ARBITRATION AGREEMENT AND INFORMED CONSENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the state and federal law, where applicable establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extend permitted by the law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient/Representative Signature: _____ Date: _____

Relationship to Patient if signing as a Representative: _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

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 treats me while employed by, working 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 or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese 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 these 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 clinic 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 Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy and if I choose to take them, I do so at my own risk. Some possible side effects of taking herbs are nausea, gas, stomach ache, 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 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 are 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 kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have 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 for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient/Representative Signature: _____ Date: _____

Relationship to Patient if signing as a Representative: _____

Office Signature: _____ Date: _____

North Florida Acupuncture

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

I would like to receive telephone communication or messages via:
(Check all that apply)
__ Home phone: _____
__ Work phone: _____
__ Cell phone: _____
__ Email: _____

_____

Please print name from above:

_____

Please sign name (signature) above:

_____

Date:

_____

_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our notice of Privacy Practices, but the acknowledgment could not be obtained because:

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgment
__ An emergency situation prevented us from obtaining acknowledgment

North Florida Acupuncture

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this consent.

I authorize you to disclose health information to (leave message with, pick-up herbs etc.):
__ No person at this time.
__ Spouse: _____
__ Family member: _____
__ Friend: _____

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

REVOCATION OF CONSENT (Note: only sign if you are revoking original consent)
I revoke my consent for your use and disclosure of my protected health information, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

North Florida Acupuncture
Electronic Communication Agreement

By signing this document I hereby give consent to North Florida Acupuncture and my physician, Jerrod Fletcher, AP to communicate with me via email or through text message communications regarding the following aspects of my medical care:

- Appointment Bookings
- Test Results
- Prescriptions
- Billing
- Consultations & Advice
- Patient Education Material

By signing this document you are acknowledging the following:

- That I understand that email and text messages are not confidential methods of communication.
- That I further understand that there is always a risk associated with text messaging & email communications between myself and North Florida Acupuncture regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended third parties.
- I also understand that any text message and/or email communication between Jerrod Fletcher, AP of North Florida Acupuncture and myself regarding my medical care and treatment will be printed out and made a part of my permanent health record.
- That it is not advisable to send or request very sensitive information via email or text messaging that you do not want others to know about
- I understand that in an urgent or emergency situation that I should call my primary care provider or immediately utilize Emergency Medical Services by dialing 911 and not rely on email communication with my Acupuncture Physician.

Authorized Consent to use email or text messaging communication:

_____ _____
Patient Signature Date

_____ _____
Patient Representative (Relationship) Date

_____ _____
Patient Email Address Patient Phone Number

_____ _____
Physician Signature Date

_nflacupuncture@protonmail.com___ __352-281-8989_____
Physician Email Address Office Phone Number

North Florida Acupuncture
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. ***Full payment is due at time of service unless otherwise negotiated with an insurance provider. We accept cash, check, and credit cards.***

Insurance

Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Any balance due on your treatments is your responsibility whether your insurance company pays or not. You will be charged for each visit until verification of your insurance coverage is obtained. Our fees are determined by the complexity of each particular case and the different services utilized during the treatment process. We bill for what we do and the time we spend.

In signing this document, you are assigning to this office (North Florida Acupuncture LLC & Jerrod Fletcher, AP) the benefits to which you are eligible to receive for care rendered in this office. Additionally in signing this document you authorize the release of any information to any insurance company, adjuster, or attorney that will assist in payment of a claim.

In the event we do not accept assignment of benefits, we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. We cannot bill your insurance company unless you bring in all insurance information with you to your appointment.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area and expertise based on estimates involving Relative Value Units (RVU's), Cost Factor, and Cost Factor Multipliers. Please be aware that some, at times perhaps all, of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance providers. Medicare currently does not reimburse for acupuncture. ***You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.***

Financial Hardships

A hardship waiver is required to legally provide discounted treatments. These hardships granted on a case by case basis, are income contingent, and must be properly documented.

Missed Appointments

Please give 24 hours notice for canceled appointments. Cancellations with less than 24 hours notice are considered missed appointments. ***We usually do not charge a fee for the first missed appointment, however, subsequent missed appointments will be charged a $35.00 cancellation fee.*** If missed appointments become excessive and problematic, we reserve the right to discharge the patient from our services.

