This confidential questionnaire will assist us in designing an individual treatment to best suit you. Thank you for taking time to complete the following.

**Initial Visit Date:** ENTER DATE

[ ]  **Ms.** [ ]  **Mrs.** [ ]  **Mr.: Name:** LASTFIRSTMIDDLE

**Address:** STREET **Apt./Ste.#:** APT OR SUITE #

**City:** CITY **State:** STATE **Zip:** ZIP CODE

**Home Phone:** ENTER # **Cell Phone:** ENTER #

**Alt. Phone:** ENTER #

**Preferred Calling Number (check one)** [ ]  **Home** [ ]  **Cell** [ ]  **Alternate**

**Emergency Contact:** ENTER # **Name of Contact:** FIRST & LAST NAME

**Relationship to Emergency Contact:** EX: MOM, DAD, SISTER, BROTHER, FRIEND, HUSBAND, WIFE, ETC.

**E-mail:** BEST E-MAIL FOR CONTACT

**Date of Birth:** MONTH/DAY/YEAR **Age:** AGE **Where were you born:** CITY

**Occupation:** JOB (EX: ACCOUNTANT, HOMEMAKER, POLICE OFFICER, ETC.

**How did you hear about us?:** [ ]  **Google Search** [ ]  **Yahoo Search** [ ]  **Facebook** [ ]  **LinkedIn**

[ ]  **NCCAOM** [ ]  **Referral: Who referred you?** FIRST & LAST NAME

**Relationship Status (click all that apply):** [ ]  **Single** [ ]  **Married** [ ]  **In a Relationship**

[ ]  **Recently Divorced** [ ]  **Recently Split** [ ]  **Widowed/Loss**

[ ]  **Attachment to Past Partner(s): Emotion(s) or feeling(s) holding connection** EX: JOY, LAUGHTER, ANGER, FEAR, SORROW, HATRED, ETC.

**Please list any ALLERGIES you may have:** EX: ANIMAL, FOOD, PERSCRIPTION, ETC.

**Have you had acupuncture before?** YES OR NO

**Readiness Assessment A large part of being able to help improve your health is understanding where and how we can adjust or change things in your daily life.**

**Please be honest as this will help in the tailoring of your at home recommendations and the best way to initiate the introduction of new lifestyle habits**

**Rate on a scale of 1 – 5 (1 not willing, 5 willing) – circle one per row**

**Significantly modify your diet** SCALE 1-5 **Take herbal remedies** SCALE 1-5

**Keep record of everything you put into your body each day** SCALE 1-5

**Modify your lifestyle (work demands, sleep habits, activities)** SCALE 1-5

**Practice relaxation techniques** SCALE 1-5

**Participate in self-enrichment activities (hobbies)** SCALE 1-5

**Engage in regular exercise and self-healing techniques** SCALE 1-5

**Date of my last medical doctor visit was:** ENTER DATE **Name of Physician:** NAME

**Type of Physician:** EX: PODIATRIST; INTERNAL MEDICINE; ENDOCRINOLOGIST

**Address of Physician:** STREET **Suite:** SUITE # IF APPLICABLE

**City:** CITY **State:** STATE **Zip:** ZIP CODE

*Office Phone:* ENTER # *Alt. Phone:* ENTER # *Note: Your Medical Physician will not be contacted without your direct consent. The requested information is used only for Natural Research and Healing Arts compiled data research*

**What was the reason for your visit to your medical physician?** EX: ROUTINE/YEARLY CHECK-UP, SEEKING DIAGNOSIS, LAB TEST/RESULTS, OPERATION, ETC.

**Was there a diagnosis offered?:** DIAGNOSIS

**Please list your typical emotional state, with 10 being the most prevalent and 1 the least:** # **Sadness** # **Worry** # **Depression** # **Fear** # **Anger** # **Joy** # **Relaxed** # **Anxious** # **Peaceful** # **Happy**

**Date of my last “alternative” medical visit was:** DATE **Name of Physician or Practitioner:** FIRST & LAST

**Type of “alternative” Physician or Practitioner:** EX: ACUPUNCTURIST; CHIROPRACTOR; MASSAGE THERAPIST; THERAPIST; REIKI MASTER

**Address of Physician:** STREET **Suite:** SUITE # IF APPLICABLE

**City:** CITY **State:** STATE **Zip:** ZIP CODE

*Office. Phone:* ENTER # *Alt. Phone:* ENTER # *Note: Your Alternative Medical Practitioner will not be contacted without your direct consent. The requested information is used only for Natural Research and Healing Arts compiled data research*

**What was the reason for your visit to your alternative practitioner?:** EX: HEADACHES, DIGESTIVE HEALTH, FERTILITY, ETC.

