Mulberry Integrative Medicine
910 Old Camp Road
Building 190, Suite 192
The Villages, Fl 32162

Health History Questionnaire

Date: ______________

Name: Mr./Mrs./Ms.______________________________ Home Phone: ______________________________

Address: ______________________________________ Cell Phone: ______________________________

City, State, Zip: ____

May we contact you by email with appointment reminders? (Y/N) _____ Email Address: ________________

Age: _____ Date of Birth: ______________ Gender: _________ Height: _________ Weight: _________

Primary Care Doctor: ____________________________ Current or Past Occupation: ________________

Emergency Contact (Name and Phone Number):____

How did you hear about our office? ____

Primary Reason for Visit: ____

____ When did this problem begin? ________________

Other Major Complaints, in order of significance to you:

1:____ 2: ______________________________________

How do these conditions affect your daily activities? ______________________________________

Are you under the care of a physician for this problem? (Y/N) _____ Physician's Name: ________________

Have you been given a diagnosis for this problem? If so, what? ______________________________

Recent Test: Please indicate results and dates

☐ MRI _______ ☐ X-Ray _______ ☐ EMG _______
☐ CT scan _____ ☐ Blood _______ ☐ Other: _______

Do you use any of the following?

☐ Alcohol ☐ Coffee ☐ Tea ☐ Soft Drinks/Diet Drinks
☐ Cigarettes/Tobacco ☐ # glasses of water per day: ____

What kind of treatments have you tried? ____

Have you ever had acupuncture before? (Y/N) _________ Used Medicinal Herbs/Supplements? (Y/N) _________

What do you hope to accomplish with acupuncture treatments? ______________________________

Please describe your regular exercise program: ____

List medications and supplements you are taking (or attach list): ____________________________

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Hospitalizations/Surgeries: ____

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Please select all that apply:

Head/Neurological:
- ☐ Headaches/Migraines
- ☐ Vertigo/Dizziness
- ☐ Meniere's
- ☐ Memory Loss
- ☐ Concussions
- ☐ Mental Fogginess
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Peripheral Neuropathy
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Post Polio Syndrome
- ☐ Balance Issues
- ☐ Numbness/Pins & Needles
- ☐ Paralysis
- ☐ Restless Leg Syndrome
- ☐ Stroke (Date):________

Emotional/Energy Level:
- ☐ Low Energy
- ☐ Sudden Drops of Energy
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Mania/Bipolar
- ☐ Anxiety
- ☐ Irritability
- ☐ Mood Swings
- ☐ Stresses
- ☐ PTSD
- ☐ Panic Attacks

Sleep:
- ☐ Insomnia
- ☐ Night Sweats
- ☐ Sleepwalking
- ☐ Excessive Dreaming

Eyes:
- ☐ Blurred Vision
- ☐ Pain
- ☐ Dryness
- ☐ Glasses/lenses
- ☐ Night Blindness
- ☐ Cataracts
- ☐ Spots in Front of Eyes
- ☐ Glaucoma

Throat:
- ☐ Difficulty Swallowing
- ☐ Recurrent Sore throats
- ☐ Swollen Glands

Nose:
- ☐ Sinus Trouble
- ☐ Allergies
- ☐ Post Nasal Drip
- ☐ Sneezing

Ears:
- ☐ Hearing Aid
- ☐ Ringing/Tinnitus
- ☐ Frequent Ear Infections
- ☐ Ear Ache/Pain

Skin:
- ☐ Contagious Skin Disease
- ☐ Rashes/Itching
- ☐ Eczema/Psoriasis
- ☐ Hair Loss
- ☐ Hives
- ☐ Bruise Easily
- ☐ Excessive Sweating

Respiration:
- ☐ Asthma
- ☐ Difficulty Breathing/ S.O.B
- ☐ Chest Pain
- ☐ Cough
- ☐ Coughing Blood
- ☐ Bronchitis
- ☐ Phlegm
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Emphysema
- ☐ COPD
- ☐ TB

Heart, Blood, and Thorax:
- ☐ Hemophilia
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Rapid Heartbeat
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Tightness in Chest
- ☐ Arteriosclerosis
- ☐ Prior Heart Attack
- ☐ Circulation
- ☐ Bruise Easily
- ☐ Cold Hands/Feet
- ☐ Fainting
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Anemia
- ☐ Hepatitis ______

