Acupuncture Health Center

1303 Astor Street, Suite 101
Bellingham, WA 98225

(360) 715-1824 **Office**
(360) 715-1648 **Fax**

Scott Paglia, L.Ac.

Structure of Appointments

Initial Exam: 45 minutes

- Consultation with an Acupuncturist to establish New Patient with clinic
- Review of health and pain history
- Verification of insurance benefits, if applicable
- Receive Pulse Diagnosis
- Does not include Acupuncture treatment

Chinese Medical Exam: 1 hour 30 minutes

- Meeting with an Acupuncturist for discussion on:
    - **a.** Explanation of the pulse and tongue diagnosis and how they relate to not only the patient's chief complaints but also secondary issues affecting health and wellness
    - **b.** Analysis of each major symptom, discussing underlying cause
    - **c.** Detailed explanation of each organ system and how they affect the whole body
    - **d.** Explanation of how the body heals: three-stage, functional analysis
    - **e.** History and Function of Chinese Medicine
    - **f.** Review the Plan of Care Options
- Receive an Acupuncture Treatment

Chinese Medical Exam Part 2: 1 hour 15 minutes

- Meeting with an Acupuncturist for discussion on:
    - **a.** Which Plan of Care option works best for the patient
    - **b.** Treatment goals
- Receive an Acupuncture Treatment

For best results, complete all three appointments from New Patient series within one week from start to finish.

Future Acupuncture Appointments: Approximately 1 hour

- Meet with an Acupuncturist for brief health intake
- Receive Acupuncture treatment

Herbal Consultation: Approximately 15 minutes

- Meet with an Acupuncturist for herbal consultation
- Receive customized Herbal Formula specifically designed for the patient's health objectives

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The following information is important to the maintenance of your account and/or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed, we will be happy to help you.

Patient Health and Insurance Information:

Name: _____ Social Security #: _____

Date of Birth: _____ o Male o Female

o Married o Divorced o Single o Separated o Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Which number would you prefer to be reached at? _____

Email: _____

Occupation: _____ Employer: _____

Responsible Party:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Insurance Information:

Subscriber Name: _____ ID#: _____

Name of Insurance:_____

Address: _____ City: _____ State: _____ Zip: _____

Customer Service Phone Number: _____ Relation to Insured: _____

Secondary Insurance: _____ ID#: _____

Address: _____ City: _____ State: _____ Zip: _____

Customer Service Phone Number: _____ Relation to Insured: _____

Emergency Contact/ Next of Kin:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Who may we thank for referring you? _____

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Health History Questionnaire *Information for your Acupuncturist*

Important: Complete these documents as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

Name of your primary physician: _____

Is there anything limiting you from care? o No o Yes If yes, please list: _____

Other physician/ therapists seen for the condition: _____

How did you hear about our office? _____

Medication(s) you are currently taking:

Name	For treatment of	Dosage	Date Started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you receiving relief from taking any of these medications? Please explain: _____

_____

Supplements (if any- vitamins, herbs, minerals, etc.):

Name	For treatment of	Dosage	Date Started
1.			
2.			
3.			
4.			
5.			

Major Complaints (in order of significance to you):

1.	4.
2.	5.
3.	Additional:

How do these conditions impair your daily activities? _____

_____

Patient Medical History

How was your childhood health? _____ Hospital visits/stays: _____

Recent Tests (Please indicate test results and date below):

Test	Date	Result
1.		
2.		
3.		

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Informed Consent

By signing below, I do herby voluntarily consent to the performance of Acupuncture and other procedures within the scope of practice of acupuncture by Scott A. Paglia L.Ac. (AC00000647) of the Acupuncture Health Center and/or other licensed acupuncturists who now or in the future treat me while employed by, working for, associated with, or serving as backup for the above named acupuncturists, including those working at the clinic or office listed above or any other office or clinic whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical, stimulation, Tui- Na (Chinese massage), Chinese Herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

I have been informed that Acupuncture is generally a safe method of treatment, but that it may have some side effects including: bruising, numbness, or tingling near the needling site that may last a few days, and dizziness or fainting. Damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile and disposable needless and maintains a clean and safe environment. Possible treatment side effects include burns, scarring, and other risks. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue, I will notify the clinical staff member caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time based on the facts then known is in my best interest. I understand that results are not guaranteed.

