Patient Medical History

Name_____Birth Date_____ Date _____

Address _____

Home Phone_____ Alternate Phone _____

E-Mail Address _____

State your MAIN problem: _____

_____

_____When did it start? _____

What makes it better?_____Worse? _____

State any SECONDARY problems:_____

_____

_____

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

_____

List **ALL REMOVED ORGANS:** _____

List **all PRESCRIPTION DRUGS** you have ever taken and are currently taking: _____

_____

_____

_____

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

Rate your **appetite:** __excessive eating __cravings __moderate __low appetite

Rate your **energy:** __great __good __O.K. __low

Rate your **work stress**: __high __moderate __low; Rate your **home stress:** __high __moderate __low

What is your occupation?: _____

Check all mental/emotional traits you ***seem to be stuck in*** ***50% or more of the time in a 24-hour day***:

__controlling __ angry __impatient __depressed __irritable __excessive laughing __passionate __anxious __sad __worry __obsessive __intolerant __intellectual __overly methodical __overly organized __aloof __melancholy __ careless __strong willed __evasive __lazy __fearful __rigid __jealous __judgemental *(Emotional traits are associated with the **condition of your internal organs**.)*

*Please describe your **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

LADIES MENSTRUATION: *Check all that relate*

Menopause: __Yes __No

__hotflashes __night sweats __irritability __dry skin __insomnia __hormone supplement

Length of period: ___ days ***Quality of blood:*** __Light __ Moderate __Hvy __Thick/Clotty __Rich/ Smooth __Pale/Thin *Cycle Pattern*:_____ *Bleed out of cycle:* __Yes __ No __nausea __ diarrhea __ edema __ovarian cysts __fibroids__endometriosis __contraceptive use presently

MEN'S GENITAL FUNCTION: *Check all that relate*
__premature ejaculation __impotence __cold semen __textured semen __testicle problems __low sperm count __prostate problems

Please Review the Following Carefully and Check All that Relate To You:
EYES: __strain __dryness __pain __blurry __nearsighted __farsighted __infections __floaters __cataracts __glaucoma __loss of eyesight (right, left, both)
EARS: __loss of hearing __aches & pain __ringing __infections __hearing aid
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 __skin cancer __infection _cysts
HAIR: __loss __dryness __itchy scalp __scabs
HEAD: __pain temples __pain head back __pain head top __pain forehead _pain whole head __ flushed face __injury __cysts__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
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 __stomach ulcer __indigestion __bloating __bruise easy __easy weight gain __muscle ache __tire after eating __difficult weight loss
LIVER / GALLBLADDER: __pain under ribs __gallbladder pain __gallbladder stones __breast distension __genital infections __groin pain __Hepatitis A, B, C, etc. __enlarged liver __ ligament pain anywhere __gallbladder REMOVED __high cholesterol
KIDNEY: __stones __frequent urination __burning urination __painful urination __ difficult urination __ incomplete urination __urine leaks __low back pain __knee joint / cap pain __bone pain __memory loss
LARGE INTESTINE: __polyps __worms __bleeding __constipation __diarrhea __surgeries __prolapse __hemorrhoids __appendicitis __cramping
BACK / SPINE: *Upper Middle Lower Whole Back (Circle One or Several)*
__bone pain __muscle pain __ligament pain __joint pain __numbness __cold __hot __swollen __stiff __tight __paralysis (present or past) __disc degeneration __disc herniation
ARM SHOULDER TOP SHOULDER JOINT ELBOW: *Right Left Both (Circle One)*
__bone pain __muscle pain __ligament pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight __torn or stretched rotator cuff __injury
HAND WRIST FINGERS: *Right Left Both (Circle One or Several)*
__bone pain __muscle pain __ligament pain __joint pain __vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight __carpel tunnel syndrome __trigger finger __injury
LEG HIP KNEE ANKLE FOOT TOES: *Right Left Both (Circle One or Several)*
__bone pain __muscle pain __ligament pain __join pain __gout __siatica (where?_____)
__vessel pain __numbness __tingling __cold __hot __swollen __stiff __tight __injury

FOOD CHART - *Please Circle All That Apply* ** Certain items can cause allergic reactions*

Chicken *(Daily, Weekly, Monthly, Yearly)*
Seafood *(Daily, Weekly, Monthly, Yearly)*
Shellfish *(Daily, Weekly, Monthly, Yearly)*
Beef *(Daily, Weekly, Monthly, Yearly)*
Pork *(Daily, Weekly, Monthly, Yearly)*
Other Meat _____ *(Daily, Weekly, Monthly, Yearly)*

Wheat* *(Daily, Weekly, Monthly, Yearly)*
Rye *(Daily, Weekly, Monthly, Yearly)*
Oat *(Daily, Weekly, Monthly, Yearly)*
Rice *(Daily, Weekly, Monthly, Yearly)*
Corn (Daily, Weekly, Monthly, Yearly)
Exotic Grains (Daily, Weekly, Monthly, Yearly)

