SAMARITAN CENTER

The Path to Wellness℠

INFORMATION ABOUT CENTER SERVICES

Welcome to the Center and thank you for choosing to use our services. It is important for you to be informed about the nature of psychotherapy, the policies and procedures governing the help you will receive here, the fees for our services, and your rights as a client. In this package there is a place for you to sign, indicating your general consent to treatment.

Psychological Testing: Psychological testing may be indicated before you begin therapy or at some point in the course of therapy. Your counselor can discuss these options with you. Psychological tests use samples of behavior in order to assess cognitive and emotional functioning about a given individual.

Psychotherapy: "Counseling" and "psychotherapy" (therapy) are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress (e.g., depression, anxiety, marital conflicts). The goals of therapy range from the relief of symptoms to significant life change as one gains a better understanding of personal, interpersonal, and social circumstances.

The Center's clinical staff is comprised of licensed psychologists, licensed professional counselors, licensed social workers, licensed marriage and family therapists, pastoral counselors and specialists with certifications in special areas of practice. We also have therapists-in-training working under the supervision of licensed therapists to obtain advanced degrees or to meet eligibility standards for licensure. All staff work within the standards and ethical guidelines of state licensing laws, professional associations, and the national accreditation standards of the Samaritan Institute. (A statement of Professional and Clinical Standards is available on request.)

Therapy Process: Therapy begins with an *intake interview* to evaluate your needs and difficulties. Your therapist will work with you in determining the best course of treatment. Therapy has been shown to have many benefits (e.g., better relationships, solutions to specific problems, significant reductions in feelings of distress). Progress in therapy depends on several factors including regular attendance, talking openly with your therapist, motivation, effort, and life circumstances.

You and your therapist will decide together when your therapy is complete, but you may choose to withdraw at any time. If you decide to withdraw, it is recommended that you have at least one final appointment with your therapist rather than terminating by telephone, mail, or by not showing up. Periodically during therapy, you may be asked to complete a survey about your progress. Your answers are used to make adjustments to the therapy process and to assist the Center in assessing the strengths and weaknesses of our services.

The Samaritan Center believes in a spiritually integrated approach to treatment and we have expertise in including your faith/spiritual beliefs and practices as a part of the therapeutic process. It is our philosophy to work within your own belief system. Our therapists will not impose their personal beliefs upon you and will include discussion of spirituality/religion/faith in accordance with your expressed wishes.

Your Rights as a Client.

You have all of the rights established by the State of Texas governing clinical practices. These include:

- The right of consent to treatment,
- The right to seeking disclosure from your therapist about his or her qualifications,
- The right to requesting a different therapist,
- The right to end treatment at any time,
- The right to access the client grievance procedures,
- The right to have your clinical record kept private (see "Confidentiality" below),
- You also have the right to have any tests, procedures, and recommendations explained to you in simple terms, and you have the right to refuse such tests, procedures, or recommendations.

Confidentiality: What you tell your therapist will be kept confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, court order, or as part of the professional practice of this Center. We believe in an integrated approach to wellness and may share information about you to other medical and/or mental health providers within or outside of the Center in order to maximize your treatment outcomes. For further information please see our *Notice of Privacy Practices* and *Privacy Practices Acknowledgement.* Feel free to ask for clarification about anything you do not understand. Your privacy is very important to us, and we want to do everything possible to protect it.

Fees and Payment: The regular fee is $120.00 for a 55-minute session for most counseling services and $150.00 for the initial session. If you cannot afford the regular fee, the Center may adjust your fee taking into account your income and number of family members. Proper documentation is required. Payment of your agreed upon fee is due at the time of your appointment unless prior arrangements have been made. You may pay by cash, check or credit card.

Returned Checks and Rejected Credit Card Charges: A $25 fee is charged on all checks returned for non-sufficient funds and rejected credit card charges.

Insurance and Other Third-Party Payments: If you wish to use insurance or other third-party coverage (e.g., a managed care organization or employee assistance program) to pay for therapy, you are responsible for providing the Center with accurate and complete information. The Center does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by your insurance or third-party payer.

Insurance & Confidentiality: You should be aware that your contract with your health insurance company requires that the Center provide the company with information relevant to the services you receive. At a minimum, we are required to provide a clinical diagnosis. Some companies require additional information such as treatment plans, summaries, or copies of your entire clinical record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become a part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your private information once it has been released to them.