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

By voluntarily signing below, I show that I have read the above and consent for treatment. I have been told about the risks and benefits of acupuncture and other procedures, and have had opportunity to ask questions. I intend for this consent to cover the entire course of treatments for my present condition and for any future conditions for which I seek treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. **Please review it carefully.**

- In my practice, I have always kept your health information secure and confidential.A new law requires me to continue maintaining your privacy, to give you this notice, and to follow the terms of notice.
- I may use or disclose your health information for my normal healthcare operations. For example one of my staff will enter your information into my computer.
- I may share your medical information with my business associates, such as a billing service. I have a written contract with each business associate that requires them to protect your privacy.
- I may use information to contact you. For example, I may send newsletters or other information. I may also want to call and remind you of your appointments. If you are not at home, I may leave this information on your answering machine or with the person who answers your telephone.
- In an emergency, I may disclose your health information to a family member or another person responsible for your care.
- I may release some, or all, of your health information when required by law.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that I not use or disclose your health information as described above, I will let you know if I can fulfill your request.
- You have the right to know of any uses or disclosures I make with your health information beyond the above normal uses.
- Because I may need to contact you from time to time, I will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. I will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give me written request regarding the information you want to see. If you also want a copy of your records, I may charge you a reasonable fee for the copies, $23 administrative fee, plus .15 cents per page copied.
- You have the right to request and amendment or change to your health information. Give me your request to make changes in writing. If you want to include a statement in your file, please give it to me in writing. I may or may not make the changes you request, but will be happy to include your statement in your file. If I agree to an amendment or change, I will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If I change any of the details of this notice, I will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence A venue, SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- This notice goes into effect as of April 14,2003.

Acknowledgement

Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

Signature: _____ Date: _____

Printed Name: _____

Patient/ Client name if being signed as a parent or guardian: _____

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Patient Name: _____

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical mal practice, that is as to whatever any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or Incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium, This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence, giving rise to any claim. This agreement is intended to bind the patient and whether born and unborn at the time of the occurrence, giving rise to any claim. This agreement is intended to bind the patient and employees while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic, or office, or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the healthcare provider, including the health care provider's associates, associations, corporation, partnership, employees, agents and estate, must be arbitrated. Including, without limitation, claims for loss of consortium, partnership, employees, agents, estate, claims for loss of consortium, wrongful death, emotional distress, injunctive relief , and punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties, Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall arbitrator, together with others expenses incurred by a party for such party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity shall be stayed pending arbitration.
The parties agree that provisions of state and federal law, where applicable, establishing the right to recover non-economic losses and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claims in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: if patient intends this agreement to cover services rendered before the date it is signed (for example emergency treatment) patient should initial here:_____ Effective as the date of first professional services.
If any provisions of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provisions. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE (or Patient Representative)	X *(Indicate relationships if signing for patient)*	(Date)
OFFICE SIGNATURE	X	(Date)

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Objective of Care

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care).
Others are interested in having the cause of the problems corrected as well as the symptoms relieved (Corrective care).
Your Acupuncturist will weigh your needs and desire when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- o Relief
- o Corrective
- o Check here if you want the Acupuncturist to select the type of care appropriate for your condition.

Patient's Signature: _____Date: _____

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Agreement by the Patient / Guarantor to Be Financially Responsible For Fees

I_____ (patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% may applied to any unpaid patient balance over 30 days past due.

Patient Signature: _____ Date: _____

Agreement by the Patient Regarding Cancelled/Missed Appointments

Patient understands that a missed appointment (No Show) will result in a $65 charge for that appointment, as well as if the patient fails to give the clinic 24 hours notice of a change of appointment.

Patient understands that a missed Re-Exam (No Show) will result in a $75 charge for that appointment, as well as if the patient fails to give the clinic 24 hours notice of a change of appointment.