Returned Checks & Unpaid Balances

There will be a $35 returned check fee for all insufficient fund checks. Payment for the treatment cost and the $35 returned check fee charge must be paid in cash or with a credit card within 10 days. Unpaid balances 90 days past due are considered delinquent and may be turned over to collections.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy. A photocopy of this form shall be considered as effective as the original.

_____ _____

Signature of Patient or Responsible Party Date

In effect as of February 22, 2022. Subject to change without notice.

North Florida Acupuncture
FEE SCHEDULE

Our fees are based on fair market value of the services we provide within our region. These fees are a monetary value we attribute to the health care procedural codes we use based on the American Medical Association Current Procedural Terminology, more commonly known as CPT codes.

Acupuncture is considered therapeutic intervention that is billed in single or multiple "units" of 15 minute increments. Proper coding of treatments and related billing must reflect the "timed services" provided, which is why our fee schedule is not set up in a "flat fee" format. Examples will be provided in regards to general cost calculation, but each individual procedural code is itemized below and is applicable for both insured & non-insured patient fees.

Medical Fees & Codes

Evaluation & Management

Evaluation & Management	*Description*	*Usual & Customary Fee*
99201-25	New Patient Evaluation- Limited (1-5 Bullets, 10 minutes)	$50.00
99202-25	New Patient Evaluation- Expanded (6 Bullets, 20 minutes)	$75.00
99203-25	New Patient Evaluation- Detailed (2 Bullets/6 Systems, 12B/2S, 30 minutes)	$100.00
99211-25	Established Patient Evaluation- Minimal (Self limited condition, 5 minutes)	$25.00
99212-25	Established Patient Evaluation- Limited (1-5 Bullets, 10 minutes)	$25.00
99213-25	Established Patient Evaluation- Expanded (6 Bullets, 15 minutes)	$50.00
EVAL15 (NR)	Additional Evaluation & Consultation Only (per 15 minute increments)	$25.00
ZYTO-S (NR)	Zyto Scan Fee	$25.00

Treatment Procedures

CPT Billing Code	*Description*		*Usual & Customary Fee*
97810	Acupuncture Initial 15 minutes (8-22 minutes)	(1 unit)	$25.00
97811	Acupuncture Additional 15 minutes (23 minutes plus)	(1-3 units)	$25.00 ea.
97813	Acupuncture w/Electrical Stimulation Initial 15 minutes	(1 unit)	$25.00
97814	Acupuncture w/Electrical Stimulation Additional 15 minutes	(1-3 units)	$25.00 ea.
97140	Manual Therapy, Manipulation, & Mobilization	(1-3 units)	$25.00 ea.
97124	Massage Therapy (Basic)	(1-3 units)	$25.00 ea.
97110	Therapeutic Exercises-Strength, Endurance, ROM, Flexibility	(1-3 units)	$25.00 ea.
97039 (NR)	Unlisted Modalities- (Moxibustion)	(1 unit)	$25.00
97026 (NR)	Infrared Therapy (Heat)	(1-3 units)	$25.00 ea.
MAG01 (NR)	Magnet Therapy (Initial application w/palpation assessment)	(1 unit)	$25.00
MAG02 (NR)	Magnet Therapy (Additional 15 minutes)	(1-3 units)	$25.00 ea.
MK01 (NR)	Magnet Kit (Includes 16 magnets & tape)	(1 kit)	$15.00 ea.
EARSCN	Electronic Ear Scan Evaluation (for seeds or acupuncture)	(1 unit)	$25.00 ea.
EAR01 (NR)	Application of Ear Seeds/Magnets (1st 15 min stand alone tx)	(1 unit)	$25.00 ea.
EAR02 (NR)	Application of Ear Seeds/Magnets (after acupuncture tx)	(1 unit)	$25.00 ea.
A9150 (NR)	Herbal & Nutritional Supplements	(Variable)	$variable

Note: **NR codes indicate "Not Reimbursable" by insurance. Some codes may also not be covered under your insurance.*

Average Approximate Cost for Visits: (cost varies depending on time, complexity, and treatment modalities used at each visit)

1. New Patient Visit 2 Hour Intake with Traditional & Modern Assessment & Treatment Cost: $150
2. Standard 1 hour Follow Up Patient Visit (office visit & acupuncture/manual therapy): $75
3. Comprehensive 1 hour Follow Up Patient Visit (office visit, ZYTO scan, acupuncture/manual therapy): $100
4. Extended 1.5-2 hour Follow Up Patient Visit (office visit, ZYTO, acupuncture, manual therapy/massage, etc): $125-150

I have read and understand the information contained herein.

