Armonía Health LLC Medical History for Initial Acupuncture & Consultation

Name: ____Today's Date: _________________

Address: ________________________________ City: _____________ State: ______ Zip: _______

Home Phone: ____________________________ Work/Cell Phone: _____________________________

Email: _____________________________ Can we add you to our email list? YES NO Occupation: _____________

Gender: _____ Age: _____ DOB: ____/____/____ Weight: ______ Referred to us by? _____________

Name & contact number in case of emergency: ____

Who is your medical doctor? ________________ Date of last visit: ________ Reason: ___________

Have you received acupuncture/Chinese herbs in the past? ______ Date: _______ Reason: _______________

Medications you are currently taking: ____

Supplements/Herbs you are currently taking: ____

Previous accidents, falls and/or surgery, with their dates: ____

____

Major Complaint

What is your primary reason for this visit? ____

____

Have you received treatment for this? If so, what? _________________________ Did it help? ___________

CIRCLE any symptoms or illnesses you have currently, **CHECK** any you have had in the past:

AIDS/HIV
Allergies
Alcoholism
Arthritis
Asthma
Back problems
Blood pressure (high/low)
Cancer
Cholesterol high

Depression/Anxiety
Diabetes
Ear/Nose/Throat
Epilepsy
Fertility issues
Menstrual/Hormonal issues
Gastrointestinal issues
Headache/Migraine
Heart disease

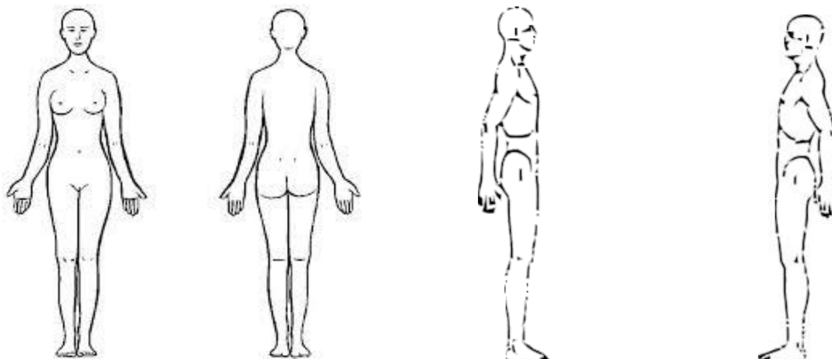
Hepatitis B/C
Indigestion/Acid Reflux
Insomnia
Low energy
Poor memory/concentration
Tuberculosis
Vertigo
Venereal disease

Smoke? _____________ Drink alcohol? _____________ Caffeine? _____________

List any other conditions or comments you'd like for us to know: ____________________________________

____

Circle the areas that currently bother you



Chinese Medicine Symptom Checklist

Name:_____________________________________ Date:__________________

Please check any of the following symptoms you experience frequently or have a tendency towards.

Spleen/Stomach Energy System

___Fatigue/Low Energy
___Bruise easily
___Tired after eating
___Low appetite
___Strong appetite
___Loose stools
___Constipation
___Abdominal bloating
___Heartburn/Reflux
___Post Nasal Drip
___Nausea/Vomiting
___Frequent hiccups or belching
___Flatulence
___Hemorrhoids
___Excessive vaginal discharge
___Bad breath
___Tendency to worry/obsess
___Stomach ulcers
___Mouth sores
___Bleeding gums

Lung/Large Intestine Energy System

___Recurrent colds/Infections
___Sinus problems
___Allergies
___Sweat easily
___Do not sweat
___Blood or mucus in stool
___Pain in the teeth or gums
___Skin problems
___Shortness of breath
___People often ask you to speak up
___Feel Sad

Heart/Small Intestine Energy System

___Difficulty sleeping
___Heart palpitations
___Anxiety
___Memory problems
___Sores on the tongue
___Startle easily
___Laugh inappropriately

Liver/Gallbladder Energy System

___Frequent irritability/Frustration
___Depression/Tendency to feel sad
___Frequent sighing
___Abdominal pain
___Pain under the ribcage
___Floaters
___Can't see well at night
___Red eyes
___Wake between 1-3am
___Trouble falling asleep
___Dizziness
___Tight muscles
___Painful periods
___Irregular periods
___Inability to cry

Kidney/Bladder Energy System

___Low back pain
___Frequent urination
___Knee pain
___Low sex drive
___High sex drive
___Erectile dysfunction
___Night sweats
___Hot flashes
___Poor hearing
___Ringing in ear
___Wear socks to bed
___Vaginal dryness
___Congenital abnormalities

Armonia Health LLC Client Confidentiality & Consent to Treat Form – Please read & initial at each paragraph

______ I understand my session with my licensed acupuncturist, is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals nor does she perform spinal manipulations. The diagnosis that I may receive is from a Chinese medicine perspective and/or an assessment based on her Arvigo Techniques of Maya Abdominal Therapy® training and may or may not correlate with a medical diagnosis I already have. The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions to the best of my understanding and take it upon myself to keep the practitioner updated on my health.

____ My session involves mainly acupuncture but the acupuncturist may include other modalities that are part of Chinese medicine into the treatment session such as guasha, glass cupping, moxabustion, energy healing. The acupuncturist may also explain to me the benefits of learning or incorporating the Arvigo® therapies. Take home recommendations and a follow up treatment plan shall be presented to me by the end of my initial session. The practitioner encourages open dialogue and will do her best to answer any questions I may have. I shall do my best to be an active participant in my own healing process. I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments.

_____ I understand that complications may result from acupuncture treatment in general. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, aggravation of present symptoms, and very rarely pneumothorax. I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person.

_____ I understand that acupuncture and Chinese medicine are not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of, or concurrently with acupuncture treatment. I fully realize that I may withdraw from my treatment at any time.

_____ I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

_____ HIPAA regulations require all practitioners obtain a signed release form from their patient/client before taking any information about them. Clients should receive a copy of the form they signed (upon request) and the practitioner maintains a copy for their records. I give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her if he/she deems necessary. I understand this information may be shared under legal obligations or with another medical professional or health care provider to enhance my quality of care. Armonia Health LLC works with an integrative model, so my file can be shared if I see another practitioner at this practice.

_____ Our office requires **48 hours** notice if you need to cancel or change your individual appointment; less than 24 hours notice of cancellation will incur a fee of 60% of the session fee. We appreciate your consideration and respect with this matter. Current session rates are payable in cash, check, or credit card to Armonía Health LLC on the day of service. Refer to our website, call our office and/or consult our online calendar for our rates.

Client Signature: ______________________ Printed name: ______________________________ Date: __________

Parent/Guardian signature and printed name ____

Practitioner signature: ________________________________ Printed name: ______________________________