Patient Signature: _____ Date: _____

Medical Release to Insurance Company & Notice of Privacy Practices

I authorize the release of medical information to my insurance company/ companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company / companies to pay directly to Acupuncture Health Center for those medical Services.

Patient Signature: _____ Date: _____

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1. Payment Options

- Cash
- Personal Check
- Credit Card (Visa, MasterCard, American Express)

2. Treatment Rates – Full Billable Amount

You are ultimately responsible for knowing what is covered by your insurance and for the balance accrued at Acupuncture Health Center. If your insurance company denies payment due to unforeseen reviews and/or determinations, we will bill any uncovered amounts to you.

- Chinese Medical Exam - $190
- Chinese Medical Exam II - $110
- Acupuncture Treatment - $110
- New patient Herbal Consultation - $100
- Herbal Consultation - $65
- Herbal Formulas - $.80 per gram + tax
- Re-Exams - $75
- Acupressure Class - $50

3. Chinese Herbal Medicine

Herbal Consultations and Herbal Formulas are NOT covered by insurance plans and are non-refundable.

_____ _____

Patient Signature Date

_____ _____

Patient Name Acupuncturist Signature

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New Patient Health History Questionnaire

Directions:

a. Please read and fill in all of the information that pertains to you.

b. On pages 2 through 11, under each category on the left side, check all symptoms that you currently are experiencing or have experienced in the last six months.

c. Add and total all of the boxes you checked.

	Test	Date	Test Results
	Physical		
	Cholesterol		
	Prostate		
	Mammography		
	Pap Smear		
	Blood (which test?)		
	HIV/STD		
	Other		

Please indicate if you have (or have been tested for) any of the following :							
	Diabetes		Allergies		Rheumatic Fever		Vein Condition
	Heart Disease		CVA (stroke)		Thyroid Disorder		Tuberculosis
	Asthma		Pneumonia		Emphysema		Chicken Pox
	High Blood Pressure		Gonorrhea		Bleeding Tendency		Polio
	Syphilis		Measles		Nervous Disorder		Migraines
	Meningitis		HIV		Mononucleosis		Other Liver Illnesses
	Epilepsy		High Fever		Multiple Sclerosis		Other Heart Illnesses
	Paralysis		Cancer		Jaundice		Other Kidney Illnesses
	Glaucoma		Mumps		Hepatitis		Other Lung Illnesses

Immunizations?	Surgeries?

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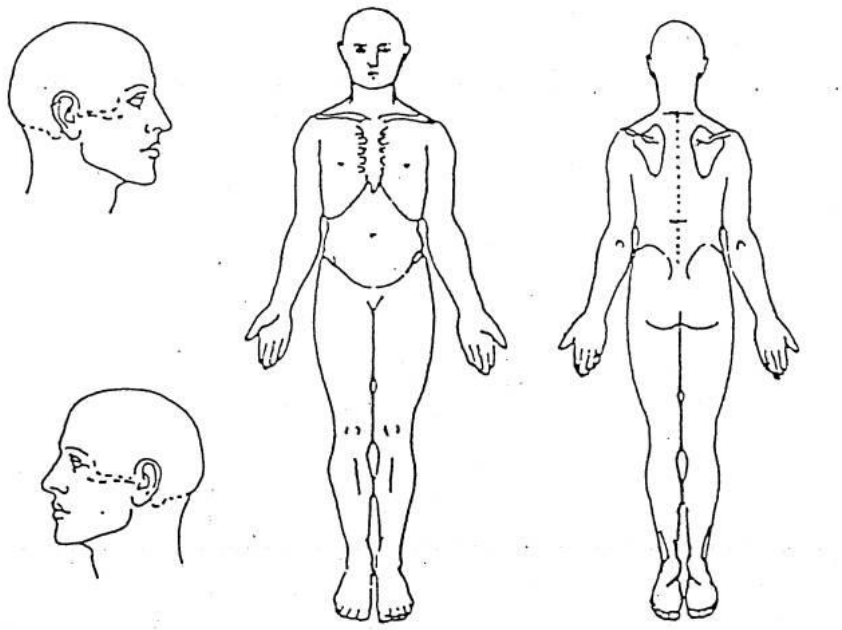
New Patient Health History Questionnaire

1. Pain:

What makes the pain better?
o Soft Pressure
o Hard Pressure
o Cold
o Heat
o Exercise
o Rest
o Other:

What makes the pain worse?
o Soft Pressure
o Hard Pressure
o Cold
o Heat
o Exercise
o Other:

On the figures below, please mark clearly any areas of pain and indicate any scars.



FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

2. Describe your pain:

	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Sharp	o	o	o	o	o	o
o Fixed	o	o	o	o	o	o
o Burning	o	o	o	o	o	o
o Moving	o	o	o	o	o	o
o Cramping	o	o	o	o	o	o
o Aching	o	o	o	o	o	o
o Dull	o	o	o	o	o	o
o Other:	o	o	o	o	o	o
Total Boxes Checked:						
☐ Date: ____	____	____	____	____	____	____

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3. Kidney Function (Overall Temperature):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Cold Hands	o	o	o	o	o	o
o Cold Fingers	o	o	o	o	o	o
o Cold Toes	o	o	o	o	o	o
o Cold Feet	o	o	o	o	o	o
o Sweaty Hands	o	o	o	o	o	o
o Sweaty Feet	o	o	o	o	o	o
o Hot Body Temperature Sensation	o	o	o	o	o	o
o Cold Body Temperature Sensation	o	o	o	o	o	o
o Afternoon Flushes	o	o	o	o	o	o
o Night Sweats	o	o	o	o	o	o
o Heat in hands, feet & chest	o	o	o	o	o	o
o Hot flashes any time of day	o	o	o	o	o	o
o Thirsty	o	o	o	o	o	o
o Perspire easily	o	o	o	o	o	o
o Lack of perspiration	o	o	o	o	o	o
o Do you take water to bed?	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

4. Lung, Kidney Function (Overall Energy):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Shortness of breath	o	o	o	o	o	o
o Difficulty keeping eyes open (day-time)	o	o	o	o	o	o
o General weakness	o	o	o	o	o	o
o Easily catch cold	o	o	o	o	o	o
o Low energy	o	o	o	o	o	o
o Feel worse after exercise	o	o	o	o	o	o
o Chronic (daily) fatigue and malaise	o	o	o	o	o	o
o Other	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

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5. Liver Function:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Dizziness	o	o	o	o	o	o
o See floating black spots	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

6. Heart Function:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Anxiety	o	o	o	o	o	o
o Sores on tip of tongue	o	o	o	o	o	o
o Restlessness	o	o	o	o	o	o
o Mental confusion	o	o	o	o	o	o
o Chest pain traveling to shoulder	o	o	o	o	o	o
o Wake un-refreshed	o	o	o	o	o	o
o Coffee? How much per week?	o	o	o	o	o	o
o Other	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

7. Spleen Function (continued on page 5)**:**	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Low appetite	o	o	o	o	o	o
o Abrupt weight gain	o	o	o	o	o	o
o Abrupt weight loss	o	o	o	o	o	o
o Abdominal bloating	o	o	o	o	o	o
o Abdominal gas	o	o	o	o	o	o
o Gurgling noise in stomach	o	o	o	o	o	o
o Fatigue after eating	o	o	o	o	o	o
o Prolapsed organs? Which ones?	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

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7. Spleen Function (continued from page 4):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Bruise easily	o	o	o	o	o	o
o Over-Thinking	o	o	o	o	o	o
o Worry	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

8. Lung Function:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Nasal Discharge (color _____)	o	o	o	o	o	o
o Cough	o	o	o	o	o	o
o Nose Bleeds	o	o	o	o	o	o
o Sinus Congestion	o	o	o	o	o	o
o Dry Mouth	o	o	o	o	o	o
o Dry Throat	o	o	o	o	o	o
o Dry Nose	o	o	o	o	o	o
o Dry Skin	o	o	o	o	o	o
o Allergies (what ? _____)	o	o	o	o	o	o
o Alternating Chills/Fever	o	o	o	o	o	o
o Sneezing	o	o	o	o	o	o
o Headache (location _____)	o	o	o	o	o	o
o Overall achy feeling in body	o	o	o	o	o	o
o Stiff Neck	o	o	o	o	o	o
o Stiff Shoulders	o	o	o	o	o	o
o Sore Throat	o	o	o	o	o	o
o Difficulty breathing	o	o	o	o	o	o
o Tobacco (# per day _____)	o	o	o	o	o	o
o Sadness	o	o	o	o	o	o
o Melancholy	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