Appointments and Cancellations: If an appointment is missed or canceled with less than 24 hours notice, you will be charged for that session. We would prefer that you give us 48-hour notice of cancellation so that we might schedule someone else in that appointment time. This charge is not covered by insurance. If you use insurance to pay your fee, the fee will be the combination of the copay and the amount paid by insurance (the contract rate). If you are paying privately, you will be charged the fee you normally pay for a counseling session (minimum charge of $20 for a missed session). If you miss an appointment two weeks in a row or twice in one month, you will lose your recurring appointment time. We ask for a two-week notification of your plans to terminate treatment.

Legal Proceedings: The staff of the Center **does not provide testimony in legal proceedings**. However, if you choose to subpoena your therapist or your records, you agree to pay for any required preparation time, for your therapist's time out of the office, and for travel at a charge that may equal or exceed the Center's hourly rate.

Emergencies: The Center does not provide "emergency services". If you have an urgent concern, we try to schedule an appointment as soon as possible. If you have a critical emergency, contact one of the following: Center on-call staff (512) 656-5517 (note that this is a wireless phone and is therefore not a secure line) or the MHMR Hotline (512) 472-4357. After-hours messages can be left on the Center's voice-mail system, but do not leave an urgent message since these messages may not be reviewed until the next business day.

Grievances: You are encouraged to talk first with our staff about any concerns you may have about our services; however, if you prefer, you may file a formal grievance with the Clinical Director within 45 days of the time you become aware of a problem. We will investigate and attempt to resolve it within 30 days. If the problem is not resolved, the Center’s CEO will investigate and prepare a written decision within 10 days. You may appeal the CEOs decision directly with the Center’s Board of Directors within 14 days. The decision from the Board of Directors is final. You will not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.

Consumer Complaint Hot-Lines: Licensed Professional Counselors and Licensed Marriage and Family Therapists (800) 942-5540; Social Workers (800) 232-3162 or in Austin 719-3521; Licensed Psychologists (512) 305-7709; Pastoral Counselors (703) 385-6967.

PERSONAL INFORMATION FORM Date____________

Please complete all information requested. Complete one form for each person that will participate in counseling.

First Name_______________________ Middle Initial _____ Last Name_________________________________

Birth Date_____/_____/_____ Age ______ Gender: ☐ Male ☐ Female

Address____City___________________State______Zip________

County ______________ Email Address____

Home Phone_____________________ Work Phone_______________________ Cell Phone____________________

Which ONE number may we use to leave messages and appointment reminders? ☐ Home? ☐ Work? ☐ Cell?

May we also contact you by ☐ Email ? ☐Text to Cell? ☐ Letter?

Emergency Contact: Name____ Phone Number ____________________

If applicable, an alternative mailing address for billing statements:

Address ____City ___________________State _____Zip_________

Name(s) of Primary care provider and/or Psychiatrist: ____

Please complete the following information required by our grant funding:

Are you a military: ☐ Current Service Member ☐ Veteran ☐ Family member ☐N/A
Relationship to Veteran or Service Member: ______________________________________

*PLEASE PROVIDE DD214 or MILITARY ID to qualify for our HOPE FOR HEROES programs and discounts

If you are part of a military family, have you or a family member been ☐ previously deployed to Iraq/Afghanistan
☐ currently deployed to Iraq/Afghanistan

Ethnicity: ☐ African- American ☐ Anglo/Caucasian ☐ Asian ☐ Hispanic/Latino ☐ Native American ☐ Other

Annual Household income: $________________ Number of people living in household:____________

INSURANCE Information:

Primary Insurance:__________________________ Member ID ______________Group # _____________________

Policy Holder Name:_________________________________ Policy Holder Date of Birth _________________

Policyholder Social Security #: ____________________ Is this a Medicare plan? ___________ (yes or no)

Secondary Insurance:__________________________ Member ID ______________Group # _____________________

Policy Holder Name:_________________________________ Policy Holder Date of Birth _________________

Policyholder Social Security #: ____________________ Is this a Medicare plan?__________ (yes or no)

Will someone other than yourself be responsible for payments? ☐ **Yes** ☐ **No** If Yes, please complete the following:

