Red Coral
ACUPUNCTURE

Patient Health History

Name (First, Middle, Last):_____ Date:_____

Date of Birth (Month, Day, Year):_____ Age:_____ Gender: M F Marital Status: S M D W

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Email:_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mental and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care?_____

For what reason?_____

2. Has your case been referred to an attorney? Y N

3. Please identity the health concerns that have brought you to Heartwood Center in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you?_____

b. _____ _____

How does this condition affect you?_____

c. _____ _____

How does this condition affect you?_____

d. _____ _____

How does this condition affect you?_____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

7. Do you have any infectious diseases? Y N If yes, please identity:_____

8. Family History: Check those applicable	FATHER	MOTHER	BROTHERS	SISTERS	SPOUSE	CHILDREN
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

9. Height:_____ Weight: Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

11. **Childhood Illness:** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

13. **Hospitalizations and Surgeries:**

REASON	WHEN	REASON	WHEN
_____		_____	
_____		_____	
_____		_____	

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

REASON	WHEN	REASON	WHEN
_____		_____	
_____		_____	

15. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood swings Nervousness Mental Tension

16. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatique Syndrome

17. **Head, Eye Ear, Nose and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

18. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems:_____		

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Heartburn
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain

21. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination	Heavy Flow
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night	

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	

23. **Menstrual/Birthing History:**

1. Age of First Menses:_____	4. Birth Control Type:_____	7. # of Abortions:_____
2. # of Days of Menses:_____	5. # of Pregnancies:_____	8. # of Live Births:_____
3. Length of Cycle:_____	6. # of Miscarriages:_____	

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Joint Pain (if so, where?)_____		

26. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?_____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many?_____

b. Exercise routine:_____

c. Spiritual practice:_____

d. How many hours per night do you sleep?_____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation:_____ Employer_____ Hours/Week:_____

g. Nicotine/Alcohol/Caffeine Use:_____

h. Have you experienced any major traumas? Y N Explain:_____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?_____

j. Television habits:_____ Reading habits:_____

k. Interests and hobbies:_____

How did you hear about us?_____

Would you like to be added to our newsletter? Y N Email_____

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Patient Payment Responsibility

All payments must be made by cash, check, or credit card on the day services are rendered. Under any circumstances, if the below authorized credit card is declined or unable to process the full amount of the charge, all outstanding funds must be paid within five (5) days of notice. Any dishonored checks will be charged directly to the below authorized credit card for the amount of the check plus a $25 processing fee and any related bank charges.

Patient Appointment Cancellation Responsibility

If you cannot make your appointment, please give a minimum of 24-hours notice. Any cancellations less than 24 hours of the appointment will be subject to a charge of $100 for new patient appointments, and $80 for follow-up appointments, made directly to the below authorized credit card.

Authorized Credit Card (Please read your patient responsibilities above)

I have read and agree to my responsibilities as a patient and the patient cancellation policy. Even though I may be paying for services rendered with cash, check or insurance, if necessary I authorize the above fees to be charged to the following credit card:

Credit Card Type (circle one): MC VISA AMEX

Card Number:_____

Exp. Date: Month/Year_____ **CVV#**_____

Name as it appears on card:_____

Card Billing Address:_____

_____

Patient Signature:_____

Date:_____

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Client Information

Client Name:_____ Date of Birth:_____

Billing Address:_____

_____

_____

Gender: Male Female Marital Status: S M W D

Email Address:_____ OK to send correspondence/statements? Y N

If minor (under 18) please write name of legal guardian:_____

Home Phone:_____ OK to call? Y N

Work/Cell Phone:_____ OK to call? Y N

Employer Name:_____ City:_____

Primary Insurance

Insurance Carrier:_____

Phone Number:_____

Identification Number:_____ Group Number:_____

Is patient policy holder? Y N Policy holder relation to patient: SELF SPOUSE CHILD OTHER

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Secondary Insurance Available: Y N If yes, attach demo sheet.

Please read the following carefully and sign below:
I give permission to Mark Sobralske, MS, L.Ac, and the billing staff to send required information to my insurance company(s) or my EAP. I am aware that I am placing my signature of file. I also understand that any unpaid balances such as co-pays, deductibles, and non-covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellations of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed:_____ Date:_____

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Secondary Insurance

Client Name:_____ Date of Birth:_____

Insurance Carrier:_____

Phone Number:_____

Identification Number:_____ Group Number:_____

Is patient policy holder? Y N Policy holder relation to patient: SELF SPOUSE CHILD OTHER

Policy Holder Name:_____ Policy Holder Date of Birth:_____

Please read the following carefully and sign below:
I give permission to Mark Sobralske, MS, L.Ac, and the billing staff to send required information to my insurance company(s) or my EAP. I am aware that I am placing my signature of file. I also understand that any unpaid balances such as co-pays, deductibles, and non-covered services I will be responsible for. I understand there may be a fee if I fail to give notice for cancellations of my appointment. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signed:_____ Date:_____

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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 ono-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, email 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 party 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 privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 773-351-3352.

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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Heartwood Center. I understand that acupuncturists practicing in the state of Illinois are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Mark Sobralske, L.Ac, Dipl. OM, as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to electrical shock, pain or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature:_____ **Date:**_____

Printed Name:_____ **Date of Birth:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____ **Phone:**_____

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

Patient's Signature:_____ **Date:**_____

Explained by me and signed in my presence:_____ **Date:**_____