

CONSENT TO QIGONG THERAPY

I, _____, voluntarily consent to be treated with qigong therapy. I understand that such treatment is intended to improve body function and relieve pain.

I have been informed that temporary, mild side effects may result from my qigong therapy; and that I may experience the temporary aggravation of pre-existing conditions as my health and well being shifts.

I accept that no guarantee is made concerning the results of my receiving qigong treatments, and I have been informed that I may stop treatment at any time.

I have also been informed that qigong therapy is not a substitute for seeking out appropriate medical advice and treatment from my physician or psychotherapist. Moreover, I understand that I should continue all medication and treatment that has been prescribed by my doctor or psychiatrist for any currently existing condition.

RELEASE OF INFORMATION

I (initial) _____ consent to the use and disclosure of my protected health information for treatment, payment, clinic operations. Also, I have given my written consent that my health information be shared with the people, their addresses and/or contact numbers on the “Client Contact Information” form. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I acknowledge that I have received a copy of the “Notice of Privacy Practices and Patient’s Rights” and that I have had the opportunity to ask questions about it. All questions I have asked have been fully answered.

Patient’s Signature

Date Signed

Guardian’s Signature

Date Signed

Client Contact Information

Patient's Name (please print) _____

1. Patient's Home Address: _____

2. Patient's Mailing Address (if different from home address):

3. Must correspondence from this office be sent in a sealed envelope marked "confidential": Yes _____ No _____

4. Please print numbers that can be called for appointment, health matters

Home _____ Office _____ Cell _____

5. Can this office leave telephone voice-mail messages concerning scheduling?

Yes _ No ____

6. Can Country Well email to you related services and seminars sponsored by us?

Yes ____ No ____

8. Your email address _____

9. Please list the persons with whom we may inform about your health condition and your treatment including family, physicians, friends:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Patient's Signature _____ **Date** _____

In the Case of a Minor

Legal Guardian's Name (print) _____

Legal Guardian's Signature _____ **DATE** _____

CLINIC POLICIES

Payment of Services: Payment for acupuncture or qigong treatment is due at the time rendered. Cash and personal checks are accepted to: Robin Bonazzoli or Country Well Acupuncture. **Insurance is not accepted at this time.**

Cancellation of Appointments: Except for in cases of illness, acts of nature, and other emergencies, the cancellation of a clinic appointment less than 24 hours prior to the scheduled visit will be charged at the full rate.

Acknowledgment: I understand and accept the terms of “Payment of Services”, “Cancellation of Appointment” as stated above.

1. Patient's Name (please print): _____

2. Signature of Patient _____ Date _____

(In the case of a minor)

1. Patient's Name (please print) _____

2. Legal Guardian's Name (please print) _____

4. Legal Guardian's Signature _____ Date _____

5. Legal Guardian's address _____ Phone _____

Country Well Healing Clinic

Patient Health History

Your Personal Information

Name: _____ Date of First Treatment _____

Address: _____

Phone (Please indicated number to call first for appointment changes):

Work: _____ Cell: _____ Home: _____

Email Address: _____

Date of Birth: _____ Place of Birth: _____

Marital Status: _____

Please describe living situation (i.e. living with husband Dave and daughter: Nicole 8)

Occupation (if retired, please describe prior work): _____

How did you find Country Well Acupuncture?

Referral _____ Yellow Pages _____ Web search _____ Newspaper Ad _____ Other _____

Have you tried acupuncture or qigong therapy before? (And if so, length of treatment and your experience):

Your Main Reason for Seeking Treatment:

**What is your main reason for seeking treatment?

When did you first notice symptoms? Has your condition been diagnosed by a physician?

List medical testing done toward above diagnosis (i.e. MRI, X-Ray, psychological testing):

Describe medical treatment thus far (i.e. physical therapy, drugs, surgery, diet/nutrition, psychotherapy, chiropractic), noting if you are still using a treatment:

Describe alternative medical therapies tried for main problem noting results and if you are still using a particular therapy:

How has your condition/symptoms changed since its onset?

Does your condition adversely affect daily life?