(This section required for minors)

Organization (if applicable):____

Person: First Name________________________ Last Name___________________ Phone# ___________________

Address____City__________________State________Zip________

Insured or Responsible person's signature: Insured or Responsible person's signature: I consent and authorize the Samaritan Center to release medical or other supporting information necessary to process my insurance claims and/or for collecting payment from the above person/organization. I authorize payment of medical benefits to The Samaritan Center. *I understand that I am responsible for all deductibles and co-pays. I understand that I am responsible for 100% of my charges if I am a Private Pay client. I understand all charges and copays are due at time of service. I understand that I must inform the Samaritan Center if my insurance is a* ***Medicare or Medicaid*** *plan and that if I do not, I am waiving my rights to use my* ***Medicare or Medicaid*** *insurance plan and I will be responsible for all charges and copays.*

Printed Name: _______________________________Signature: ________________________________Date: _________

FINANCIAL WORKSHEET

FOR PRIVATE PAY, REDUCED-FEE CLIENTS ONLY

Determination of Fees for Counseling:

If you are unable to use insurance, you may be eligible for a reduced fee. Please complete the information below **and provide proper documentation to verify income.**

Part 1 **Monthly Family/Household Income** ___

Gross Salary and Wages	_______________
Child Support	_______________
Retirement	_______________
Social Security	_______________
Rental-Lease Income	_______________
Other Income	_______________
Total Income	_______________

Part 2 **Major Exceptional Expenses**

Major Medical	_________________
Child Care	________________
Adult Care	________________
Other	________________
Total Expenses	_______________

Number of Family Members Income Supports: ________

Acknowledgement

I have been informed of my reduced fee and understand that I am responsible for paying any balance that I accrue. I understand this reduced fee is a scholarship that is based on current financial information given to the Center at the time of intake. **If at any time my financial situation changes, I will inform the Center and supply updated information to be used in the determination of a new fee arrangement.** I further understand that if I have accrued a credit balance at the time of service termination, those additional monies on my account will be applied to reimburse the Samaritan Center for any scholarship funds that I have received.

I am waiving my right to use insurance, including Medicare and Medicaid, and I understand the Samaritan Center will not be billing insurance for any services provided.

Printed Name: ______________________________Signature: _______________________________Date: ___________

SCCPC Staff Signature ____Date ______________________

To Be Completed By Samaritan Staff

Adjusted Annual Income ____________________ Agreed Upon Fee _____________

Copy of Income Documentation Verified and Collected by (staff initials) _______________

Treating Therapist _______________________________________

Approval/signature of Executive Director or Clinical Director for all insurance or payroll subsidies:

____

Name Title

Consent to Treatment Form

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 Integrative Medicine at the Samaritan Center. I understand that acupuncturists practicing in the state of Texas 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 moxibustion 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, the possible aggravation of symptoms existing prior to acupuncture treatment, and pnuemothorax. 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

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 effects 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 Integrative Medicine as soon as possible.

Cupping: I understand that if I receive cupping as a part of therapy, there is a risk of burning, bruising, minor bleeding, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy.

Acupressure/Asian Bodywork Therapy (ABT): I understand that I may also be given acupressure or ABT 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.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

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: ____ **Date of Birth:** ___________________

SAMARITAN CENTER
The Path to Wellness™

PRIVACY PRACTICES ACKNOWLEDGEMENT

Please Print Client Name__________________________

Please read and complete ONE form for each couple and/or family.

I have reviewed the *Notice of Privacy Practices* and understand and acknowledge that:

- SCCPC's *Notice of Privacy Practices* is posted in the waiting room where I can view it at any time, and I may request a copy of the notice at any time. The notice is also posted on the website: www.samaritan-center.org.
- If I have any questions about the notice, I should ask my therapist, or SCCPC's Privacy Officer, for clarification
- SCCPC may change or modify its *Notice of Privacy Practices* at any time and I have the right to obtain a revised *Notice of Privacy Practices* by accessing www.samaritan-center.org, calling the office and requesting a revised copy be mailed to me, or asking for one at the time of my next appointment.