_____ _____

Signature of Patient or Responsible Party Date

In effect as of February 22, 2022. Subject to change without notice.

North Florida Acupuncture

Jerrod Fletcher, AP

4509 NW 23rd Ave, Suite 19C
Gainesville, FL 32606
www.nflacupuncture.com
nflacupuncture@gmail.com

Name: _____ Date: _____

Address: _____City: _____ State & Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Business Address: _____ City: _____ State & Zip:_____

Place of Birth: _____ Date of Birth: _____Age: _____ Height:_____ Weight: _____

Biological (Birth) Sex: _____ Gender Identity _____ Preferred Pronoun _____

Marital Status: (Single, Married, Life Partner, Divorced, Widowed, etc.) _____

Contact In Case of Emergency:

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How did you hear about our clinic? _____

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

Do you have any reason to believe you may be pregnant? Yes No If so, how far along are you? _____

Do you have any infectious diseases? Yes No If yes, please identify the condition: _____

Has your medical case been referred to an attorney? Yes No

Please list your primary health complaints/concerns: _____
_____
_____
_____
_____

Please list any medications (including natural remedies) you are currently taking or attach a list: _____
_____
_____
_____

Please list any none allergies you may have: _____
_____
_____
_____

List any and all previous "significant health events" in chronological order (include surgeries, traumas, illnesses):

Health Event	**Age Occurred**
Ex. Concussion from bicycle accident	*5 years old*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

General Health Assessment: Please check those symptoms that apply**. *Circle those things that apply the most.*** Please include all symptoms or conditions that you suffer from, including those you are currently taking medications for. *Example: if you take a hypertensive drug for hypertension and even though it is controlled, please include that as one of your complaints.*

Family's Medical History Only:
(Please check those that reflect your family history, not personal history)

___ Asthma
___ Allergies/Hay fever
___ Cancer
___ Degenerative conditions
___ Diabetes
___ Heart disease
___ Hepatitis
___ High Blood Pressure
___ Infectious disease
___ Kidney disease
___ Mental illness: _____
___Rheumatic Fever
___ Parkinson's disease
___ Seizures
___ Stroke
___ Thyroid disorders
___ Tuberculosis
___ Venereal disease
___Other: _____

Personal Birth /Medical History:

___ Alcohol/drugs used by mother
___ Mother and/or father exposed to toxins before conception or during pregnancy
___ Emotional or physical trauma suffered by mother during pregnancy
___ Poor nutrition by mother
___ Mother smoked/second hand
___ Prior miscarriage by mother
___ Late delivery
___ Premature delivery
___ Rapid labor by mother
___ Slow, long labor by mother
___ Induction of labor
___ High forceps
___ Breech birth
___ Cord wrapped around neck
___ Cesarean section
___ Birth weight in lbs.: _____
___ Spent time in incubator after birth
___ Jaundiced as an infant
___ Bottle-fed
___ Breastfed
___ APGAR score _____
Number of siblings: _____
Position among your siblings: _____
___ Chicken Pox
___ Diphtheria
___ Ear infections
___ Measles
___ Mumps
___ Rheumatic Fever
___ Rubella
___ Scarlet Fever
___ Tonsillitis
___ Slow or delayed development
___ Childhood obesity
___ ADD/ADHD
___ Hyperactivity
___ Learning disabilities
___ Physical, emotional, sexual abuse
___ Tubes in ears
___ Other: _____

Ears, Eyes, & Mouth Health:
___ Ear discharge
___ Ear pain
___ Ear infection history _____
___ Hearing loss
___ Ringing in the ears (tinnitus)
___ Cataracts
___ Conjunctivitis
___ Dry, itchy, watery eyes
___ Double Vision
___ Eye stress, easily fatigued
___ Floaters (spots in visual field). *Please list color and shape:* _____
___ Glaucoma
___ Glasses/contacts: _____
___ Grit or stickiness to the eyes
___ Macular degeneration
___ Styes
___ Bleeding Gums
___ Blisters or canker sores
___ Gingivitis/gum disease
___ Other: _____

