Child's Medical History

Name_____Birth Date_____ Date _____

Address _____

Home Phone_____ Alternate Phone _____

State child's MAIN problem: _____

_____

_____

When did it start? What makes it better?_____Worse? _____

State any SECONDARY problems:_____

_____

List **ALL CURRENT or PAST DISEASES:** _____

List **all prescription drugs** child has ever taken and is currently taking: _____

_____

_____

Rate child's **sleep:** __deep & restful __light __restless __nightmares __trouble falling __wake up a lot

Rate child's **appetite:** __excessive eating __cravings __moderate __low appetite

Rate child's **energy:** __great __good __O.K. __low

Rate child's **school stress**: __high __moderate __low; Rate your **home stress:** __high __moderate __low

Do both parents work?: ____ Does child go to daycare or after school care?___

Check all mental/emotional traits child ***exhibits 50% or more of the time in a 24-hour day***:

__controlling __ angry __impatient __depressed __irritable __excessive laughing __passionate

__ loving __anxious __sad __diplomatic __tolerant __grounded __worry __obsessive __intolerant

__intellectual __methodical __organized __aloof __melancholy _ easygoing __courageous __creative

__strong willed __evasive __lazy __fearful __rigid

In Chinese Medicine particular emotional traits are associated with the condition of your internal organs.

Please describe child's ***bowel movements:*** Check all that relate -

__ regular __irregular __irritable __loose __constipated __dry __little balls __large __light __dark

__unusually bad odor __bloody __mucus __watery __fully formed __difficult __1x day __up to 3x day

__every other day __few times a week __only with laxatives

Please describe your ***urination:*** Check all that relate

__frequent __infrequent __lose when couch or sneeze __lose when laugh __lose when exercise __wear pads

__ get up during sleep __burning __bad odor __cloudy __bloody __light color __dark color

GIRL'S MENSTRUATION: *Check all that relate*

Age of onset: _____ *Length of period:* _____ days *Amount of blood:* __Light __ Moderate __Hvy

Quality of blood: __Thick/Clotty __Rich/Smooth __Pale/Thin *Cycle Pattern* _____

Bleed out of cycle: __Yes __ No *Any and All Body Pains* during Period:_____

Other problems during Period: __nausea __ diarrhea __edema *Growths*: __ovarian cysts __fibroids

__endometriosis

BOY'S GENITAL FUNCTION: *Check all that relate*

__premature ejaculation __impotence __cold semen __textured semen __testicle problems __prostate problems

Please Review the Following Carefully and Check All that Relate To Your Child:

EYES: __strain __dryness __pain __blurry __nearsighted __farsighted __infections __floaters __cataracts __glaucoma

EARS: __loss of hearing __aches & pain __ringing __infections

NOSE: __stuffy __nasal drip __dry mucus __thick mucus __can't breath __nose bleeds

NAILS: __brittle __infections __ridged __white spots __hangnails

SKIN: __pimples __itching __rashes __moles __spots __dryness __thin/delicate __spider veins & location:_____ varicose veins & location:_____

HAIR: __loss __dryness __itchy scalp **HEAD:** __pain & location_____ flushed face __injury __bumps __dizziness __heavy / full sensation **MOUTH:** __jaw clicks __sores on lips __sores on tongue __grind teeth __gum problems __teeth problems __tmj __dry throat

LUNGS: __short breath __heavy sensation __pain on breath __chest phlegm __cough __asthma __bronchitis __pneumonia __lose breath when exercising __wheezing

HEART: __low pressure __high pressure __palpitations __chest tightness __rapid rate __slow rate __ chest pain __irregular beat __blood clots __surgeries __vessel blocks __strokes __heart attacks

SPLEEN & STOMACH: __edema __nausea __belching __hiccups __ulcer __indigestion __bloating __ bruise easy __easy weight gain __muscle ache __tire after eating __difficult weight loss

LIVER / GALLBLADDER: __gallbladder pain __stones __pain under ribs __breast distension __genital infections __groin pain __hepatitis A B C __enlarged liver __ ligament pain anywhere in body

KIDNEY: __stones __frequent urination __burning urination __painful urination __ difficult or incomplete urination __urine leaks __low back pain __knee joint / cap pain __bone pain anywhere in body __memory loss

LARGE INTESTINE: __polyps __worms __bleeding __constipation __diarrhea __surgeries __prolapse __hemorrhoids __appendicitis __cramping

