Benevida Wellness

Health Questionnaire

Although some of the questions may seem unrelated to your condition, they may play a contributing role in diagnosis and treatment. Thank you for filling this out completely.

Contact Information

Today's Date: ___/___/___

Last Name: _____ First: _____ Sex F ☐ M ☐ Date of Birth: ___/___/___ Age: _____

Street: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Best Phone Number: _____

Can we text you for appointment reminders? _____

Occupation: _____ Marital Status: M ☐ S ☐ D ☐ W ☐ Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical/mental conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Name of Emergency Contact: _____ Phone #: _____ Relation: _____

Have you had acupuncture before? Y ☐ N ☐ Who may we thank for referring you? _____

Major Health Complaint(s)

Please list in order of significance to you and circle which you would like us to focus on today.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

When did the circled problem begin? _____ What are the precipitating factors? _____

Have you been given a diagnosis for this problem? If so, please describe. _____

What kind of treatments have you tried? _____

What makes this problem worse? _____ Better? _____

Is there anybody in your family with the same problem?

_____

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

_____

Past Medical History

Check any conditions that you have had in the past or are currently experiencing:

☐ Diabetes	☐ Vein Condition	☐ Thyroid Disorder	☐ Heart Disease	☐ Stroke
☐ Tuberculosis	☐ Asthma	☐ Pneumonia	☐ Profuse Bleeding or Hemorrhage	
☐ Blood Transfusion	☐ Jaundice	☐ Nervous Disorder	☐ Venereal Disease	☐ Epilepsy
☐ HIV	☐ Hepatitis	☐ Hypertension	☐ Auto Immune Disorder	☐ Migraines
☐ Anemia	☐ Mental Illness	☐ Cancer	☐ Liver Disease	☐ Hepatitis
☐ Kidney Disease	☐ Glaucoma	☐ Digestive Disorder	☐ Breathing Problems	☐ Arthritis

Other Conditions: _____

Known allergies (food or other): _____

Significant trauma (car accident, sports injuries etc.):_____

Do you get regular immunizations? Y ☐ N ☐ Do you (or have you in the past) received allergy shots? Y ☐ N ☐

Hospitalizations (procedures and dates): _____

Dental Procedures (include any silver fillings/mercury amalgams):_____

Do you have a history of frequent antibiotic use? Please Describe. _____

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

_____

Family Medical History (please specify family member)

☐ Cancer _____
☐ Hepatitis _____
☐ Heart Disease _____
☐ Asthma _____
☐ Miscarriage _____
☐ Diabetes _____
☐ Hypertension _____
☐ Stroke _____
☐ Alcoholism _____
☐ Other _____

Current Health & Lifestyle

Do you smoke? Y ☐ N ☐ How much? _____ For how long? _____

Do you exercise? Y ☐ N ☐ If yes, how many times per week? _____ Please Describe. _____

Do you travel frequently? Y ☐ N ☐ Have you traveled overseas/ to any 'developing' countries? Y ☐ N ☐

Do you sit in traffic/commute as a daily routine? Y ☐ N ☐

Height _____ Weight: Now _____ One year ago _____ Maximum _____ @ Year _____

How many hours do you sleep in general? _____ When do you usually go to bed? _____

List 3 things you do currently that support your overall health.

_____
_____
_____

List your 3 favorite vices (eg smoking, social drinking, sweet tooth…)

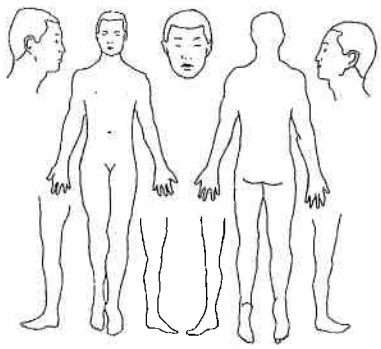
_____
_____
_____

Overall, do you feel that your lifestyle **contributes to OR takes away from** your health?

_____

_____ Soft drinks per day _____ Cups of tea per day _____ Cups of coffee per day _____ Glasses of water per day _____ Alcoholic beverages per week. Are you a vegetarian? Yes, strict ☐ No ☐ Yes, but not strict ☐

Please indicate areas of discomfort or pain



Medications & dose	Vitamins/Minerals/Herbs	Allergies

Notification Form Regarding Evaluation of Patient by Physician

(Pursuant to the requirements of 22 T.A.C §183.7 of the Texas State Acupuncture Examiners' rules (relating to Scope of Practice) and Texas Code Ann., §205.351, governing the practice of acupuncture)

Choose only one of the three options below.

I (patient's name) _____ am notifying Michael Meuth, L.Ac. of the following:

Yes ____ No ____ I have been evaluated by a physician or dentist for the condition being treated within twelve (12) months before the acupuncture was performed. I recognize that a physician or dentist should evaluate me for the condition being treated by the acupuncturist.

_____ _____

Patient's signature (required) Date signed

OR

Yes ____ No ____ I have received a referral from a chiropractor within the last 30 days for acupuncture. The date of the referral is _____, and the most recent date of chiropractic treatment prior to acupuncture treatment is _____. After being referred by a chiropractor, if after 60 days 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 to follow this advice.

_____ _____

Patient's signature (required) Date signed

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 one of the following conditions:

___Chronic Pain
___Weight Loss
___Smoking Cessation

_____ _____

Patient's signature (required) Date signed

Benevida is not responsible for untrue statements made by patients.

Informed Consent to Oriental Medical Healthcare

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Michael Meuth, licensed acupuncturist: acupuncture and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle, and orthopedic testing (modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation), the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation; exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my professional practitioner, and/or with other clinic personnel the nature and purpose of acupuncture and Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implicated.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pin or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise such judgment, during the course of my treatment, as the doctor feels as the time, based on the facts known, to be in my interest. I authorize the staff to perform any necessary services needed during diagnosis and treatment.

I have read, or have had read to me, this informed consent form. 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 any future condition(s) for which I seek treatment at Benevida Wellness.

Patient's name (please print)	Patient's signature
Date signed	Witness
Print name of patient's representative (if applicable)	Relationship or authority of patient's representative
Signature of patient's representative (if applicable)	Date signed

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HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that Benevida "Notice of Privacy Policies" has been provided to me. I understand I have a right to review the "Notice of Privacy Policies" prior to signing this document. "The Notice of Privacy Policies" is also provided upon request.

Members of the staff may need to contact you with appointment reminders of information related to your treatment. If this contact is made by phone, and you are not at home, a message will be left on your answering machine or with whoever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

_____ _____

Patient Name Printed Date

_____

Patient Signature

Authorization for Release of Health Information (Optional)

I, _____, herby authorize ***Benevida Wellness*** the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Name of Persons/Organizations authorized to receive information (please print).

_____ _____

_____ _____

_____ _____

Patient Signature Date