



INTEGRATIVE ACUPUNCTURE

Harmony Brown, L. Ac.

Date \_\_\_\_\_

Kimberly Marrone, L. Ac.

**Please Read and Initial**

**Treatment Time**

Your treatment time includes paperwork, late arrival (on your behalf), undressing and dressing, exercises/stretchers, and any questions or concerns that you may have.

Initial \_\_\_\_\_

**Water**

It is advised to drink plenty of water after a treatment. This will help assist in flushing out any toxins that may have accumulated in your system and will prevent you from feeling tired.

Initial \_\_\_\_\_

**Canceling Appointments**

A broken appointment is a loss to everyone. Please inform us in advance if you are unable to keep your appointment. A non-cancellation fee of \$65.00 will be added to your next visit for missed appointments that have not been cancelled.

Initial \_\_\_\_\_

**Telephones, Cell Phones and Pagers**

Talking on phones is not permitted throughout the center. We require that all cell phones and pagers be turned off or on vibrate prior to entering the waiting room. This is to benefit you, as well as provide a tranquil and healing environment for those in the surrounding offices.

If you decide to talk during your session, please step outside and understand that this is part of your treatment time.

Initial \_\_\_\_\_

**The Scope of Acupuncture in the state of Florida and the modalities used at this clinic includes but is not limited to:**

- Use of acupuncture needles to stimulate points and meridians
- Moxibustion
- Use of Micro-Current to stimulate acupuncture needles (i.e. similar to TENS unit)
- Cupping (Suction applied to areas of stagnated energy to improve blood flow & circulation)
- Dermal Friction Technique (Gua Sha- friction on the skin to stimulate the body's energy)
- Herbal Medicine/Homeopathic Medicine
- Dietary Therapy based on Traditional Chinese Medicine
- Bodywork/Tuina/trigger point therapy/cranial sacral
- Nutritional Supplements
- Injection Therapy

**Possible Side Effects:**

- Drowsiness may occur in a small number of patients and if affected you are advised to recuperate before driving
- Minor bleeding or bruising may occur as a result of acupuncture, cupping, injections, & Gua Sha
- Symptoms may become worse before they improve for 1-2 days following your treatment. Please advise us if worsening of the condition continues for over 2 days
- Fainting or a lightheaded sensation may occur (sitting after treatment for a minute or two will generally alleviate this symptom)
- Please do not come in for treatment under influence of drugs or alcohol or in a heavily medicated condition

**Please check any items that apply to you:**

Pregnant? How far along? \_\_\_\_\_

Pacemaker or other electrical implants? \_\_\_\_\_

Bleeding disorder? \_\_\_\_\_

Anti-coagulants (blood Thinner) or other medications? \_\_\_\_\_

\_\_\_\_\_

Have a damaged heart valve(s) or have any particular risk of infection? \_\_\_\_\_

\_\_\_\_\_

**Initial** \_\_\_\_\_



INTEGRATIVE ACUPUNCTURE

I confirm that I have read and understand the above information, and I consent to having treatments and procedures from this clinic.

I release Harmony Brown L. Ac and Kimberly Marrone L. Ac and Integrative Acupuncture LLC from any and all claims incurred to me as a result of treatment. I voluntarily consent to and understand that no statement is intended as a medical diagnosis, nor is it considered as such. I also understand that I may refuse treatment at any time. I also understand that there is a no refund policy and any unused treatments may not be transferred to another person. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

All information that is given is confidential and will not be released without written consent by you, or unless legally required to do so.

**Patient Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

If represented by another.

**Representative Name** \_\_\_\_\_

**Date** \_\_\_\_\_

**Representative Signature** \_\_\_\_\_

**Integrative Acupuncture LLC**  
**Client Consent for Use and Disclosure**  
**of Protected Health Information**

**Please also Read the Notice of Privacy Practices**

I hereby give my consent for Integrative Acupuncture LLC., to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation (TPO). The Notice of Privacy Practices provided by Integrative Acupuncture, describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Integrative Acupuncture reserves the right to revise its Notice of Practices at any time.