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9. Spleen, Stomach (Small/Large Intestine Function):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Loose Stools	o	o	o	o	o	o
o Constipated	o	o	o	o	o	o
o Incomplete Stools	o	o	o	o	o	o
o Diarrhea	o	o	o	o	o	o
o Blood in Stools	o	o	o	o	o	o
o Mucous in Stools	o	o	o	o	o	o
o Undigested food in the Stools	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

10. Stomach Function:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Burning sensation after eating	o	o	o	o	o	o
o Large appetite	o	o	o	o	o	o
o Bad Breath	o	o	o	o	o	o
o Canker Sores (mouth)	o	o	o	o	o	o
o Bleeding, swollen or painful gums	o	o	o	o	o	o
o Heartburn	o	o	o	o	o	o
o Acid Regurgitation	o	o	o	o	o	o
o Ulcer (diagnosed?)	o	o	o	o	o	o
o Belching	o	o	o	o	o	o
o Hiccups	o	o	o	o	o	o
o Stomach Pain	o	o	o	o	o	o
o Vomiting	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

Acupuncture Health Center

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11. Dampness (Trapped in body):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Bodily sensation of heaviness	o	o	o	o	o	o
o Mental heaviness	o	o	o	o	o	o
o Mental sluggishness	o	o	o	o	o	o
o Mental fogginess	o	o	o	o	o	o
o Swollen hands	o	o	o	o	o	o
o Swollen feet	o	o	o	o	o	o
o Swollen joints	o	o	o	o	o	o
o Chest congestion	o	o	o	o	o	o
o Nausea	o	o	o	o	o	o
o Snoring	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

12. Liver Function (Eyes):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Itchy	o	o	o	o	o	o
o Bloodshot	o	o	o	o	o	o
o Hot	o	o	o	o	o	o
o Dry	o	o	o	o	o	o
o Watery	o	o	o	o	o	o
o Gritty	o	o	o	o	o	o
o Blurry Vision	o	o	o	o	o	o
o Decreased Night Vision	o	o	o	o	o	o
o Near-sighted	o	o	o	o	o	o
o Far-sighted	o	o	o	o	o	o
Total Boxes Checked: ☐						
Date: ____	____	____	____	____	____	____

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13. Liver, Gall Bladder Function:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Alternating Diarrhea & Constipation	o	o	o	o	o	o
o Chest Pain	o	o	o	o	o	o
o Bitter taste in the mouth	o	o	o	o	o	o
o Depression	o	o	o	o	o	o
o Frustration	o	o	o	o	o	o
o Irritability	o	o	o	o	o	o
o Skin Rashes	o	o	o	o	o	o
o Headache at the top of the Head	o	o	o	o	o	o
o Tingling Sensation	o	o	o	o	o	o
o Muscle twitching	o	o	o	o	o	o
o Muscle cramping	o	o	o	o	o	o
o Muscle Spasms	o	o	o	o	o	o
o Seizures	o	o	o	o	o	o
o Convulsions	o	o	o	o	o	o
o Lump in the Throat	o	o	o	o	o	o
o Neck Tension	o	o	o	o	o	o
o Shoulder Tension	o	o	o	o	o	o
o Limited Range-of-Motion (Neck)	o	o	o	o	o	o
o Limited Range-or-Motion (Shoulder)	o	o	o	o	o	o
o How much Alcohol/day? (_____)	o	o	o	o	o	o
o Recreational drugs? Which? (_____)	o	o	o	o	o	o
o High-pitched Ringing in Ears	o	o	o	o	o	o
o Gall Stones (history or current)	o	o	o	o	o	o
o STD's? Which (_____)	o	o	o	o	o	o
o Unable to adapt to Stress	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