Describe anything that worsens your condition (i.e. heat, cold, massage, exercise, weather changes, stress, lack of sleep, diet/foods):

Describe anything that improves your condition (i.e. heat, cold, massage, meditation, exercise, rest, diet/foods):

Your Doctor's Diagnoses: From Childhood to Present

****Circle** symptom within the past 2 years, **Check and date** notable conditions from your past

Addiction	AIDS	Allergies
Anemia	Anxiety	Arthritis
Asthma	Attention Deficit Disorder	ADHD
Bipolar Syndrome	Birth Trauma	Broken Bones
Bronchitis	Cancer	Chemical Sensitivity or Toxicity
Chronic Fatigue	COPD	Crohn's Disease
Depression	Diabetes	Eating Disorder
Endometriosis	Epstein Barr Virus	Fibromyalgia
Headaches	Heart/Vascular Disease	Hepatitis
Hemorrhoids	Hernia	High Blood Pressure
Hypoglycemia	Hyperactivity	Infertility
Irritable Bowel Syndrome	Kidney Disease	Lyme's Disease
Migraine Headaches	Muscle tear	Miscarriage
Neuralgia	Osteoporosis (-penia)	Panic Disorder
Parkinson's Disease	Pneumonia	Polio
Postpartum Depression	Post Traumatic Stress Disorder	Premenstrual syndrome
Prostate inflammation	Prostatitis	Repetitive stress injury
Rheumatic Fever	Seizures	Sexually transmitted disease
Skin Condition (specify)	Sinus infection	Sleep disorder (specify)
Strep Throat	Stroke	Tendon or ligament tear
Thyroid Disease	Tropical Disease	Tuberculosis
Tumor (benign)	Ulcers	*Other (specify)

Family Medical History

*Indicate family member

Allergies _____

Asthma _____

Cancer _____

Heart Disease _____

High Blood Pressure _____

Mental or Emotional Condition (specify) _____

Stroke _____

Other _____

*Are your parents still living? _____

Surgeries, Traumas

* Include date/age

Surgeries _____

Accidents _____

Shock/Emotional Trauma _____

Occupational Stress

How many hours do you usually work/week? _____ # of days vacation/year? _____

Describe any physical or psychological stress at your work? _____

Have you ever been subjected to chemical toxins at work? _____

Sleep

How is your sleep? _____

Do you wake up feeling rested? _____

What time do you go to bed? _____

How many hours do you typically sleep? _____

**Please check if any of the following apply:

Difficulty falling asleep _____

Light sleeper _____

Sleep walking _____

Heavy dreaming _____

Nightmares _____

Waking mid-sleep cycle _____

Hypersomnia _____

Your Diet

*Please describe a typical meal:

Breakfast

Lunch

Snack(s)

Dinner

Do you feel that you over or under eat?

How does stress affect this?

Do you crave particular food(s) or flavors?

Do you skip meals?

Do you eat breakfast regularly?

How late do you eat/have dinner?

What beverages do you typically consume/day?

How much water do you drink?

Do you eat junk food?

Please describe:

How much caffeine do you consume/day (in oz.) of coffee, teas, sodas or chocolate?

Do you smoke?

If so, how much do you smoke/day?

Do you drink alcohol?

If so, kind and quantity/day?

Exercise

What do you do to stay physically fit? _____

If you are not presently exercising regularly, when was the last time you consistently exercised? _____

Do you easily feel winded? _____

Are you as flexible and coordinated as you would like to be for your age? _____

General Health

****Circle** if condition is within the last 2 years, **Check and date** if a past concern

Tendency to feel hot _____ Tendency to feel cold _____ Always thirsty _____
Rarely thirsty? _____ Bleeding or bruising _____ Weight gain _____
Weight loss _____ Fluctuating weight _____ Hair loss _____
Exhaustion _____ Feverish over-activity _____

Have you taken antibiotics over a long period of time? Specify:

Have you taken steroids over an extended period of time (i.e. steroid inhaler, prednisone, sports?)