**Was there a diagnosis offered?:** ENTER DIAGNOSIS

**What are your primary physical health concerns (i.e. headache, arthritis, weight control, hypertension):** ENTER HEALTH CONCERNS

**What is your primary emotional concern at this time?:** IF NONE THEN PLEASE LIST THE TYPICAL EMOTIONS YOU FEEL WHEN STRESSED OR TRIGGERED

**My physical health concerns began (please offer approximate time and/or correlation of incident):** ENTER TIME AND/OR INCIDENT

**What aggravates your condition(s)?:** EX: FOOD, STRESS, ENVIRONMENT, PEOPLE

**What alleviates your condition(s)?:** EX: REST, QUIET, EXERCISE, DISCUSSION

**Have you ever had surgery, if so, please list procedure and purpose, date, amount of time to recover, outcome, and any lasting effects:**

**1.** PROCEDURE & PURPOSEDATERECOVERY TIMEOUTCOMELASTING EFFECTS (IF ANY)

**2** PROCEDURE & PURPOSEPROCEDURE & PURPOSEPROCEDURE & PURPOSEPROCEDURE & PURPOSELASTING EFFECTS (IF ANY)

**3.** PROCEDURE & PURPOSEPROCEDURE & PURPOSEPROCEDURE & PURPOSEPROCEDURE & PURPOSELASTING EFFECTS (IF ANY)

**4.** PROCEDURE & PURPOSEPROCEDURE & PURPOSEPROCEDURE & PURPOSEPROCEDURE & PURPOSELASTING EFFECTS (IF ANY)

**Please list all medications you are currently taking and for what condition (prescribed and over the counter):**

**1.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**2.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**3.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**4.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**5.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**6.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**7.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**8.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**9.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**10.** PRESCRIPTION & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**Please list all supplements/vitamins/remedies you are currently taking and for what condition:**

**1.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**2.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**3.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**4.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**5.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**6.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**7.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**8.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**9.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**10.** SUPPLEMENT & PURPOSELENGTH OF TIME TAKINGDOSAGERESULTSSIDE EFFECTS EXPERIENCED

**What is your intake of the following: \*PLEASE NOTE IF CONSUME DAILY (EX: COFFEE 24OZ/DAY)**

**Coffee: #** OUNCES **/week Alcohol: #**OUNCES **/week Red Wine: #** OUNCES **/week White Wine: #** OUNCES **/week Soda: #** OUNCES **/week Cigarettes: #** # **/week**

**Type of water (click all that apply):** [ ]  **Tap** [ ]  **Filtered** [ ]  **Bottled** [ ]  **Other**

**Temperature of water (click all that apply):** [ ]  **Cold** [ ]  **Room Temp** [ ]  **Warm** [ ]  **Hot**

**How often do you exercise per week:** [ ]  **I Don’t** [ ]  **1-2** [ ]  **3-4** [ ]  **5-6**

**What exercises do you participate in?:** EX: YOGA, WEIGHTLIFTING, PILATES, RUNNING, TENNIS, ETC.

**How many times do you urinate per day** # **At night** #

**Bowel movements per day** [ ]  **0-1x** [ ]  **1-2x** [ ]  **2-3x** [ ]  **More often** [ ]  **Less often**

**What is your height?** EX: 5’10”

**What is your weight? Does this fluctuate?** EX: 220lbs; YES – DEPENDS ON WHAT I EAT

**What foods do you crave?:** EX: SWEETS, POTATO CHIPS, SALT, CHOCOLATE, ETC.

**Do you consume these craved foods in small, moderate, or large amounts? Can you stop once you start?** FILL IN

**What “mood” best represents your typical eating time?:** EX: RELAXED, STRESSED, GRATEFUL, PLANNING AHEAD, CHEERFUL, ANGRY, JOY, ANXIOUS, RESENTFUL, TAKING YOUR TIME, RUSHING, PANIC, DETACHED

**What pace do you typically consume your food at?:** EX: SLOW, MODERATE, FAST

**What size do you typically chew your food to before swallowing?:** EX: 1 TO 4 BITES THEN IT’S DOWN, TAPIOCA PUDDING CONSISTENCY, IT’S COMPLETE MUSH

**2-Day Food Log**

**Day 1 \*PLEASE INCLUDE DRESSINGS, TOPPINGS, CONDIMENTS, ETC.\***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Food Item** | **Quantity** | **Temp When Consumed** | **Raw or Cooked** | **Source** |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
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| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |

