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:_____

Questions? Call Don Matesz, C.N., L.Ac. or Tracy Minton, L.Ac., C.C.H. at 602.672.0676

BAREFOOT HOLISTIC HEALTH CLINIC

HEALTH INVENTORY

Cardiovascular	**Psychological**	**Energy & Immunity**	**Respiratory**
__Heart disease __Pacemaker __High blood pressure __Low blood pressure __Chest pain __Palpitations __Stroke __Varicose veins __Edema __Hemophilia	__Clinical depression __Mild depression __ADD or ADHD __Schizophrenia __Mood swings __Panic attacks __Nervousness __Anxiety __Alzheimer's __Dementia __Substance abuse	__Chronic fatigue synd. __General fatigue __Slow wound healing __Easy bruising __Chronic infections __Frequent allergies __Anemia	__Pneumonia __Asthma __Frequent infections __Difficulty breathing __Emphysema __Persistent cough __Pleurisy __Tuberculosis __Breath shortness __Hoarse voice __Weak voice
Musculoskeletal	**Head and EENT**	**Urinary**	**Gastrointestinal**
__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	__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	__Kidney disease __Kidney stones __Painful urination __Dribbling urination __Frequent UTI __Frequent urination __Blood in urine __Discharge __Incontinence __Night-time urination How many times?___	__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
Endocrine	**Neurological**	**Skin**	**Other**
__Hypothyroid __Hyperthryoid __Diabetes type I __Diabetes type II Other_____	__Vertigo/ dizziness __Paralysis __Numbness/tingling __Loss of balance __Seizures	__Eczema __Psoriasis __Acne __Dry skin	__Cancer Type:_____ __Autoimmune Type:_____
Female ____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			**Male** __Impotence __Vasectomy __Prostate problems __Painful intercourse __Seminal emissions __Testicular pain

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PAIN

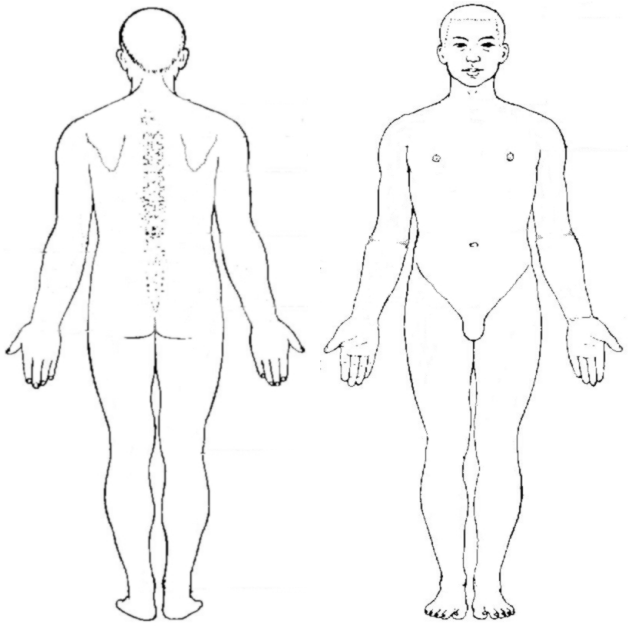
Please answer the following questions if you have pain. Indicate location of pain on diagram.

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

Thermal	**Sweating**	**Thirst**
__Feel hotter than others __Feel colder than others __Hot flashes __Cold hands __Cold feet __prefer cold or cool beverages __prefer neutral beverages __prefer warm or hot beverages	__Spontaneous sweating __Excessive sweating __Night sweating __Insufficient sweating	__0-4 cups of fluid daily __4-8 cups of fluid daily __about 8 cups daily __8-12 cups daily __12-16 cups daily __drink in sips __drink in gulps
Appetite __Good appetite __Weak appetite __Cravings for __Sweet __Salty __Sour __Spicy __Bitter __Other_____	**Bowel movements** __Soft or loose stool __Hard stool __Alternating stool consistency __BM < 3 times weekly __BM 3-5 times weekly __BM 6-7 times weekly __BM 2-3 times daily __BM > 3 times daily	**Emotions** I frequently feel __Angry __Joy __Irritable __Fear __Impatient __Timid/shy __Anxiety __Indecisive __Worry __Obsessive __Sadness __Grief __Depression

BAREFOOT HOLISTIC HEALTH CLINIC

MEDICATIONS
Please list the medications and supplements you currently take:
Drug or supplement Reason for use For how long Dose Frequency

_____

_____

_____

_____

_____

_____

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 understant 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 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 conjuction with medications or self-chosen over-the-counter herbal products. If you presently take any prescription medications pleas 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 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:_____

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BAREFOOT HOLISTIC HEALTH CLINIC

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

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