MEDICAL HISTORY

This information is essential for the diagnosis procedure and helps me to provide you with a better treatment.

THIS INFORMATION IS CONFIDENTIAL

Name:_____ Referred by:_____

Address:_____

Home Phone:_____Work phone:_____

Birth date:_____ Height:_____ Weight:_____

Describe your principle complaint:_____

_____

What has been diagnosed (By M.D.)?_____

_____

Any problems during your birth?_____

_____

Vaccination History: Any reactions that you remember? Any unusual vaccinations?_____

_____

Childhood Illnesses: Any surgery or accidents?

Age:_____

_____

Age:_____

_____

Adolescence Illnesses: Any surgery or accidents?

Age:_____

_____

Age:_____

_____

Adulthood: Any surgery or accidents?

Age:_____

_____

Age:_____

_____

Age:_____

_____

Age:_____

_____

Age:_____

_____

Please note all major illnesses in your immediate family, like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc.

_____

_____

_____

_____

_____

_____

_____

Are you taking any medication? Please note all medication, hers, vitamins, and minerals you are even if you take them only occasionally.

_____

_____

Do you have any scars? Note location of all operation or injury scars (even minor ones)

_____

_____

Symptom list

Circle any problem, disease, or symptom you have now. Underline items that affected you in the past.

Skin: eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

Heart and vascular: fast pulse (over 100 beats/min.) slow pulse (less than 60 beats/min.) palpitation irregular pulse feeling of pressure in the chest short of breath chest pain dizziness migraine headache with nausea cold hands/cold feet Raynaud's disease flushed face anemia high blood pressure low blood pressure cold sweats red face feel dizzy or faint when standing up quickly or standing for a long time.

Gastrointestinal: constipation diarrhea no appetite stomach pain indigestion heartburn intestinal gas belching ulcer gastritis lack of stomach acid hemorrhoids ileocecal valve spasm peritonitis pancreatitis irritable bowel polyps GI tumors

Respiratory: asthma bronchitis emphysema cough wheeze pneumonia lung abscess

Hormonal imbalance: low thyroid overactive thyroid diabetes hypoglycemia blood sugar

Other hormonal imbalance_____

Male: impotence premature ejaculation prostate gland problem vasectomy infertility

Female: menstrual problems cramping heavy/light/irregular periods PMS emotional reactions menopause symptoms tubal ligation infertility low libido

Autoimmune and inflammatory conditions: Hashimoto's disease (thyroid) rheumatism systemic lupus erythematous colitis Crohn's disease alopecia (baldness) allergy food allergy atopic dermatitis neurodermatitis cellulitis sinus allergy vulvitis low immunity

Effects of focal infections: rheumatic disease rheumatic fever arthritis skin disease
Connective tissue or ligament diseases: Myofascial pain syndrome fibromyalgia tendinitis ligaments pericarditis constant slight fever glomerulonephritis plantar fasciitis scarlet fever ear infections streptococci infection staphylococci infections easily catch cold or sore throat swollen glands

Ear, nose & throat: deafness tinnitus (ringing in the ear) itchy ear ear pain frequent ear infections sinus head aches yellow mucus stuffy nose post-nasal drip dry throat itchy throat constant sinus congestion streptococci throat infections sore throat

Oral disease: bleeding gums periodontis dental abscess mumps stomatitis (inflammation of the mouth) TMJ toothaches without cavities

General: insomnia psychosomatic weakness exhaustion emotional problems (angry, irritable, depressed, anxious) difficult concentrating on a task easily get car sick, sea sick, or air sick no appetite for breakfast moody in mornings unusual sweating (palm, sole, or elsewhere)

Before noon time: no energy feel spacey scattered minded energetic all evening through midnight, but hate to wake up early in the morning long shower or bath makes you feel dizzy or faint

Medication and drugs: Birth control pill cigarettes alcohol cocaine marijuana

Other:

INFORM CONSENT.