Apples *(Daily, Weekly, Monthly, Yearly)*
Oranges* *(Daily, Weekly, Monthly, Yearly)*
Strawberries* *(Daily, Weekly, Monthly, Yearly)*
Bananas *(Daily, Weekly, Monthly, Yearly)*
Berries *(Daily, Weekly, Monthly, Yearly)*
Other Fruit _____ *(Daily, Weekly, Monthly, Yearly)*

Broccoli *(Daily, Weekly, Monthly, Yearly)*
Asparagus *(Daily, Weekly, Monthly, Yearly)*
Green Beans *(Daily, Weekly, Monthly, Yearly)*
Corn *(Daily, Weekly, Monthly, Yearly)*
Potato *(Daily, Weekly, Monthly, Yearly)*
Leafy Greens *(Daily, Weekly, Monthly, Yearly)*
Other Vegetable _____ *(Daily, Weekly, Monthly, Yearly)*

Cow Milk* *(Daily, Weekly, Monthly, Yearly)*
Half & Half* *(Daily, Weekly, Monthly, Yearly)*
Yogurt* *(Daily, Weekly, Monthly, Yearly)*
Butter* *(Daily, Weekly, Monthly, Yearly)*
Cheese* *(Daily, Weekly, Monthly, Yearly)*
Pudding* *(Daily, Weekly, Monthly, Yearly)*
Ice Cream* *(Daily, Weekly, Monthly, Yearly)*
Soy Milk *(Daily, Weekly, Monthly, Yearly)*
Goat Milk *(Daily, Weekly, Monthly, Yearly)*
Rice Milk *(Daily, Weekly, Monthly, Yearly)*
Eggs* *(Daily, Weekly, Monthly, Yearly)*
NUTS *(Daily, Weekly, Monthly, Yearly)* **-** Peanuts, Cashews, Pecans, Macadamia,, Almonds, Pistachios, Brazil, Pine, Hazelnut, Walnut
Alcohol - Wine, Beer, Hard Liquor *(Daily, Weekly, Monthly, Yearly)*
Yeast Products* (Baked Goods) *(Daily, Weekly, Monthly, Yearly)*
Packaged / Boxed / Bagged / Preserved Foods* *(Daily, Weekly, Monthly, Yearly)*
Restuarant / Fast Food *(Daily, Weekly, Monthly, Yearly)*

INSURANCE VERIFICATION SHEET

Please fill out the following form to collect and verify insurance coverage. (You may call the provider yourself if you choose to do so.)

Insurance Company *Name*

_____

Insurance Company Claim Submission *Address*

_____

Customer Service Phone Numbers

_____

Name of Person Insured on the Plan

_____

Your Relationship to the Insured (Self, Spouse, Parent)

_____

Patient Membership No._____ Group Policy No_____

Spouse/Parent Membership No._____Group Policy No _____

Patient Date of Birth_____ Spouse/Parent Date of Birth _____

Patient/Spouse/Parent Employer_____

Employer Address_____

Employer Phone _____

QUESTIONS TO ASK INSURANCE REPRESENTATIVE

*It is **very important** that all of the following questions are asked **to ensure coverage.** Remember insurance companies are **in the business of not paying if they can get around it.***

Has my ***deductible been met?***_____ ***How many*** acupuncture treatments are allowed on this plan?_____

Who may perform these treatments? _____

May a ***licensed acupuncture physician perform*** these treatments?_____

What **kinds of diseases** may by treated with acupuncture ***for coverage?*** _____

_____

_____

Will you cover acupuncture treatments performed by a physician ***out of network?***_____

What percentage of the acupuncture treatment will you cover?_____

HUNGERFORD MEDICAL INC

Iqlia Hungerford, A.P., M.S.
Acupuncture Physician • Herbalist
3306 SW 26th Avenue • Unit 403 • Ocala, FL 34471 • 352-804-8620

STATEMENT OF PRIVACY POLICIES

Hungerford Medical Inc. is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

This office gathers personal information and health information in several ways:
- Information received from you;
- Information received from other healthcare providers;
- Information received from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you I will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize me to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have for your protected health information.

Marketing
This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletter and appointment reminder, by calls, post cards or letters.

Disclosure
This office may use or disclose your Protected Health Information when required by this law.

Patient Rights
1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that this office amends your Protected Health information; the request must be in writing.
5. You have a right to receive all notices in writing.

You may send a written complaint to the U.S. Department of Health and Human Services.

If you have questions, complaints or want more information, contact this office.

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ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I, *(print name please)* _____, have read, reviewed, understand and agree to the Statement of the Privacy Policy for healthcare services in the office of Hungerford Medical Inc. This practice has provided me with a Statement of Privacy Policies.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Provider's Original Signature Date