Gastrointestinal:
- ☐ Poor Appetite
- ☐ Excessive Hunger or Thirst
- ☐ Belching
- ☐ Gas
- ☐ Heartburn/Gastritis/Acid Reflux
- ☐ Abdominal Pain/Cramps
- ☐ Nausea
- ☐ Constipation
- ☐ Chronic Laxative Use
- ☐ Loose Stools or Diarrhea
- ☐ Blood in Stools
- ☐ Hemorrhoids
- ☐ IBS, Colitis or Crohn's

Urination:
- ☐ Frequent
- ☐ Urgent
- ☐ Incontinence
- ☐ Dripping/Leakage
- ☐ Bladder/Kidney Infections
- ☐ Kidney Stones
- ☐ Prostasis/Enlarged Prostate

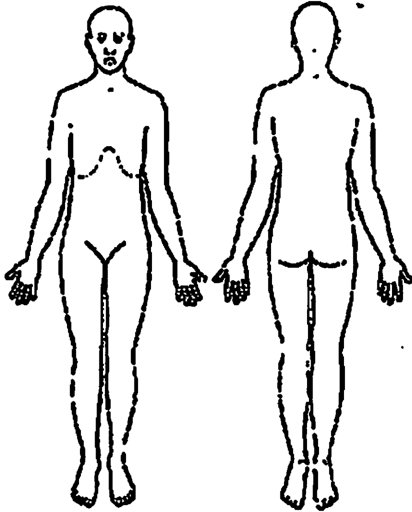
Neuromuscular/Skeletal:
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Numbness or Tingling
- ☐ Osteoporosis/Osteopenia
- ☐ Disc Herniations
- ☐ Muscle Spasms/ Twitching
- ☐ Fibromyalgia
- ☐ Sciatica
- ☐ Tendinitis
- ☐ Neck/Back Surgery

Women:
- ☐ Currently Pregnant
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Prolapse: __________
- ☐ Menopause
- ☐ Irregular Periods/PMS

Other:
- ☐ Cancer: ___________
- ☐ Lymph Nodes Removed
- ☐ Transmittable Diseases
- ☐ Thyroid Condition
- ☐ Diabetes
- ☐ Lyme's Disease
- ☐ Recurrent Antibiotic Use
- ☐ Other:______________

For Patients with Pain Only

Patient Profile: Mark Pain Below



Is the pain...:

- ☐ Sharp
- ☐ Cramping
- ☐ Burning
- ☐ Aching
- ☐ Dull
- ☐ Moving
- ☐ Fixed
- ☐ Other: ______________

Does any of the following relieve the pain?

- ☐ Pressure
- ☐ Exercise
- ☐ Cold
- ☐ Heat
- ☐ Other: ____________

How long have you had these pain symptoms? ______________________________

Would you describe the pain as recurrent or continuous? ______________________________

What treatments or medications are you receiving or have received for the pain? ______________________________

____

Please answer the following questions based on your pain symptoms in the last two weeks.

1. **How many days in the past two weeks have you been in pain?**

   1-2 days 3-4 days 5-6 days 7-8 days 9-10 days 11-12 days 13-14 days

2. **In the past two weeks, what has your usual/average pain level been?**

   0 --------- 1--------- 2 --------- 3--------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 --------- 10
   No Pain Worst Pain

3. **On average, how many hours per day has the usual/average pain lasted?**

   1-2 hours 3-5 hours 6-8 hours 9-12 hours 12-18 hours 18-24 hours

4. **In the past two weeks, what has your worst pain level been?**

5. 0 --------- 1--------- 2 --------- 3--------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 --------- 10
   No Pain Worst Pain

6. **On average, how many hours per day has the worst pain level lasted?**

   1-2 hours 3-5 hours 6-8 hours 9-12 hours 12-18 hours 18-24 hours

Self-Pay Fee Schedule

If your insurance does not cover the cost of acupuncture, the self pay fee schedule is as follows:

- **Individual acupuncture treatment - $70.00**

We offer the following discounted treatment packages. These packages are to be bought at the time of the first visit and paid in full in order to receive the savings.