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 named below and/or other licensed acupuncturists who now, or in the future, treat me while employed by, working with or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Oriental massage), Oriental 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 have 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 clinician 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 effects 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 Oriental 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 keep confidential and will not be released without my written consent.

I understand that any services, consultation, advice, products or treatments that I receive from the acupuncturist are not a substitute or replacement for conventional western medical services or treatments.

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.

Acupuncturist: Monica Uriarte Arri. Dipl. O.M., A.P, FL License AP-3217

Patient Signature: _____ Date: _____

OR

Patient Representative: _____ Date: _____

(Indicate relationship to patient)

PATIENT QUESTIONNAIRE.

1) Please list the family members or other persons, if any, with whom we may communicate with about your general medical condition and your diagnosis (including treatment, payment, and general health care):

2) Please list the family members or other persons, if any, whom we may and should inform about your medical condition ONLY IN AN EMERGENCY: Name_____ Phone Number_____ Name_____ Phone Number_____ Name_____ Phone Number_____

3) Do you have a special address that anything mailed to you should be sent? YES _____ NO _____

4) If anything is mailed to you, do you need it specially marked “CONFIDENTIAL” YES _____ NO _____

5) Do you have a special phone number that must be used to call you? YES _____ NO _____

6) If so, what is that number?: _____

7) May confidential messages be left on your telephone answering machine or voicemail? YES _____ NO _____

PATIENT NAME _____ PATIENT SIGNATURE_____
DATE _____

PATIENT PRIVACY CONSENT.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that: Protected health information may be disclosed or used for treatment, payment or health care operation.

The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice

The Practice reserves the right to change the Notice of Privacy Policies

The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions

The patient may revoke this Consent in writing at any time and all future disclosures will then cease

The Practice may condition treatment upon the execution of this Consent.

Print name: _____
Signed by: _____ Date: _____

* For medical treatment
  * To obtain payment for our services
  * In emergency situations
  * For appointment and patient recall reminders * To run our Practice more efficiently and ensure all our patients receive quality care
  * For research
  * To avert a serious threat to health or safety * For organ and/or tissue donation
  * For workers' compensation programs
  * In response to certain requests arising out of lawsuits

* SUMMARY OF PRIVACY PRACTICES
  This summary of our privacy practices contains a CONDENSED version of our "Notice of Privacy Practices". Our full-length Notice is available upon request.
  THIS SUMMARY OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the "Notice of Privacy Practices", that is available):
If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include: * The right to inspect and copy
* The right to amend
* The right to an accounting of disclosures

The right to request restrictions
* The right to a paper copy of this notice
* The right to request confidential communications
For more information about these rights, please see the detailed "Notice of Privacy Practices". Date of Last Revision: April 2003

APPOINTMENT CANCELLATION, RESCHEDULING,LATE ARRIVALS AND NO-SHOW POLICIES

Cancellation Policy for Private sessions

We strive to render excellent care to you and all of our clients.

When an appointment is scheduled, that time and therapist has been assigned for you in a mutual agreement, and when it is missed, that time cannot be used to treat another person.

We request a 24 hour notice for private appointment cancellation /rescheduling.

Cancellations with less than 24 hour notice will incur in a $60 cancellation fee.

Appointments can be cancelled or rescheduled by calling or texting 954 767-8005 or email Clientcare@propilates.com

Cancellations made with less than 90 min notice, will be charged the full price of the session.

Late Arrivals.

Please arrive on time for your scheduled appointment. Although we try to accommodate time and always give you the full length of your session, your private treatment may be shortened to respect the clinic schedule if you arrive late.

If you are more than 30 minutes for an appointment, you may be asked to reschedule.

Clients that do not show for their scheduled appointment will be charge the full price of the session.

I have read and understand the Appointment Cancellation , Rescheduling and Late Arrivals and No-Show policies of the practice and I agree to be bound by its terms.

Signature:

Date:

Name (first & last):