FILL OUT COMPLETELY – PLEASE PRINT

Name _____ Birth Date_____ Marital Status_____

Address_____ City_____ State_____ Zip _____

Phone #'s Home_____ Cell_____Work_____

Employer _____ Occupation _____Email Address_____

Spouse's Name_____Contact Number_____ Are you pregnant? ☐ Yes ☐ No

Referred by: ☐ Sign ☐ Ad ☐ My Website ☐ On Insurance Plan ☐ Newspaper ☐ Phonebook

Friend/Relative _____

Acupuncture Before ☐ Yes ☐ No If yes, when? _____ Doctors Name_____

Were you happy with the treatment? ☐ Yes ☐ No If No, why not? _____

_____

Briefly describe what's bothering you right now or recent past: _____

_____

Are your symptoms/complaints due to an auto accident? ☐ Yes ☐ No If yes, ask for auto accident forms.

Check any problems you have ever been diagnosed as having or are currently suffering from:

☐ Broken bones/fracture	☐ Osteoarthritis	☐ Alcoholism	☐ Epilepsy
☐ Rheumatoid Arthritis	☐ Pace Maker	☐ Drug Addiction	☐ Tumors
☐ Seizures/Convulsions	☐ Strokes	☐ HIV Positive	☐ Depression
☐ A Congenital Disease	☐ Circulation Problems	☐ Gall Bladder	☐ Ruptures
☐ High/Low Blood Pressure	☐ Coughing Blood	☐ Head Problems	☐ Ulcers
	☐ Eating Disorders	☐ Cancer	☐ Other _____

Payment Arrangements: ☐ Cash/Check ☐ Credit Card ☐ Groupon ☐ Insurance

READ CAREFULLY – IF YOU UNDERSTAND AND AGREE, SIGN BELOW

Authorization & Assignment: I hereby authorize and assign any and all insurance and/or third party benefits directly to this office. I promise to pay my medical bills from any settlements or verdicts I receive from the accident/incident for which the clinic and its doctors are treating me. I authorize the release of any and all information this office deems necessary to anyone in order to process a claim for insurance or third party benefits on my behalf, and hereby release this office of anyconsequences thereof.

I hereby authorize the doctor(s) to treat my condition(s) with accupuncture throughout my spine/body. I understand and agree the amount paid the doctor for x-rays, is for the examination and analysis of the x-rays only and the x-ray negatives will remain the property of this office. The doctor will not be held responsible for any pre-existing medically diagnosed conditions or medical diagnosis. I understand and agree that I am responsible for any and all charges at this office whether paidby insurance or not.

I give all the doctor's in this office consent to treat me and or my minor children. I understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. All information is true and accurate to the best of my knowledge.

Signature _____ Date _____

(Patient – Guardian)

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, this office may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. This office reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to your doctor at 1340 Tuskawilla Rd. Suite 112, Winter Springs, FL 32708.

The doctors at this office may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care. The doctors at this office may email me, text my cell phone, or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, and patient statements as long as they are marked Personal and Confidential.

I have the right to request that my doctor restricts how he uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement. By signing this form, I am consenting to my chiropractor to have the right to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do no sign this consent, the doctors at this office may decline to provide treatment to me.

_____	_____	_____
Signature of Patient	Printed name of patient	Date

_____

Signature of Patient's Representative
(if minor)

Patient Health History Worksheet - Pg 1 (PLEASE PRINT)

Patient Name:_____ Date:_____

Present Health History

When did your present condition begin?

☐ Gradual Onset (no specific date)

☐ Date:_____

What caused your present condition?

☐ No specific injury (gradual onset)

☐ Home injury ☐ Work injury

☐ Auto injury ☐ Sports Injury

☐ Other _____

What happened to cause your present problem(s)?

_____

_____

Ever had these symptoms/complaints before?

☐ No ☐ Yes: When:_____

What time of the day are your complaints BETTER?

☐ Morning ☐ Evening

☐ Afternoon ☐ None – constant pain

What time of the day are your complaints WORSE?

☐ Morning ☐ Evening

☐ Afternoon ☐ All times – constant pain

Have you missed any time from work/school?