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14. Kidney, Urinary Bladder Function:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Frequent Cavities, Teeth Problems	o	o	o	o	o	o
o Easily Broken Bones	o	o	o	o	o	o
o Sore Knees	o	o	o	o	o	o
o Weak Knees	o	o	o	o	o	o
o Cold Sensation In The Knees	o	o	o	o	o	o
o Low Back Pain	o	o	o	o	o	o
o Memory Problems	o	o	o	o	o	o
o Excessive Hair Loss	o	o	o	o	o	o
o Low-Pitched Ringing In The Ears	o	o	o	o	o	o
o Kidney Stones	o	o	o	o	o	o
o Bladder Infections	o	o	o	o	o	o
o Lack Of Bladder Control	o	o	o	o	o	o
o Wake During The Night 2 (Or More)	o	o	o	o	o	o
o Times To Urinate	o	o	o	o	o	o
o Fear	o	o	o	o	o	o
o Easily Startled	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

15. Libido:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o High	o	o	o	o	o	o
o Low	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
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16. Urination (Bladder Function):	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Color: o Pale o Dark Yellow o Clear	o	o	o	o	o	o
o Reddish	o	o	o	o	o	o
o Cloudy	o	o	o	o	o	o
o Scanty	o	o	o	o	o	o
o Profuse	o	o	o	o	o	o
o Strong Odor	o	o	o	o	o	o
o Burning	o	o	o	o	o	o
o Painful	o	o	o	o	o	o
o Discharge	o	o	o	o	o	o
o Difficult	o	o	o	o	o	o
o Urgent	o	o	o	o	o	o
o Frequent	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

Women Only

o Yes o No Do you have a regular menstrual cycle?
o Yes o No Are you pregnant?
o Yes o No Do you have bleeding between periods?
o Yes o No Do you have a vaginal discharge?

_____ Age of first menstruation
_____ Average number of days in flow
_____ Average number of days in entire cycle
_____ Number of children
_____ Number of pregnancies
_____ Age of menopause (if applicable)

Please fill in the menstrual chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color: Normal, Pale, Bright, Red, Brown, Rust, Dark, Purple, Other							
Amount of Flow: Normal, Heavy, Light							
Pain/Cramps: Dull, Sharp, Other							
Vomiting (Yes or No)							
Nausea (Yes or No)							

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Women Only:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Irregular Menstrual Cycle	o	o	o	o	o	o
o Bleeding Between Periods	o	o	o	o	o	o
o Excessive Vaginal Discharge	o	o	o	o	o	o
o Cramping With Period	o	o	o	o	o	o
o Nausea	o	o	o	o	o	o
o Vomiting	o	o	o	o	o	o
o Food Cravings	o	o	o	o	o	o
o Breast Swelling	o	o	o	o	o	o
o Breast Tenderness	o	o	o	o	o	o
o Migraines	o	o	o	o	o	o
o Dull Pain? Where? (_____)	o	o	o	o	o	o
o Sharp Pain? Where? (_____)	o	o	o	o	o	o
o Depression Surrounding Period	o	o	o	o	o	o
o Irritability Surrounding Period	o	o	o	o	o	o
o Anxiety	o	o	o	o	o	o
o Pain During Intercourse	o	o	o	o	o	o
o Other? Explain: (_____)	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____

Men Only:	Re Exam 1	Re Exam 2	Re Exam 3	Re Exam 4	Re Exam 5	Re Exam 6
o Swollen Testes	o	o	o	o	o	o
o Testicular Pain	o	o	o	o	o	o
o Impotence	o	o	o	o	o	o
o Premature Ejaculation	o	o	o	o	o	o
o Feeling of Coldness or Numbness in External Genitalia	o	o	o	o	o	o
o Pain During Intercourse	o	o	o	o	o	o
o Other? Explain: (_____)	o	o	o	o	o	o
☐ **Total Boxes Checked:**						
Date: ____	____	____	____	____	____	____