**2-Day Food Log**

**Day 2 \*PLEASE INCLUDE DRESSINGS, TOPPINGS, CONDIMENTS, ETC.\***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Food Item** | **Quantity** | **Temp When Consumed** | **Raw or Cooked** | **Source** |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
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| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |
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| FOOD ITEM | CUP OR OUNCE | FROZEN, COLD, ROOM TEMP, WARM, HEATED | RAW OR COOKED | CONVENTIONAL, ORGANIC, HOME GROWN, CSA |

**Which of the following symptoms have you experienced and to what degree of occurrence (please check or mark within the box that best explains your symptoms; you may leave boxes empty if a symptom does not apply to you):**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Currently**(Within the last 6 months) | **Previously**(Up to 1 year or more since last symptom occurrence) | **Chronic**(As long as I can remember) |
| **Excessive Appetite** |[ ] [ ] [ ]
| **Digestive Problems** |[ ] [ ] [ ]
| **Abdominal Cramps** |[ ] [ ] [ ]
| **Gas** |[ ] [ ] [ ]
| **Loose Stool / Diarrhea** |[ ] [ ] [ ]
| **Blood in Stool** |[ ] [ ] [ ]
| **Rectal Pain** |[ ] [ ] [ ]
| **Colitis/Diverticultis** |[ ] [ ] [ ]
| **Constipation** |[ ] [ ] [ ]
| **Hemorrhoids** |[ ] [ ] [ ]
| **Vomiting** |[ ] [ ] [ ]
| **Belching / Burping** |[ ] [ ] [ ]
| **Heartburn** |[ ] [ ] [ ]
| **Bloating** |[ ] [ ] [ ]
| **Asthma** |[ ] [ ] [ ]
| **Seasonal Allergies** |[ ] [ ] [ ]
| **Coughing** |[ ] [ ] [ ]
| **Shortness of Breath** |[ ] [ ] [ ]
| **Decreased Sense of Smell** |[ ] [ ] [ ]
| **Nasal Congestion** |[ ] [ ] [ ]
| **Nose Bleeds** |[ ] [ ] [ ]
| **Nasal Polyps** |[ ] [ ] [ ]
| **Sinus Infection** |[ ] [ ] [ ]
| **Bleeding Gums** |[ ] [ ] [ ]
| **Sore Gums** |[ ] [ ] [ ]
| **Metallic/Sour/Acid/Bitter taste in mouth** |[ ] [ ] [ ]
| **Sore Throat** |[ ] [ ] [ ]
| **Lack of Perspiration** |[ ] [ ] [ ]
| **Excessive Perspiration** |[ ] [ ] [ ]
|  | **Currently**(Within the last 6 months) | **Previously**(Up to 1 year or more since last symptom occurrence) | **Chronic**(As long as I can remember) |
| **Night Sweats** |[ ] [ ] [ ]
| **Pneumonia** |[ ] [ ] [ ]
| **Feeling of Claustrophobia** |[ ] [ ] [ ]
| **Bronchitis** |[ ] [ ] [ ]
| **Tightness in Chest** |[ ] [ ] [ ]
| **Dryness of mouth / sinus** |[ ] [ ] [ ]
| **HIV+ or T-cell Deficit** |[ ] [ ] [ ]
| **Skin Rashes** |[ ] [ ] [ ]
| **Skin Acne** |[ ] [ ] [ ]
| **Dandruff** |[ ] [ ] [ ]
| **Eczema** |[ ] [ ] [ ]
| **Changes in Skin Color** |[ ] [ ] [ ]
| **Lower Back Pain** |[ ] [ ] [ ]
| **Burning Urination** |[ ] [ ] [ ]
| **Frequent Urination** |[ ] [ ] [ ]
| **Blood in Urine** |[ ] [ ] [ ]
