

GENERAL INFORMATION FORM

First name: _____ Last name: _____

DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail: _____

Profession: _____ + _____

How did you hear about us: _____

In the event we need to contact you, how can we do so (check all that applies):

Phone: Home _____ Work _____ Cell _____ Mail _____ E-mail _____

Emergency contact: _____ Phone _____

Are you interested in receiving our FREE monthly E-Newsletter? (if yes, please write your email address) : _____

Have you ever used any of the following professionals in the past?

Medical Doctor	_____	Acupuncturist	_____	Personal Trainer	_____
Orthopedic Surgeon	_____	Chiropractor	_____	Nutritionist	_____
Pain Management	_____	Counselor	_____	Other:	_____
Neurologist	_____	Physical Therapist	_____		
GYN	_____	Massage Therapist	_____		

What is your chief complaint:

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> <p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Back <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Feet <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hands <input type="checkbox"/> Shoulders</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful urination</p>	<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p>	<p>EYE, EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Vision - Flashes</p> <p><input type="checkbox"/> Vision - Halos</p> <p>SKIN</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p>	<p>MEN only</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p> <p>WOMEN only</p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Other</p> <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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CONDITIONS Check (✓) conditions you have or have had in the past.

<p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Breast Lump</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem</p> <p><input type="checkbox"/> Psychiatric Care</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Suicide Attempt</p> <p><input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> Tonsillitis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid Fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Vaginal Infections</p> <p><input type="checkbox"/> Venereal Disease</p>
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MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS **PREGNANCY HISTORY**

Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Month of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Informed Consent for Acupuncture Treatment and Care_____

I hereby request and consent to the performance of Acupuncture and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by Dr. Marie Perkins, licensed acupuncturist.

I understand that methods or treatment may include and are not limited to Acupuncture, Manual Therapies (moxibustion, cupping, gua sha, E-Stim, cold laser) and Chinese Herbal Medicine. I have had the opportunity to discuss with Dr. Marie Perkins the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological function, to modify the perception of pain and to treat certain diseases or dysfunctions of the body. I have been informed that Acupuncture is a safe method of treatment but that occasionally there may be some bruising or tingling near the sit of insertion that may last a few days. There have been very rare instances reported of fainting, infections and scarring. Bruising also may appear after Cupping.

The herbs (which are from plants, animals and mineral source) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergies to the herbs, I will inform Dr. Perkins.

I do not expect Dr. Perkins to be able to anticipate and explain all risks and complications, and I wish to rely on her to exercise judgment during the course of the procedure based upon the facts then known.

I understand that the clinical and administrative staff may review my medical records and lab reports but all my records will be kept confidential and will not be released without my written consent.

Informed Consent for Massage Treatment and Care_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I have read, or have had read to me, understand and agree with the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment.

A photocopy of this form shall be considered as effective as the original.

Patient's name

Patient or responsible party signature

Date

Consent to Treatment of Minor:

By my signature below, I hereby authorize _____ to administer above stated treatment to my child or dependent as they deem necessary.

Patient's name

Patient or responsible party signature

Date

Marie Page-Perkins, A.P.

34876 US Highway 19 N
Palm Harbor, FL 34684

Office Policies

After hour care:

Our office does not use an answering service, only voice mail and e-mail. Phone calls will be returned during regular office hours along with answering e-mails. If you feel that you need immediate attention, call 911 or proceed to the hospital emergency room nearest you.

Missed appointments:

Our office prides itself with individualized and caring medical services. Since we do not double nor over book, you are being assigned between 30 and 90 minutes of the physician's time. Therefore not showing up or canceling within 24 hours of your appointment time results in expenses not recuperated related to the operation of this office not to mention time not utilize helping patients in need of medical attention. Our office reserves the right to charge for not showing or canceling an appointment without 24 hours notice. Payment of \$ 75.00 will have to be made prior to your next appointment. That is applicable whether you are paying privately for you services or not. Insurance companies will not pay for these charges.

Insurance coverage:

We will verify coverage prior to your treatment. If for any reason we are unable to do so, you will be charged for each treatment until verification is obtained. Our fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on your treatment is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event we do not accept assignment of benefits, we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Usual and Customary Rates (UCR):

Our practice is committed in 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 of 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.

I have read, or have had read to me, understand and agree to the above office policies.

A photocopy of this form shall be considered as effective as the original.

Patient or responsible party signature

Date: _____

Marie Page-Perkins, A.P.

34876 US Highway 19 N
Palm Harbor, FL 34684

Patients paying at the time of service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the New Patient office visit. The bill will show the office visit and my fee. However, there are several procedures that may occur during your visit, which will be modified. Any of these procedures used during your treatment will be reduced to \$ 0.00 and you will be responsible for the office visit only.

97810-52	Acupuncture 1 st 15 min.	97813-52	Acupuncture w/ E-stim. 1 st 15 min.
97811-52	Acupuncture 2 nd15 min.	97814-52	Acupuncture w/ E-stim. 2 nd15 min.
97010-52	Heat Therapy	97140-52	Manual Therapy
97014-52	E-stim. (unattended)	97530-52	Kinetic Activities
97032-52	E-stim (attended)	97110-52	Therapeutic Exercises
99070-52	Needles		

The fee for the New Patient office visit is \$ 120.00
The fee for each office visit after initial visit is \$ 75.00

I have read, or have had read to me, and understand the information contained therein.

A photocopy of this form shall be considered as effective as the original.

Patient's name: _____

Patient or responsible party signature

Date: _____