Respiratory System

*Do you feel that you easily susceptible to respiratory illness? _____

****Circle** conditions within the last 2 years, **Check and date** notable past conditions:

Asthma _____ Allergies _____ Sinus infections _____
Cough _____ Coughing up blood _____ COPD _____
Nose bleeds _____ Bronchitis _____ Pneumonia _____
Strep Throat _____ Recurrent sore throats _____ Sinus infections _____
Sinus headaches _____ Excessive phlegm _____ Postnasal drip _____
Dry nose or throat _____ Difficulty inhaling _____ Pain with inhalation _____
Difficulty exhaling _____ Pain with exhalation _____ Respiratory Flu _____

Skin

Do you feel that you are easily susceptible to skin conditions? _____

****Circle** conditions within last 2 years, **Check and date** notable past conditions:

Itching _____ Eczema _____ Hives _____
Skin Ulcerations _____ Rashes _____ Moles _____
Skin Pain _____ Dandruff _____ Oily skin _____
Dry skin _____ Sweating _____ Scanty sweating _____
Night sweats _____ Dry fever at night _____ Body odor _____
Easily chilled _____ Skin infection _____ Sunburn _____

Cardiovascular

****Circle** conditions within last 2 years, **Check and date** notable past conditions:

High blood pressure _____	Low blood pressure _____	Chest pains _____
Left shoulder/arm pain _____	Irregular heartbeat _____	Dizziness _____
Fainting _____	Blood clots _____	Swelling of hands _____
Swelling of feet _____	Cold hands _____	Cold feet _____
Phlebitis _____	Palpitations _____	*Other _____

Upper Digestion

Are you tired or energized after eating a normal meal? _____

List any foods you feel bother your upper abdominal digestive organs: _____

****Circle** condition within the last 2 years, **check and date** notable past conditions

Nausea _____	Vomiting _____	Lack of taste _____
Belching _____	Bad breath _____	Indigestion _____
Heartburn _____	Acid reflux _____	Gall stones _____
Sluggish digestion _____		Blood in stools (red) _____
Poor appetite/lack of hunger _____		Difficulty deciding what to eat _____
Fixed pain/cramps upper abdomen _____		Migrating pain upper abdomen/sides _____
Stomach Flus _____		

Intestines/Lower Digestion

Frequency of bowel movement? _____ Are your stools often hard, dry, soft or watery? _____

Do you take a stool softener? _____ Do you take a fiber supplement? _____

List any foods you feel bother your lower abdominal digestive organs: _____

****Circle** symptoms within the last 2 years, **check and date** notable past conditions:

Black stools _____	Passing gas (mild or strong odor?) _____
Lower abdominal fixed pain/cramps _____	Lower abdominal migrating pain _____
Rectal pain _____	Hemorrhoids _____
Diarrhea _____	Constipation _____
Chronic laxative use _____	Irregularity _____
Worms _____	Bacterial Bowel infection _____
Lower digestive Flus _____	Undigested food in stools _____
	*Other _____

Head and Face

***Do you experience migraine or other headaches?** Describe age of onset, frequency, duration, location, circumstance of arising, mood, and notate if accompanied by nausea or vomiting.

****Check if any of the following conditions apply to you:**

Bell's Palsy _____	Other Stroke of Head or Face _____
Dizziness _____	Concussion _____
Jaw pain _____	Jaw Clenching _____
Jaw clicks _____	Teeth Grinding _____
Other head and face _____	

Teeth, Gums, Mouth

How often do you brush your teeth? _____ Do you use an electric toothbrush? _____

***Please indicate with a check if you have experienced any of the following:**

Teeth Grinding _____	Cavities _____
Broken teeth _____	Soft teeth _____
Root Canals _____	Tooth Implants _____
False Teeth _____	Gum disease _____
Sores on lips _____	Sores on tongue or in mouth _____
Other teeth, gums, mouth (describe) _____	

Eyes

Do you wear glasses (since when? For reading or distance?) _____

Please check any of the following symptoms that apply, indicating which eye:

Spots in front of eyes _____	Visual acuity fluctuations _____	Blurred vision _____
Eyes strain _____	Eye pain _____	Poor night vision _____
Color blindness _____	Cataract(s) _____	Glaucoma _____
Macular Degeneration _____	Dry eyes _____	Itchy eyes _____
Watery Eyes _____	Eye Infections _____	*Other (specify) _____

Ears

****Circle** conditions within the last 2 years, **Check and date** significant past conditions

Earaches _____ Ringing in ears _____ Ear infections _____
Itchy ears _____ Damp ears _____ Diminished hearing _____
Other ear conditions (describe) _____