- **4 visits - $240.00 (savings $40)**
- **6 visits - $300.00 (savings $120)**
- **10 visits - $475.00 (savings $225)**
- **15 visits - $675.00 (savings $375)**
- **20 visits - $850.00 (savings $550)**

Package Notes:

- Packages are nonrefundable **one year** from the date of purchase.
- If you request a refund of your package within the year of purchase, the used visits will convert to the individual self-pay price of $70.00 per treatment
- Packages do not expire
- Packages are transferable

I confirm that I have read and understand the above fee schedule. By signing below, I am acknowledging and consenting to the following terms of the self pay fee schedule.

Signature

____

Date

____

Insurance Information

Mulberry Integrative Medicine uses an outside billing company to verify if you have insurance coverage. This company calls your insurance company and speaks directly with a representative who reads your policy and makes a decision on coverage based on the terms of your policy. **We will only follow the result of that coverage determination.** If you feel that this coverage determination is in error, please call your insurance company to verify the information and acquire a verification number. You may then give us the verification number and we will re-run your insurance with this updated information.

Insurance Notes

1. If you are on Medicare (no coverage) and your secondary insurance will cover acupuncture, please note that you may receive a rejection letter in the mail stating that the secondary needs a Medicare EOB. We also receive that notice and take care of it in our offices. There is no need to call us if you receive that notice in the mail.
2. Many plans have a deductible. If your plan has a deductible and that has not been met, we will send the claim for you if there is acupuncture coverage. You will, however, be responsible for the cost.
3. If you are on a plan that is out of network, we will file for you if you have coverage.

Assignments of Benefits

I request that payment of authorized insurance benefits be made on my behalf to Mulberry Integrative Medicine for any equipment or service provided to me by Mulberry Integrative Medicine.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services, my insurance company or other entity if requested. The original authorization will be kept on file by Mulberry Integrative Medicine.

I understand that I am financially responsible to Mulberry Integrative Medicine for any charges not covered by my health insurance company that are billed from this office. It is my responsibility to notify Mulberry Integrative Medicine of any changes in my health insurance coverage. In some cases exact insurance benefits cannot be determined by Mulberry Integrative until your insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Mulberry Integrative Medicine. I understand that by signing this form, I am accepting financial responsibility, as explained above, for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organizations Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of Person Signing: ____________________ Relationship to Insured: ________________

Signature: ______________________________ Date: ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data.

IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the **NOTICE OF PRIVACY PRACTICES** that your practitioner has provided you.

I. How we may use and share health data about you:
   a. Treatment - To give you medical treatment or other types of health services.
   b. Payment - To bill you or a third party for payment for services provided to you.
   c. Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object.
   a. To you.
   b. As required by federal, state or local law.
   c. If child abuse or neglect is suspected.
   d. Public health risks (for public health activities to prevent and control spread of disease).
   e. Lawsuits and disputes (in response to a court or administrative order).
   f. Coroners, medical examiners and funeral directors.
   g. Organ or tissue donation facilities, if you are an organ donor.
   h. To avert a threat to an individual or to public health safety.

III. Disclosure where we have to give you a chance to agree or object:
   a. Patient directories ~ you can decide what health data, if any, you want to be listed in patient directories.
   b. Person involved in your care or payment of your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
   a. Right to inspect your health record and to receive a copy of your health record upon request.
   b. Right to amend information in your health record you believe is inaccurate or incomplete.
   c. Right to know to whom we have disclosed your health information.
   d. Right to ask for limits on the health information data we give out about you.
   e. Right to receive communication from us about your health information in alternate ways.
   f. Right to a paper copy of the complete Notice of Privacy Practices.

I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES** of this practice.

Signature of patient or representative: ______________________________ Date: ________________

I have read the posted HIPPA Notice of Privacy Practices posted in the waiting room and have no questions about this policy.

Signature of patient or representative: ______________________________ Date: ________________

Consent to Treatment

While acupuncture, Oriental Medicine, and other treatments provided by this office have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive.
- Minor bleeding or bruising can occur from acupuncture.
- In less than 3% of patients, symptoms may become worse for 1-2 days following treatment before they improve. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
- Although rare, fainting can occur in certain patients, particularly at the first treatment.

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensation.
- If you have a **pacemaker** or any **electrical implants**.
- If you are pregnant.
- If you have a bleeding disorder.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this office. I have read the possible risks of treatment outlined above, and do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can resute treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand that the practitioner may review my medical records and lab reports, and that all records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, 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 further conditions for which I seek treatment.

Print Name:________________________________

Signature:________________________________ Date:____________________