Hair, Nail, & Skin Health:
___ Brittle or dry hair
___ Dandruff
___ Hair loss (alopecia)
___ Nail fungus (hands or feet)
___ Poor nail health or other irregularities: _____
___ Acne
___ Boils
___ Body odor
___ Cancers (melanoma, basal, etc)
___ Cold sores (herpes simplex)
___ Dry skin
___ Excessive perspiration
___ Hives or rashes
___ Itching skin
___ Lipomas (fatty tissue growths)
___ Moles, recent or changes to
___ Oily skin
___ Reactions to insect bites
___ Scars (locations): _____
___ Sebaceous cysts
___ Shingles (herpes zoster)
___ Skin tags
___ Swellings, lumps, nodules
___ Warts
___ Other: _____

Respiratory Health:
___ Allergies/hay fever
___ Asthma
___ Bronchitis
___ Colds, frequent
___ Cough (acute or chronic)
___ Emphysema
___ Hoarseness
___ Laryngitis
___ Nasal congestion
___ Phlegm, excessive production
___ Pleurisy
___ Pneumonia
___ Post-nasal drip
___ Shortness of breath
___ Snoring
___ Sore throat (acute or chronic)
___ Other: _____

Blood/Cardiovascular Health:
___ Anemia
___ Aneurysm
___ Angina/heart pain
___ Blood clots
___ Blood type: A O B AB *(circle)* Positive or Negative type *(circle)*
___ Bruise easily
___ Chest pain or tightness
___ Cold hands and feet
___ Heart attack (history of)
___ Irregular heart beat
___ Heart disease
___ High cholesterol
___ Hypertension (high BP)
___ Hypotension (low BP)
___ Mitral valve prolapse
___ Murmur
___ Palpitations
___ Stroke (history of)
___ Varicose veins
___ Other: _____

Gastrointestinal & Weight Health:
___ Abdominal pain/cramps
___ Acid reflux/heartburn
___ Anorexia or Bulimia
___ Bloating & distension
___ Chronic use of laxatives
___ Colitis
___ Crohn's Disease
___ Constipation
___ Diarrhea
___ Esophageal spasms
___ Food allergies/sensitivities
___ Gallbladder disease
___ Gas/flatulence
___ Greasy, fatty food intolerance
___ Liver Disease (cirrhosis)
___ Liver, fatty
___ Hemorrhoids
___ Hiccoughs
___ Indigestion
___ Irritable Bowel Syndrome
___ Mouth taste *(circle which apply): bitter; metallic; sticky; sweet, other* _____
___ Nausea and/or vomiting
___ Pancreatitis
___ Parasites (history of)
___ Rectal itching
___ Stomach or duodenal ulcers
___ Stools (please circle those that apply): bloody; tarry; clay colored; mucus in stools; undigested food
___ Weight: overweight underweight *(circle)*. How many lbs over or underweight? _____
Frequency of bowel movements per day: _____
Do your bowel movements float or sink? _____
___ Other: _____

Genito-Urinary Health:
___ Bed wetting (or history of)
___ Blood in the urine
___ Cystitis (bladder pain)
___ Dribbling after urination
___ Edema/leg swelling
___ Frequent urination
___ Incontinence
___ Kidney disease
___ Kidney stones
___ Nocturia (night-time urination)
___ Nephritis
___ Urethritis
___ Urinary tract infection history
How many times a day do you urinate? _____
What color is your urine?_____
Other: _____

Women's Reproductive History:
___ Age of 1st menses _____
___ Length of menses _____
___ Time between cycles _____
___ Heavy Bleeding
___ Light Bleeding
___ Menstrual blood color: _____
___ Clotting *(please describe the color of the clots)* _____
___ Lack of menstruation
___ Irregular menstruation
___ Painful menstruation
___ Pre-menstrual syndrome- breast tenderness, irritability, cramps, etc
___ Bloating, water retention with period
# of abortions: _____
# of live births: _____
# of miscarriages: _____
___ Traumatic births
___ Use of birth control *(age & duration)* _____
___ Postpartum weakness
___ Difficult conception/infertility

Women's Health (if applicable):
___ Abdominal lumps or masses
___ Breast cancer
___ Breast cysts or lumps