Urinary Bladder and Kidney

How often do you urinate/day? _____ Do you wake nightly to urinate (#of times)? _____

What color is your urine upon waking? _____

***Circle** conditions within last 2 years, **Check and date** significant past conditions

Pain on urination _____ Frequent urination _____ Blood in urine _____
Cloudy urine _____ Urgency to urinate _____ Unable to hold urine _____
Decreased urine flow _____ Bladder infection(s) _____ * Other Urinary Bladder _____
Kidney stones _____ Kidney Disease _____ *Other Kidney _____

Musculoskeletal: Pain, Numbness or Weakness

***Circle** conditions within the last 2 years, **Check and date** significant past conditions.

*** Indicate if injury** Describe condition as ***pain, numbness or weakness**

***Is Condition concentrated in the flesh, muscle body, joint or bone?**

Head/Skull _____	Face _____
Jaw _____	Neck _____
Shoulders _____	Back _____
Hip _____	Leg _____
wrist _____	knee _____
Arm _____	ankle _____
Hand _____	foot _____
Chest _____	Groin _____
Side of Torso _____	Other _____

Concentration

****Check** any of the following that pertain to you at present:

Poor concentration ____ Poor long term memory ____ Poor short term memory ____
Block in creativity ____ Excessive thinking ____ Difficulty finishing projects ____
Difficulty planning ____ Difficulty making decisions ____ Difficulty prioritizing ____

Neuropsychological

Have you ever been in counseling with a psychotherapist or social worker?

Have you ever been diagnosed with a mental or emotional condition? If so, what was the diagnosis?
How were you treated?

Have you ever seriously considered or attempted suicide? Explain:

****Please check** if any of the below apply to you:

Tremors ____ Seizures ____ Dizziness ____
Lack of coordination ____ Areas of numbness ____ Concussion ____

*Other neurological or psychological issues (specify)

Emotional

****Check** if any of the following emotional states predominate in your personality/life at present:

Anxiety ____ Bad temper ____ Depression ____
Unresolved grief ____ Lack of joy ____ Excessive Worry ____
Excessive jealousy ____ Boredom ____ Fearfulness ____
Lack of inspiration ____ Pessimism ____ Excitability ____
Lack of self esteem ____ Heartbroken ____ Critical of self and others ____
Excessive risk-taking ____ Feelings of guilt ____ Other _____

Free Time/Relaxation

How do you spend your free time?

Is it easy for you to relax?

What do you do to promote relaxation?

Male Reproductive

Please check if any of the following apply to you and describe where necessary:

Erectile dysfunction _____ Low sex drive _____ Sores on genitals _____
Penile discharge _____ Pain of genitalia _____ Sexually transmitted disease _____
Prostate condition _____ Vasectomy _____
Other genital or sexually related symptoms _____

All Women: Reproductive and Gynecologic

**Please fill in the following as pertains to you:

Age of first menses _____ Age at menopause (indicate if hysterectomy) _____

Indicate birth control methods used now and in past _____

Indicated number of: Pregnancies _____ Miscarriages _____ Abortions _____

****Circle** conditions present in last 2 years, **Check and date** significant past conditions:

Fibroids _____ Endometriosis _____
Sexually transmitted disease _____ Vaginal dryness _____
Vaginal yeast infections _____ Vaginal discharge (color and smell?) _____
Pain with intercourse _____ Lack of interest in sex _____
Hot Flashes _____ Night sweats _____
Dry Fever _____ Uterine prolapse _____
Other, please describe _____

For Menstruating Women Only

*Please indicate:

of days menstruating _____ Time between cycles _____

****Circle** conditions within the last 2 years, **Check and date** significant past conditions:

Menstrual clots _____ Thin, bright red blood _____ Thick brownish blood _____
Pre-menses breast tenderness _____ Pre-menses bloating _____ Pre-menses mood changes _____
Pre-menses cramping _____ Pre-menses exhaustion _____ Painful menses _____
Irregular menses _____ Heavy menstrual flow _____ Scanty menstrual flow _____
Bleeding mid-cycle _____ Exhaustion after menses _____
*Other (describe _____
