

Sacred Rhythms LLC Patient Health History

Name: _____ Date: ____/____/____
(first) (middle) (last)

Date of Birth: ____/____/____ Gender: M/F Primary Phone # (____) _____ Cell # (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Emergency Contact _____ Phone # (____) _____

How did you hear about us? _____

Reason for visit: _____

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

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

Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

Please circle any that you experience now and underline any that you have experienced in the past:

- | | | | | |
|---------------------|----------------------|----------------------|-----------------------|---------------------|
| Mood Swings | Nervousness | Mental Tension | Depression | Anger |
| Fatigue | Chronic Fatigue | Impaired Vision | Eye Pain/Strain | Glaucoma |
| Glasses/Contacts | Tearing/Dryness | Impaired Hearing | Ear Ringing | Earache |
| Headaches | Sinus Problems | Nose Bleeds | Frequent Sore Throats | Teeth Grinding |
| TMJ/Jaw Problems | Hay Fever | Difficulty Breathing | Emphysema | |
| Shortness of Breath | Heart Disease | Chest Pain | Swelling of Ankles | High Blood Pressure |
| Stroke | Varicose Veins | Gall Bladder Disease | Liver Disease | Hepatitis B or C |
| Abdominal Pain | Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination |
| Neck/Shoulder Pain | Muscle Spasms/Cramps | | Arm Pain | Upper Back Pain |
| Mid Back Pain | Low Back Pain | Leg Pain | Joint Pain | Vertigo/Dizziness |
| Paralysis | Numbness/Tingling | Loss of Balance | Seizures/Epilepsy | Hypothyroid |
| Hypoglycemia | Hyperthyroid | Diabetes Mellitus | Night Sweats | Feeling Hot or Cold |
| Anemia | Cancer | Rashes | Eczema/Hives | Cold Hands/Feet |

Is there anything else we should know? _____

Lifestyle:

- a. Do you typically eat at least three meals per day? Y N If no, how many? _____
- b. Exercise routine: _____
- c. How many hours per night do you sleep? _____ Do you wake rested? Y N
- d. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
- e. Nicotine/Alcohol/Caffeine Use: _____
- f. Have you experienced any major traumas? Y N Explain: _____

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

Consent to Treatment

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 Sacred Rhythms LLC. I understand that acupuncturists practicing in the state of Wisconsin 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.

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 effect 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 Chinese Medical Clinic 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.

Cupping/Guasha: I understand these treatments may leave bruise like marks on my skin for up to one or two weeks, with some swelling.

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: _____

Practitioner's Signature: _____

Sacred Rhythms, LLC

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

NAME _____

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:

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1 Denied

Signature

Title

Date