Health Information and Privacy Use & Disclosure

Dear Valued Client,

This notice describes this 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 this office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation, or with other medical practitioners that you authorize. This would always be discussed with you prior to sharing.

*****I consent to such uses as permitted by law: Please initial ___________***

Safeguards in place at this office include:

- Limited and locked access to where information is stored; email communication password protected
- In office Policies and Procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records are kept on permanent file for 7 years as determined by law.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include nonpublic 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 other third party administrators *(e.g.* requests for medical records, claim payment information).

I request the following restrictions to the use or disclosure of my health information:

____

Please identify the name(s) of individuals we may discuss your health information with:

Glenys Eldred for DUO purposes____

(Physician, family member, other healthcare practitioners, etc.)

May we leave a message on your cell, work and/or home # using practitioner's name: yes no

*****I fully understand and *accept or decline* (circle one) the information of this consent.**

____ __________________________

Signature Date

Health History

Name: ____ Date:_____/_____ /_____

Date of Birth:____ /____ /____ Age: _____ Gender: M F

Address: __________________________________ Phone: _________________________________

__________________________________ Cell #: _________________________________

Email: __________________________________

Emergency Contact: ___________________________ Phone: _________________________________

How did you hear about this center? ____

Successful holistic health care and wellness is possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible.

2. Are you currently under a physician's care? Y N Name of physician: _________________________

Currently being treated for? ____

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

Condition | How Long & 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:
____

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

If so, how far along are you? ____

7. **Family History**: Check those applicable:	**Father**	**Mother**	**Brothers**	**Sisters**
Health (G=Good, P=Poor)	______	______	_______	______
Cancer	______	______	_______	______
Diabetes	______	______	_______	______
Heart Disease	______	______	_______	______
High Blood Pressure	______	______	_______	______
Stroke	______	______	_______	______
High Cholesterol	______	______	_______	______
Asthma/Hay fever/Hives	______	______	_______	______
Kidney Disease	______	______	_______	______

8. Weight: Recent gain or loss? Y N Fluctuates often? Y N

9. Blood Pressure: What is your most recent blood pressure reading? ____ /____ Date Taken:___/___/___

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles Chicken Pox German Measles

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

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

Others: ____

12. **Hospitalizations and Surgeries**:

Reason	When	Reason	When

13. X-Rays/CAT Scans/MRI'sINMR's/Special Studies:

Reason	When	Reason	When

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

Mood Swings Anxiety/Nervousness Stress Depression

15. **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 Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** / Teeth/ Gums (please circle any that you experience now and underline any that you have experienced in the past): Gum Disease Root Canals Mercury Fillings Braces/Orthodontics

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

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

Pneumonia Frequent Common Colds/Flu Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis COPD

Shortness of Breath Other Respiratory Problems: ____

18. 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   Stroke

Palpitations/Fluttering   Heart Murmurs   Rheumatic Fever   Varicose Veins

19. 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   Hernias

Heartburn   Belching   Gall Bladder Disease   Liver Disease   Hepatitis B or C

Hemorrhoids   Abdominal Pain   Celiac   IBS   Diverticulitis   BM's a day:_____________

20. 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

21. 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   Heavy Flow   Clotting
Vaginal Discharge   Premenstrual Problems   Bleeding Between Cycles   Light flow
Painful Periods   Menopausal Symptoms   Difficulty Conceiving   Hormonal Fluctuation

22. 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 (28-30 days, etc.): _______   6. # of Miscarriages: _______   Uterus or ovary removal_____

23. 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   ED

24. 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   Back Pain: Upper Mid Low   TMJ

Leg Pain Fibromyalgia Arthritis Joint Pain (if so, where?): ___________________

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

Vertigo/Dizziness/Lightheadedness Paralysis Numbness/Tingling Sciatica Seizures/Epilepsy

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

Hypothyroid Hyperthyroid Hashimotos HypoParathyroid HyperParathyroid Graves

Night Sweats Addisons Feeling Hot or Cold Hyper/Hypoglycemia Diabetes Mellitus Type 1/2

27. 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 Scars

Is there anything else we should know? ____

28. Lifestyle:

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

b. Do you exercise? Y N How many days per week? _____________________

c. Spiritual or religious practice that may conflict with treatment/recommendations? Y N

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

e. Occupation: ____ Hours/Week:__________

Do you enjoy work? Y N Why / Why not? ___________________________________

f. Nicotine/Alcohol/Caffeine Use: ____

g. How many glasses of water & non-caffeinated, non-carbonated beverages do you drink per day?________

h. Interests and hobbies: ____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, herbal and nutritional supplements, Bioenergetic Holopathic and other complementary therapies listed below:

Acupuncture/Moxibustion/Gua Sha/Cupping/Tui Na: I understand that acupuncture is performed by the insertion of sterilized single use 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. I also understand that if I receive Moxibustion as part of therapy, there is a possible risk of burning or scarring from its use. Gua Sha and Cupping may cause skin bruising and/or irritation and some individuals may request that no herbal liniments be used with these treatments due to sensitive skin. I understand that I may refuse any of these therapies at any time.

Chinese Herbs/Tinctures/Vitamins/ Other Nutritional Supplements: I understand that these may be recommended to me to assist in the treatment of bodily dysfunction or disease, to modify / decrease pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but should 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 the office as soon as possible.***

Estim-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: slight pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that it is my obligation to let this therapist know if I have a pacemaker or suffer from any type of seizure disorder. I understand that I may refuse this treatment at any time.

CranioSacral/Lymphatic Drainage/Visceral Manipulation/Neurolink Integration (NIS) /NAET/Touch for Health/NET/Zyto/ Bioenergetic Kinesiology: I understand that all of these treatment approaches are gentle, non-invasive methods of evaluating body function that are used to support body wellness. I understand that these treatment approaches are not to be considered a substitute for medical treatment or medications. I am also aware that these modalities do not diagnose or cure disease and upon assessment or during future sessions it may be necessary for this practitioner to refer me to a physician, psychologist, chiropractor, etc. for further evaluation. I understand that I may refuse any of these treatments at any time.

I understand that there may be other treatment alternatives that may be appropriate in the future and that the treating practitioner will discuss them with me prior to their use. 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:____