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: _____

☐ Ms. ☐ Mrs. ☐ Mr.: Name: _____
Last ***First*** ***MI***

Address: _____ Apt./Ste.#: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Alt. Phone: ( ) _____

Preferred Calling Number (circle one) Home Cell Alternate

Emergency Contact: ( ) _____ Name of Contact: _____

Relationship to Emergency Contact: _____

Email: _____

Date of Birth: ____/_____/_____ Age: _____ Where were you born: _____

Occupation: _____

How did you hear about us?: ☐ Google Search ☐ Yahoo Search ☐ Facebook ☐ LinkedIn ☐ NCCAOM ☐ Referral: Who referred you? _____

Marital Status: ☐ Single ☐ Married ☐ In a Relationship

Please list any allergies you may have:_____
_____

Have you had acupuncture before? YES NO

<u>Readiness Assessment</u>
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 understand this is in no way used to judge or rate your ability to heal but rather ensure we're both on the same page and the proper suggestions and approach may be applied during your treatments here at Harmonized Health.

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

Significantly modify your diet	**1**	**2**	**3**	**4**	**5**
Take herbal remedies	**1**	**2**	**3**	**4**	**5**
Keep record of everything you put into your body each day	**1**	**2**	**3**	**4**	**5**
Modify your lifestyle (work demands, sleep habits, activities)	**1**	**2**	**3**	**4**	**5**
Practice relaxation techniques	**1**	**2**	**3**	**4**	**5**
Participate in self-enrichment activities (hobbies)	**1**	**2**	**3**	**4**	**5**
Engage in regular exercise and self-healing techniques	**1**	**2**	**3**	**4**	**5**

Date of my last medical doctor visit was: ___/___/___ Name of Physician: _____

Address of Physician: _____ Suite: _____

City: _____ State: _____ Zip: _____

Ofc. Phone: ( ) _____ Alt. Phone: ( ) _____
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? _____
_____

Was there a diagnosis offered?:
_____

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: ___/___/___ Name of Therapist:_____

Address of Therapist: _____ Suite: _____

City: _____ State: _____ Zip: _____

Ofc. Phone: ( ) _____ Alt. Phone: ( ) _____
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?:_____
_____

Was there a diagnosis offered?: _____
_____

What are your primary physical health concerns (i.e. headache, arthritis, weight control, hypertension): _____
_____

What is your primary emotional concern at this time?:_____
_____

My physical health concerns began (please offer approximate time and/or correlation of incident):
_____
_____

What aggravates your condition(s)?: _____
_____

What alleviates your condition(s)?: _____

Have you ever had surgery, if so, please list procedure(s) and date(s) and for what purpose:

_____ _____
Surgical Procedure / Purpose Date

_____ _____
Surgical Procedure / Purpose Date

_____ _____
Surgical Procedure / Purpose Date

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

_____ For: _____ Length of time on / start date _____
Medication

_____ For: _____ Length of time on / start date _____
Medication

_____ For: _____ Length of time on / start date _____
Medication

_____ For: _____ Length of time on / start date _____
Medication

_____ For: _____ Length of time on / start date _____
Medication

_____ For: _____ Length of time on / start date _____
Medication

Please list any vitamins, supplements or herbal remedies you are currently taking and for what:

_____ _____
Vitamin/Supplement/Remedy Enhancement Vitamin/Supplement/Remedy Enhancement

_____ _____
Vitamin/Supplement/Remedy Enhancement Vitamin/Supplement/Remedy Enhancement

What is your intake of the following:

Coffee: #_____/week **Alcohol: #_____/week** **Red Wine: #_____/week**

White Wine: #_____/week **Soda: #_____/week** **Cigarettes: # _____/week**

Type of water: ___Tap ___Filtered ___Bottled ___Other

How often do you exercise per week: ☐ I Don't ☐ 1-2 ☐ 3-4 ☐ 5-6

What exercises do you participate in?: _____
_____

What foods do you crave?: _____
_____

How many times do you urinate per day ___ At night___

Bowel movements per day ___0-1x ___1-2x ___2-3x ___More often ___ Less often

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			
Night Sweats			
Pneumonia			
Feeling of Claustrophobia			
Bronchitis			
Tightness in Chest			
Dryness of mouth / sinus			
HIV+ or T-cell Deficit			
Skin Rashes			
Skin Acne			
Dandruff			

	Currently (Within the last 6-12 months)	**Previously** (Up to 1 year or more since last symptom occurrence)	**Chronic** (As long as I can remember)
Skin 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			
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			

	Currently (Within the last 6-12 months)	**Previously** (Up to 1 year or more since last symptom occurrence)	**Chronic** (Lifetime of occurrences with symptom)
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			
Poor Circulation			
High Blood Pressure			
Low Blood Pressure			
Chest Pain			
Heart Attack			
Palpitations			
Irregular Heartbeat			
Seizures			
Concussion			
Shaking/Trembling/Chills			
Tumors/Cysts/Boils			
Do You Experience Pain In Any of the Following Joints			
Neck Pain			
Shoulder			
Upper Back			
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? _____

_____

_____

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.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship

HIPAA

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

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

Office Use Only:
Accepted _____ _____ _____
Denied Signature Title Date

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