☐ No ☐ Yes: Date_____

What makes your complaint/symptom BETTER?

☐ Rest

☐ Ice ☐ Heat ☐ Both

☐ Prescription Medications

☐ OTC Meds (aspirin, Advil, Tylenol, etc.)

☐ Other:_____

What makes your complaints/symptoms WORSE?

☐ Activity (work, school, repetitive motions)

☐ Ice ☐ Heat ☐ Both ☐ Driving (or riding in car)

☐ Sitting ☐ Standing ☐ Squatting ☐ Bending

☐ Lifting ☐ Pushing ☐ Pulling ☐ Stepping up-down

☐ Other_____

What home remedies have you tried so far?

☐ Rest ☐ Ice ☐ Heat

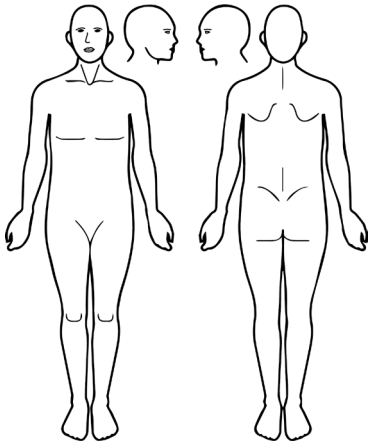
☐ OTC Meds ☐ Exercise

Have any of the home remedies helped so far?

☐ No Yes ☐ Yes to begin with, but not now.

☐ Other _____

Please mark the area(s) where your problem(s) are:



_____

_____

_____

_____

Significant Past Health History

Have you ever been hospitalized?

☐ No ☐ Yes (If yes, list date and reason)

Date: _____ Reason _____

Date: _____ Reason _____

Date: _____ Reason _____

Have you had any surgeries?

☐ No ☐ Yes (If yes, list date and reason)

Date: _____ Reason _____

Date: _____ Reason _____

Date: _____ Reason _____

Do you have any significant health problems?

☐ No ☐ Yes Explain: _____

_____

Patient Health History Worksheet – Pg 2

Significant Past Medical History

Have you seen any other doctor(s) for this condition? ☐No ☐Yes,
if yes give doctors name & date seen.

Name Date

_____ _____
_____ _____
_____ _____

Did this doctor recommend any treatment?
☐No ☐Yes If yes, list treatment recommended.

_____
_____

Are you taking any medications?
☐No ☐Yes If yes, list them and for what.
Medication For what?

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you taking any vitamins?
☐No ☐Yes If yes, list them and for what.
Vitamin For what?

_____ _____
_____ _____
_____ _____
_____ _____

Do you play any sports?
☐No ☐Yes If yes, list them.

_____
_____

Do you exercise regularly?
☐No ☐Yes If yes, how often: _____

_____

How many hours do you sleep at night? _____
How many hours a week do you work? _____

Did your father have any health problems?
☐No ☐Yes:_____
Did your mother have any health problems?
☐No ☐Yes:_____
Did your brother(s) have any health problems?
☐No ☐Yes:_____
Did your sister(s) have any health problems?
☐No ☐Yes:_____
Did your grandfarther have any health problems?
☐No ☐Yes:_____
Did your grandmother have any health problems?
☐No ☐Yes:_____

Health Risk Factors

Do you drink alcohol?
☐No ☐Yes Amount:_____
Do you smoke?
☐No ☐Yes Amount:_____
What is your height: _____ ft _____
What is you weight: _____

Anything else the doctor should know?
☐No ☐Yes Explain:_____
_____
_____
_____
_____
_____
_____
_____

All of the information I have provided on this Health History Worksheet is true to the best of my knowledge.

_____
Patient/Guardian Signature

Formed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various moves of physiotherapy on me (or 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 treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that is may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.
I do not expect the acupuncturist to be able to anticipate and explain all the possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in the best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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 or my present condition and for any future condition(s) for which I seek treatment.

	Dr. David Scoppa
Print Name of Patient	Print Name of Acupuncturist
Signature of Patient (or Representative)	Signature of Acupuncturist
Print Name of Patient Representative	Print Name of Witness/Translator
X_____ Date Consent Completed	_____ Signature of Witness/Translator