I understand that State and/or Federal laws permit or require the use or disclosure of my Health Information without my consent or authorization in the following circumstances:

- **Child Abuse:** If we have reason to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report within 48 hours to the Texas Department of Protective and Regulatory Services.
- **Adult Abuse:** If we have reason to believe that an elderly or disabled person has been or may be abused, neglected, or exploited, we must immediately report this to the Texas Department of Protective and Regulatory Services.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Judicial or Administrative Proceedings:** We can share health information about you in response to a court or administrative order.

Each ADULT Participant in Counseling must sign below (only one form is needed for each couple and/or family):

____ ______________________________
Counseling Participant or Legal Representative Date Description of legal representative's authority

____ ______________________________
Counseling Participant or Legal Representative Date Description of legal representative's authority

____ ______________________________
Counseling Participant or Legal Representative Date Description of legal representative's authority

____ ______________________________
Counseling Participant or Legal Representative Date Description of legal representative's authority

If counseling participant is a minor:

____ ___________________________________
Print Minor's Name Print Minor's Name

____ ___________________________________
Print Minor's Name Print Minor's Name

____ ______________________________
Signature of Parent, Guardian or Legal Representative Date Description of legal representative's authority

____
SCCPC Staff Signature Date

Medical Evaluation

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care".
*As a result Integrative Medicine at Samaritan Counseling Center is required to have you respond to the following statements before you are treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to **all** of these statements is "No".*

I have been evaluated by a physician or dentist for the condition being treated within the last twelve months.

Yes No

OR

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. (It is my responsibility and choice whether to follow this advice.)

Yes No

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome. In an effort to maximize your clinical results, we may want to contact your counselor, physician, dentist, or chiropractor and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your Doctor(s)?

Yes No

Name of Doctor, dentist or chiropractor ____

I have completed this form correctly to the best of my knowledge.

Patient Name OR Name of Parent/Guardian: ____

Signature: ____ Date : _________________

Samaritan Center for Counseling and Pastoral Care
Healthcare Coordination Form

Client Name: ____________________________Date of Birth _________________

Client: Research indicates there is a close relationship between physical and mental health and that better treatment outcomes will be achieved if your therapist and your primary care physician coordinate your care. Many physical complaints are rooted in psychosocial issues and physical symptoms can be signs of mental stress. This coordination and consultation is especially important if you are on medication. Medication may have side effects that could affect your mood, ability to concentrate and fully participate in therapy. This form is to give your consent to consult with your psychiatrist, primary care physician, nurse practitioner, or other providers to ensure you receive the best possible care from the Samaritan Center. Most insurance companies require coordination of care with all appropriate behavioral health and medical providers.

Please check one:

_____I give permission for you to coordinate my care with my other healthcare providers

_____I do not have a Primary Care Physician or see any other doctors at this time

_____I do not give permission for consultation with other providers at this time

Physician Name: ______________________________ Clinic Name: _____________________________________

Telephone: ___________________ Fax number: _________________________________

Physician Name: ______________________________ Clinic Name: _____________________________________

Telephone: ___________________ Fax Number:_________________________________

Physician Name: ______________________________ Clinic Name: _____________________________________

Telephone: ___________________ Fax Number: _________________________________

____

Client (or guardian) signature Date

____ ____________________________________

Therapist signature Date Therapist name printed

PHYSICIAN/PROVIDER: You have been identified as this client's medical provider. We want to inform you that your patient was seen for outpatient psychotherapy at the Samaritan Center and has authorized us to consult with you as necessary regarding their treatment. **Please feel free to contact us if you would like additional information.**

Please acknowledge below that this client is a patient of yours and that you will be available for consult.

1. _____ We have no record of having provided recent medical care to the client.

2. _____ This is our patient and we will be available for consult if needed.

Comments/Medication:

Physician's signature (or official representative) Date

Please Return by fax: 512-451-8729 Or mail to:

Samaritan Center for Counseling and Pastoral Care, 8956 Research Blvd., Bldg 2, Austin, TX 78758 (www.samaritan-center.org)

For Samaritan Center Office Use Only: Date faxed to Physician _____________________ initials _________

Express Payments and
Missed Appointment Charges

As a courtesy to you, we try to make reminder calls for most appointments; however, it is your responsibility to remember your appointment times. If you are unable to make your appointment, you must call to cancel and/or reschedule at least 24 hours in advance. Please understand your appointment has been reserved just for you. If we don't receive adequate notice to fill your allotted time, we cannot give another person the same opportunity to receive services. Failure to give 24-hr notice will result in a cancellation charge equal to your session fee. If you use insurance to pay for counseling, the session fee includes your copay and the amount we receive from your insurance or EAP. If you pay privately, the full session fee is what you normally pay for a session. In no case will the charge be less than $20. The cancellation charge will be applied whether or not you receive a reminder call. If you have questions about this policy, please discuss with your therapist. Thank you.