___ Breast tenderness
___ Endometreosis
___ Estrogen replacement use
___ Fibroids
___ Hot flashes
___ Menopause, age begun
___ Menopausal symptoms
___ Menstrual odor, strong
___ Nipple discharge
___ Pelvic/genital pain
___ Positive mammogram/pap smear
___ Severe menstrual cramps
___ Painful sex
___ Sex drive, low
___ Sex drive excessive, difficult to control impulses
___ Vaginal discharge
___ Vaginal dryness
___ Vaginal odor
___ Venereal disease
___ Yeast infections
___ Other: _____

Men's Health (if applicable):
___ Erectile dysfunction
___ Impotence
___ Penile discharge
___ Premature ejaculation
___ Prostate enlargement/problems
___ Seminal incontinence
___ Sex drive diminished
___ Sex drive excessive
___ Venereal disease
___ Other: _____

Endocrine Health:
___ Addison' disease
___ Cushing's syndrome
___ Diabetes Type I or II
___ Diabetes Insipidus
___ Fatigue (*time of day*): _____
___ Feeling hot or cold (*circle*)
___ Hypoglycemia
___ Hypothyroid
___ Hyperthyroid (Grave's Disease)
___ Insulin resistance
___ Lethargy
___ Pituitary disorder
___ Night sweats
___ Weight gain
___ Weight loss
___ Other: _____

Neurological & Brain Health:
___ Concussion history
___ Difficulty concentrating
___ Drowsiness
___ Epilepsy
___ Lack of coordination and balance
___ Numbness & tingling in the limbs
___ Paralysis
___ Seizures
___ Tremors
___ Vertigo or dizziness
___ Other: _____

Musculo-skeletal Health & Pain:
___ Arm and elbow pain
___ Hand and wrist pain
___ Knee pain
___ Leg & calf pain
___ Gout
___ Hip pain and/or sciatica
___ Lower back pain
___ Neck, shoulder, upper back pain
___ Whole body pain
___ Facial pain/paralysis
___ Jaw tension/pain (TMJ syndrome)
___ Headaches *(location & sensation):* _____
_____
___ Migraines
___ Rheumatoid arthritis
___ Osteo-arthritis
___ Osteopenia (weakening bones)
___ Osteoporosis (bone loss)
___ Sciatica (down back of leg, side of leg, or both?)
___ Spinal curvature (scoliosis, lordosis, kyphosis, etc)
___ Tension in the back, shoulders, & neck related to stress response
___ Other: _____

Immune Health & Toxicity:
___ Candidiasis or other fungal infection history
___ Chemical sensitivities
___ Chemotherapy or radiation treatment history
___ Chronic Fatigue Syndrome
___ Chronic infections:
_____
___ Epstein Barr Virus
___ Hepatitis A, B, C, D, E
___ HIV/AIDS
___ Leukemia
___ Lyme disease
___ Lymph node swelling
___ Lymphoma
___ Mononucleosis
___ Parasites:_____
___ Reactions to food additives
___ Recent or past exposure to toxins, chemicals, pesticides, herbicides, mold, heavy metals, etc in the home, work places, or living environment
___ Live in home older than 30 years
___ Other:
_____
_____
_____

Environmental Adaptation:
___ Changes in weather or barometric pressure cause aggravations to symptoms or adverse reactions
___ Cold/damp environments cause aggravations to symptoms or adverse reactions
___ Cold/dry environments cause aggravations to symptoms or adverse reactions
___ Hot/humid environments cause aggravations to symptoms or adverse reactions
___ Hot/dry environments cause aggravations to symptoms or adverse reactions
___ Seasonal changes cause aggravations to symptoms or adverse reactions

Lifestyle: *(Please indicate amount)*
___ Alcohol consumption: _____
___ Caffeinated and carbonated beverages: _____
___ Coffee or black tea:
___ Exercise: _____
___ Recreational drugs _____
_____
___ Tobacco consumption _____
___ Water consumption:_____
How often do you eat? _____
Do you suffer from insomnia? _____
Is it more difficult to get to sleep, stay asleep, or both? _____
How many hours do you sleep per night?_____
If you sleep for 8 hours are you rested or still wake tired? _____

Psychological/Emotional Health:
___ Anxiety
___ Depression
___ Bi-polar
___ Schizophrenia
___ ADD or ADHD
___ Addictions
___ Attempted suicide or thoughts of
___ Panic attacks
___ Post Traumatic Stress Disorder
___ Other: _____

Patient Signature:
_____

Date: _____

Practitioner Signature:
_____

Date: _____

Note: Information provided will be kept in strict confidentiality