BACK / SPINE: *Upper Middle Lower*

__bone pain __muscle pain __ligament pain __joint pain __numbness __cold __hot __swollen __stiff __tight

HAND: *Right Left Both*

__bone pain __muscle pain __ligament pain __wrist pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight

FINGERS: *Right Left Both*

__bone pain __muscle pain __ligament pain __joint pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight __top of hand __bottom of hand

ARM: *Right Left Both*

__bone pain __muscle pain __ligament pain __shoulder pain __elbow pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight

LEG: *Right Left Both*

__bone pain __muscle pain __ligament pain __hip pain __knee pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight

FOOT: *Right Left Both*

__bone pain __muscle pain __ligament pain __ankle pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight __top of foot __bottom of foot

TOES: *Right Left Both*

__bone pain __muscle pain __ligament pain __joint pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight

Please Check All Food Items That Your Child Eats:

FOOD ITEM	Daily	Weekly	Monthly	Never
Chicken				
Seafood				
Shellfish				
Beef				
Pork				
Other Meat:				
Wheat*				
Rye				
Oat				
Other Grain:				
Apples				
Oranges*				
Strawberries*				
Bananas				
Berries				
Other Fruit:				
Broccoli				
Green Beans				
Corn				
Potato				
Other Vegetable:				
Cow Milk*				
Soy Milk*				
Goat Milk				
Rice Milk				
Yogurt*				
Cheese*				
Pudding*				
Ice Cream*				
Eggs*				
Peanuts*				
Tree Nuts* (Circle Items)				
Cashews, Pecans, Macadamia,				
Almonds, Pistachios, Brazil, Pine,				
Hazelnut, Walnut				
Yeast Products* (Baked Goods)				
Packaged / Preserved Foods*				

Acupuncture & Herbs, feeling well naturally

Dr. Andrea Murphy, AP, DOM

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated above and/or other licensed acupuncturists who now or in the future treat 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 above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, cosmetic acupuncture, homeopathy, gua sha, acupuncture injection therapy. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutritional supplement.

I have been informed that acupuncture and acupuncture injection therapy are generally safe methods 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. Burns and /or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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, at all times.

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. Some possible side effects of taking herbs are nausea, gas, stomachache, 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely 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, is 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 had 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE _____ ***DATE*** _____

Consent for Communication and/or Disclosure

1. May our Patient Care Coordinator contact you:

   At home? Yes No
   If yes, may we leave the following information on your home voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

   At work? Yes No
   If yes, may we leave the following information on your work voicemail?
   Appointment Information: Yes No Billing Information: Yes No Medical Information: Yes No

2. Please indicate the number you wish us to use to contact you:
   Home:_____ Work:_____ Cell:_____

3. Please print the names of family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and heath care operation):

   o NONE
   Name_____Phone_____
   Name_____Phone_____
   Name_____Phone_____

4. Please list family members or significant others, if any, whom we may inform about your medical condition ONLY IN CASE OF EMERGENCY:
   Name_____Phone_____

5. Please print the address where you wish billing statements and/or correspondence from our office to be sent.
   o Use my home address
   o Use this one: _____

6. Do you require that all correspondence from our office be marked "CONFIDENTIAL"? Yes No

7. May we send you email messages, such as newsletters and Family Healing Center updates, events and specials?
   Yes, at this email_____ No

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Family Healing Center and give my permission to share the information as indicated with the person(s) named above.

_____ _____

PATIENT SIGNATURE ***DATE***

Andrea Murphy, DOM

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 all patients to read and sign below before any treatment.

Full payment is due at time of service. We accept credit card, cash, and checks.

Regarding Insurance:

At this time our office is not set up to file your insurance for you unless you have been in an accident. We will be glad to supply you with all the necessary forms to file with your insurance company. You are responsible for payment of each treatment at the time of treatment.

By signing this document, you are authorizing the release of any information requested by any insurance company, adjuster or attorney that will assist in the payment of a claim.

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. Please be aware that some, and at times, perhaps all the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

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 and the original.

X_____DATE_____

Signature of Patient or Responsible Party

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:_____
Printed Name - Patient or Representative

_____
Signature

Relationship to Patient (if other than patient):_____
Date:__/__/____

Witness _____
Printed name - Practice representative

Date:__/__/____