Card type: _____ Visa _____ MasterCard _____American Express _____ Discover_____

Card number: ____

Expiration date (month/year): ____________________________

3 digit security code on back of card: _________________

Billing zip code: _____________________

Name as printed on card: ____

I understand my credit card will be kept on file and charged when I fail to cancel an appointment 24 hours in advance.

____ ________________________

Client Signature Date

Express Payment Option

The Samaritan Center can keep your credit card on file and automatically charge it for each appointment. Please indicate below if you would like this Express Service.

_____I would like the Samaritan Center to run my credit card each time I receive treatment and services, for my convenience.

____ ________________________

Client signature Date

Integrative Medicine at Samaritan Counseling Center

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your information will be kept confidential.

Full name ____ Sex F M Date of Birth ____________________

E-mail Address ____________________________________ Allow email contact by Samaritan Center? Yes No

Would you like to be added to our monthly newsletter? Yes No

Emergency contact name & phone ____

Integrative Medicine treatments are on a sliding scale based on income and number of household members. Based on this information I agree to pay the rate of $____________ per acupuncture treatment. If an acupuncture treatment is missed, or less than 24 hours notice is given for a cancelation, I understand I will be charged **$35** for the missed treatment. Patient Initials: _______________

Health Concern(s) Please list your top three health concerns in order of priority.

1. ____
2. ____
3. ____

Treatment Goals: (Please Circle One) Maintenance Resolve Symptoms-Fix Cause Optimal-Health/ Wellness

What diagnosis, if any, have you received for your primary concern? ______________________________

When did this problem begin? ___________ What are the causes of this problem? ____________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? ______________

What kind of treatment have you tried? ____

What makes this problem worse? ___________________What makes this problem better? _______________

Is there anybody in your family with the same/similar problems? ________ ______________________________

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY
Cancer (what type)			Venereal Disease		
Breathing problems			Emotional Disorders		
Tuberculosis			Seizures		
Hepatitis			Alcoholism		
Digestive Disorders			Anemia		
High Blood Pressure			Arthritis		
Thyroid Disease			Depression or Anxiety		
OTHER					

Surgeries: ______________________________ **Hospitalizations:** ______________________________

Significant trauma: (auto accidents, sports injuries, etc.): ______________________________

Allergies: (drugs, chemicals, foods, environmental):______________________________

Please provide a complete list of all medications taken within the last two months, including vitamins, OTC drugs, herbs, etc:

____

____

____

____

Personal

How many hours do you sleep in general? _________________What time do you usually go to bed? _____________________________

How much coffee do you drink? ________cups/day Colas _______number/day Tea _________cups/day

What kind of alcoholic beverages do you usually drink, if any? _____________Average # of drinks/week? _________

How much water do you drink per day? _____________

Are you a vegetarian? Yes No Yes, but not so strict. Do you eat a lot of spicy food? Yes No

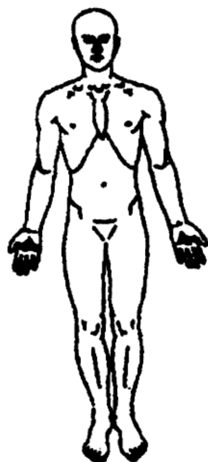
Remarks and additional information (re: diet) ____

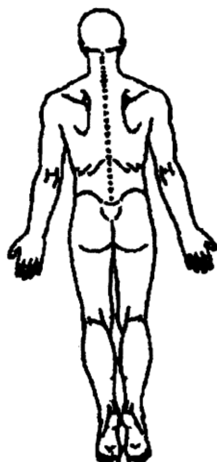
If you are a smoker, # of cigarettes per day ________________How long have you been smoking? _______________________

