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)

East West HEALING SOLUTIONS

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

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE / JOINT / BONE

Pain, weakness, numbness in:

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision - Flashes
- ☐ Vision - Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mamogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS (Check (✓) conditions you currently have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatits
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

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

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please give approximate dates _____

SERIOUS ILLNESS/INJURIES

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

Year	M/F	Complications if any

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

	Caffeine
	Tobacco
	Drugs
	Other

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 _____

East West Healing Solutions
34786 US 19 N.
Palm Harbor, FL 34684

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 gastro-intestinal 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.

_____ Date:_____

Patient or responsible party signature

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: _____

_____ Date: _____
Patient or responsible party signature