| **Bladder Infection** |[ ] [ ] [ ]
| **Knee Problems** |[ ] [ ] [ ]
| **Hearing Impairment** |[ ] [ ] [ ]
| **Inner Ear Infection** |[ ] [ ] [ ]
| **Loss of Balance** |[ ] [ ] [ ]
| **Ringing In Ears** |[ ] [ ] [ ]
| **Kidney Stones** |[ ] [ ] [ ]
| **Insomnia** |[ ] [ ] [ ]
| **Trouble Staying Asleep** |[ ] [ ] [ ]
| **Nightmares** |[ ] [ ] [ ]
| **Mentally Restless** |[ ] [ ] [ ]
| **Nervous Laughter** |[ ] [ ] [ ]
| **Angina Pains** |[ ] [ ] [ ]
| **Pressure in Eyes** |[ ] [ ] [ ]
| **Blurry Vision** |[ ] [ ] [ ]
| **Seeing Spots** |[ ] [ ] [ ]
|  | **Currently**(Within the last 6 months) | **Previously**(Up to 1 year or more since last symptom occurrence) | **Chronic**(As long as I can remember) |
| **Cataracts** |[ ] [ ] [ ]
| **Jaundice** |[ ] [ ] [ ]
| **Hepatitis** |[ ] [ ] [ ]
| **Difficulty Digesting Oily Foods** |[ ] [ ] [ ]
| **Gall Stones** |[ ] [ ] [ ]
| **Light Colored Stools** |[ ] [ ] [ ]
| **Soft or Brittle Nails** |[ ] [ ] [ ]
| **Easily Angered / Agitated Anxious / Impatient** |[ ] [ ] [ ]
| **Difficulty Making Decisions** |[ ] [ ] [ ]
| **Spasms / Twitching of Muscles** |[ ] [ ] [ ]
| **Grind Teeth** |[ ] [ ] [ ]
| **Soreness / Tightness of Jaw Upon Awaking** |[ ] [ ] [ ]
| **Fist Clenching** |[ ] [ ] [ ]
| **Fatigue** |[ ] [ ] [ ]
| **Edema** |[ ] [ ] [ ]
| **Easily Bruised** |[ ] [ ] [ ]
| **Dizziness** |[ ] [ ] [ ]
| **Head Feels Heavy** |[ ] [ ] [ ]
| **Varicose Veins** |[ ] [ ] [ ]
| **Difficult to Stop Bleeding** |[ ] [ ] [ ]
| **Tendency to Catch Colds** |[ ] [ ] [ ]
| **Easily Intolerance to Weather Changes** |[ ] [ ] [ ]
| **Fainting Spells** |[ ] [ ] [ ]
| **High Cholesterol Levels** |[ ] [ ] [ ]
| **Sudden Weight Loss** |[ ] [ ] [ ]
| **Sudden Weight Gain** |[ ] [ ] [ ]
| **Organs “Falling” Out of Place** |[ ] [ ] [ ]
|  | **Currently**(Within the last 6 months) | **Previously**(Up to 1 year or more since last symptom occurrence) | **Chronic**(As long as I can remember) |
| **Poor Circulation** |[ ] [ ] [ ]
| **High Blood Pressure** |[ ] [ ] [ ]
| **Low Blood Pressure** |[ ] [ ] [ ]
| **Chest Pain** |[ ] [ ] [ ]
| **Heart Attack** |[ ] [ ] [ ]
| **Palpitations** |[ ] [ ] [ ]
| **Irregular Heartbeat** |[ ] [ ] [ ]
| **Seizures** |[ ] [ ] [ ]
| **Concussion** |[ ] [ ] [ ]
| **Shaking/Trembling/Chills** |[ ] [ ] [ ]
| **Tumors/Cysts/Boils** |[ ] [ ] [ ]
| **Neck Pain** |[ ] [ ] [ ]
| **Shoulder Pain** |[ ] [ ] [ ]
| **Upper Back Pain** |[ ] [ ] [ ]
| **Mid Back Pain** |[ ] [ ] [ ]
| **Lower Back Pain** |[ ] [ ] [ ]
| **Elbow Pain** |[ ] [ ] [ ]
| **Pain/Tingling Down Arms** |[ ] [ ] [ ]
| **Hip Pain** |[ ] [ ] [ ]
| **Pain in Stomach Area (Above Navel)** |[ ] [ ] [ ]
| **Pain in Intestinal Area (Below Navel)** |[ ] [ ] [ ]

