other medical practitioner. You also agree to receive some or all of the above therapies (fully described on the next page), at your discretion, and accept the risk of any side effects or consequences that arise from the normal practice of Chinese traditional medicine.

Always feel free to ask any questions that you may have.

I have read and fully understand the statements above. I understand that I freely choose to use Chinese traditional medicine services and products to improve my overall health. I choose to proceed and receive acupuncture, herbal medicines, and other traditional medicine therapies listed above and with informed consent I further understand that Barefoot Acupuncture Clinic does not warrant, either expressly or by implication, the results, effects, or outcome of the therapies. Should any grievance arise, I hereby agree to binding arbitration as a means of handling any dispute. I understand that Medicare does not cover most therapies of Chinese traditional medicine. I agree to take full responsibility for payment for services and products I agree to use.

Signature (Parent or guardian if patient is a minor or incompetent)

Date

BAREFOOT HOLISTIC HEALTH CLINIC

Informed Consent Form

By signing below, I do hereby voluntarily consent to receive treatment with acupuncture, medicinal herbs, and other therapies described below from a Licensed Acupuncturist at Barefoot Acupuncture Clinic. I understand that acupuncture providers practicing in the state of Arizona do not provide primary care and that I have the responsibility to seek primary care from a licensed physician when appropriate.

Acupuncture involves the insertion of single-use sterile fine needles at specific points on the body and may include twirling the needles or other stimulation of the needles while in place. Needled points may feel sore, achey, numb, heavy, distended, or swollen; this signifies arrival of the qi (chi) and good treatment effect. Acupuncture generally has a high level of safety but certain adverse effects may result, including but not limited to: local bruising, minor bleeding, dizziness, fainting, pain, or aggravation of symptoms existing prior to acupuncture treatment. Needling points over the rib cage involves a rare but potential risk of pneumothorax.

Tuina body therapy and reflexology involve pushing and pulling on muscles, bones, and reflex zones of the body. You may experience mild to moderate discomfort depending on the degree of tension in your body. You may occasionally have minor temporary post-treatment bruising or soreness in the area of the therapy, or temporary aggravation of symptoms existing prior to treatment.

Indirect moxibustion and other heat therapies involve treating acupoints or body surfaces with heat produced by burning herbal substances or using electrical devices such as TDP lamps. These therapies involve a small risk of minor burns.

Spooning (guasha) involves scraping the skin with the rounded edge of a porcelain spoon or other similar blunt object. This therapy may involve mild discomfort and often brings about a temporary discoloration of the skin that resembles a bruise. **Cupping** involves creating a vacuum in a cup applied to the skin and may also cause a temporary discoloration of the skin that resembles a bruise. These bruises appear unsightly but usually do not usually cause pain. These treatments may cause certain post-treatment effects including but not limited to: bruising, sore muscles or aches, or aggravation of symptoms existing prior to treatment.

Herbal medicines have few and rare side-effects when prescribed by a professional herbalist. If I decide to utilize herbal treatment, I understand that I must follow the directions for administration and dosage. The professionally prescribed herbs may not work as efficiently or may produce unwanted effects if taken in conjunction with medications or self-chosen over-the-counter herbal products. If you presently take any prescription medications please consult the responsible physician before changing your medication use. I understand that use of herbal medicines may cause certain effects including but not limited to: changes in elimination, abdominal pain or discomfort, nausea, vomiting, or the possible aggravation of symptoms existing prior to treatment. If I experience any such problems I will suspend use of the herbs and contact my acupuncture therapist as soon as possible.

Hypnotherapy involves guided relaxation and visualization. You may feel drowsy or sleepy during the session. The therapist will design the session to improve your self-awareness and self-control. There are no known adverse side effects of hypnotherapy.

Signature: _____ Date: _____



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:

X _____
Patient Signature or Legal Representative Date Witness Signature

I have read the above and decline to take a copy. _____ initials

Office Use Only:

Accepted _____
 Denied Signature Title Date