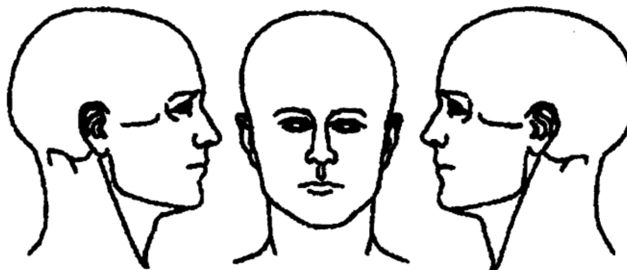
Do you want to quit? Yes No (Level of determination to quit – 1 2 3 4 5 6 7 8 9 10)

Indicate pain or discomfort with:

Sharp • **Dull X** **Tingle :::** **Burn Δ** **Cramp +** **Numb =** **Cold O**







Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General □ Poor appetite □ Poor sleep □ Fatigue □ Fevers □ Chills □ Night sweats □ Sweat easily □ Tremors □ Cravings □ Change in appetite □ Poor balance □ Bleed or bruise easily □ Localized weakness □ Weight loss □ Weight gain □ Peculiar tastes □ Desire hot food □ Desire cold food □ Strong thirst (cold or hot drinks) □ Sudden energy drop (What time of day) _______________
Favorite time of year ___________ Worst time of year _________

Skin & hair □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles □ Loss of hair □ Purpura □ Change in hair or skin texture □ Other?____

Musculoskeletal □ Neck tightness □ Neck pain □ Shoulder pain □ Hand/wrist pain □ Elbow pain □ Back pain □ Hip pain □ Knee pain □ Pain/soreness in the muscles □ Muscle weakness □ Joint disorders □ Tremors □ Cold hands/feet □ Swelling of hands/feet □ Hernia □ Numbness □ Tingling □ Paralysis □ Joint Sprain □ Difficulty walking □ Spinal curvature: □ Cervical □ Thoracic
□ Lumbar □ Other? ____

Head, eyes, ears, nose, and throat □ Dizziness □ Concussions □ Migraines □ Glasses/lens □ Eye strain □ Eye pain
□ Color blindness □ Night blindness □ Poor vision □ Cataracts □ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing
□ Spots in front of eyes □ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain
□ Jaw clicks □ Sores on lips/tongue □ Difficulty swallowing □ Other? ____

Cardiovascular □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting □ Phlebitis □ Irregular heartbeat □ Rapid heartbeat □ Varicose veins □ Other? ____

Respiratory □ Cough □ Coughing blood □ Shortness of Breath □ Wheezing □ Difficulty breathing □ Bronchitis □ Pneumonia
□ Chest pain/ tightness/ congestion □ Production of phlegm – What color? ____

Gastrointestinal □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Bloating □ Belching □ Black stools □ Blood in stools
□ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites
□ Chronic laxative use Bowel movements: Frequency _______ Color ______ Odor ______ Texture/ Form _____________

Neuro-psychological □ Loss of balance □ Lack of coordination □ Concussion □ Poor Memory □ Poor Concentration
□ Difficulty Making Decisions □ Speech problem □ Depression □ Anxiety □ Stress □ Short temper □ Mood Swings □ Bi-polar
□ Other ____

Genito-urinary □ Painful urination □ Frequent urination □ Blood in urine □ Urgency to urinate □ Kidney stones
□ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent urinary tract infection □ Genital pain □ Genital itching
□ Genital rashes □ STD □ Other ____

Female □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge □ Fibroids □ Ovarian cysts
□ Regular periods □ Clots □ Pain/cramps prior/during periods □ Breast tenderness □ Breast Lumps □ Fertility Problems
□ Hot flashes □ Moodiness related to periods □ Hysterectomy/ ovaries removed
First date of last period ________________ Age of first period ______ Duration of periods ______days, cycle ____ days
______ Number of pregnancies ______ Number of births ______ Miscarriages ______ Abortions ______ Premature births ______
C-section ______ Difficult delivery______
Do you practice birth control? □ Yes □ No. If yes, what type and for how long? ____
If you're on birth control pills, what are you taking and for how long? ____

Male □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems □ Frequent seminal emission
□ Fertility problems □ Painful/swollen testicles □ Other ____

I have completed this form correctly to the best of my knowledge.
□ Adult Patient □ Parent or Guardian □ Spouse

____

Signature **Date**

Are there any other health issues you want to discuss with us?