**Are there any other complaints that you feel are important which have not been covered by this questionnaire?** ADDITIONAL HEALTH CONCERNS NOT NOTED IN THE PAGES ABOVE

**This is the fertility and reproductive health section – check and fill in what applies to you, leave blank what does not (or do not feel would be helpful in your healing journey)**

**At what age did you “hit” puberty or begin your “cycle”?:** AGE

**Did you experience any considerable physical or emotional difficulties with this onset?:** EX: DIGESTIVE, BOWEL, SLEEP, ETC; ANXIETY, DEPRESSION, ANGER, ETC

**Current libido status (and any fluctuations throughout the month – men included):** VERY LOW, LOW, MODERATE, HIGH, OVERLY HIGH, MOOD DEPENDENT

**Do you experience any discomfort with urination and/or any abnormal discharge?:** FILL IN

**List any difficulties associated with intercourse (do these difficulties come on immediately or some time during?):** ERECTILE DYSFUNCTION, DRYNESS, PAIN, BLEEDING, RASHING, COLDNESS OF THE GENITALS, UNCOMFORTABLE SWELLING OR HEAT, ETC.

**What are your feelings about intercourse?:** EX: I ENJOY THE CONNECTION WITH MY PARTNER; IT IS A MEANS TO AN END; I DREAD IT

**Describe your typical cycle and flow:** EX: NOT A PROBLEM (A COMPLETELY BALANCED EXPERIENCE); FINE UNTIL MID CYCLE; FINE UNTIL JUST BEFORE CYCLE STARTS; HORRIBLE; CRAMPS; HEAVY CLOTTING; ETC.

**Are you or have you ever taken birth control?:** YES OR NO

**Do you have any diagnosed reproductive health issues?:** EX: ENDOMETRIOSIS, PROSTATITIS, UTERINE FIBROIDS, ERECTILE DYSFUNCTION, INTERSTITIAL CYSTITIS, HYDROCELE, ETC.

**How long have you been attempting to conceive?:** ENTER TIME

**How do you feel about having a child?:** EX: EXCITED, SCARED, INDIFFERENT, HAPPY, DON’T WANT A CHILD BUT MY SPOUSE DOES OR FAMILY EXPECTS IT, ETC.

**Do you feel physically and mentally ready to have a child?:** YES OR NO (IF YOU WANT TO ELABORATE FEEL FREE)

**What will your life be like if you can’t have a child?:** EX: I WILL BE FINE; I WILL BE RUINED

**Have you had any operations or trauma to your reproductive organs?:** IF NOT LISTED IN THE SURGICAL OPERATIONS SECTION PLEASE LIST HERE

**Have you had any miscarriages?:** IF SO HOW MANY, WHAT TERM(S)

**What (if any) fertility treatments have you undergone?:** ACUPUNCTURE, IVF, IUI, CHIROPRACTIC, REIKI, ETC.

**If you are experiencing when did menopause/andropause start for you and what do you experience?:** FILL IN

**Any additional reproductive and fertility related information not covered thus far:** FILL IN

**Consent for Purposes of Treatment, Payment and Health Care Operation**

I consent to the use or disclosure of my identifiable health information by Harmonized Health, LLC (hereafter noted as HH) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at HH may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. HH is not required to agree to the restrictions that I may request. However, if HH agrees to a restriction that I request, the restriction is binding upon HH.

I have the right to revoke this consent, in writing, at any time except to the extent that has taken action in reliance on this consent.

My identifiable health information means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review HH’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Harmonized Health. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of Michael T.M. Clark and Harmonized Health, LLC with respect to my identifiable health information.

Harmonized Health reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

TYPE SIGN HERESignature of Patient or Authorized Representative Date

FIRST & LAST NAME (& RELATIONSHIP IF APPLICABLE)Printed Name and Relationship

**HIPAA**

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

NAME FIRST & LAST NAME

BIRTHDATE BIRTHDATE

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 of 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 TYPE SIGN HERE

**Patient Signature or Legal Representative Date Witness Signature**

Office Use Only: Accepted Denied Signature Title Date OFFICE USE ONLY

**Our Clinic Protects Your Health Information and Privacy**

Dear Valued Patient,

This notice describes our office’s policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company ̧ with Worker’s Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize. Safeguards in place at our office include:

• Limited access to facilities where information is stored.

• Policies and procedures for handling information.

• Requirements for third parties to contractually comply with privacy laws.

• All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file. Types of information that we gather and use: In administering your health care, we gather and maintain information that may include non-public personal information:

• About your financial transactions with us (billing transactions).

• From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

• From health care providers, insurance companies, workman’s comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information). In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.). We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 248-636-2156.

Yours truly,

Michael T.M. Clark Harmonized Health, LLC 420 North Center Street Northville, MI 48167

**NOTICE OF PRIVACY PRACTICES**

I. Understanding Your Health Record/Information

Each time you visit a hospital, physician, acupuncturist, chiropractor, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

a) basis for planning your care and treatment b) means of communication among the many health professionals who contribute to your care c) legal document describing the care you received d) means by which you or a third-party payer can verify that services billed were actually provided e) a tool for educating health professionals f) a source of data for medical research g) a source of information for public health officials charged with improving the health of the nation h) a source of data for facility planning and marketing i) a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

a) ensure its accuracy b) better understand who, what, when, where and why others may access your health information c) make more informed decisions when authorizing disclosure to others