With this consent, Integrative Acupuncture, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and Client statements as long as they are marked "Personal and Confidential."

With this consent, Integrative Acupuncture may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and client statements. I have the right to request that Integrative Acupuncture restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Integrative Acupuncture to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Integrative Acupuncture may decline to provide me treatment.

**Print Client's Name or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Client's Name or Legal Guardian** \_\_\_\_\_

**Integrative Acupuncture LLC**  
**HIPPA AUTHORIZATION FORM**

Client Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Integrative Acupuncture LLC, to use and/or disclose certain protected health information (PHI) about me.

This authorization permits Integrative Acupuncture LLC, to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed such as date(s) of service, type of services, level of detail to be released, origin of information, etc.)

The information will be disclosed for the following purpose:

(If the client requests disclosure, purpose may be listed as "at the request of the individual")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

The practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Integrative Acupuncture LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Integrative Acupuncture LLC. 220 Congress Park Dr. Suite #230, Delray Beach, FL. 33445

**Print Client's Name or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Client's Name or Legal Guardian** \_\_\_\_\_

**Relationship to Client** \_\_\_\_\_



INTEGRATIVE ACUPUNCTURE

Full Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Email \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Have you ever been treated with Acupuncture before? Yes  No

If yes, where and when? \_\_\_\_\_

Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment; however it may restrict some of our treatment modalities)

Hepatitis  HIV  High Blood Pressure  Seizures  Pacemaker

Blood-Thinning Medication  Pregnant

Please describe the reason for the visit today (the Chief Complaint)?

\_\_\_\_\_

What seems to be the initial cause? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

Does it affect your Sleep? Work  Other , explain \_\_\_\_\_

Initial \_\_\_\_\_

**Personal Lifestyle Habits (how much, how many, or how often)** Initial \_\_\_\_\_

Cigarettes (Packs) \_\_\_\_\_ Coffee/Tea (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_

Marijuana \_\_\_\_\_

Other Recreational Drugs \_\_\_\_\_

Vitamins & herbs \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Food cravings \_\_\_\_\_

Diet: What might you eat on a typical day?

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Exercise \_\_\_\_\_ How Often? \_\_\_\_\_

What non work activities do you enjoy doing?(reading, TV, Meditation, Music, etc)

\_\_\_\_\_

**MEDICINES:**

Prescription drugs you are currently taking:

For what condition?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Over – the –counter medication you are currently taking:

For what condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Major Hospitalizations:** If you have ever been hospitalized for any serious medical illness or operation, write the most recent on below (do not include normal pregnancies)

**Year**

**Operation/Illness**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date of last physical examination? \_\_\_\_\_

Name and Address of physician? \_\_\_\_\_

Phone number of physician? \_\_\_\_\_

**Initial** \_\_\_\_\_

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IN·TE·GRA·TIVE, adj.

To make into a whole by bringing all parts together; Unify.



Please put a "C" if the condition is current or a "P" if you had it in the past.

Initial \_\_\_\_\_

**General**

- \_\_\_ Insomnia
- \_\_\_ Dreams/nightmares
- \_\_\_ Irritability
- \_\_\_ Depression
- \_\_\_ Mood swings
- \_\_\_ Fatigue
- \_\_\_ Poor Memory
- \_\_\_ Strongly like Cold Drinks
- \_\_\_ Strongly like hot Drinks
- \_\_\_ Recent weight loss/gain
- \_\_\_ Cold hands &feet
- \_\_\_ Chills
- \_\_\_ Fever

**Head and Neck**

- \_\_\_ Headaches
- \_\_\_ Migraines
- \_\_\_ Stiff neck
- \_\_\_ Dizziness
- \_\_\_ Fainting
- \_\_\_ Swollen Glands

**Neurological**

- \_\_\_ Seizures
- \_\_\_ Tremors
- \_\_\_ Numbness or Tingling
- \_\_\_ Pain
- \_\_\_ Paralysis
- \_\_\_ Poor coordination

**Skin**

- \_\_\_ Hives
- \_\_\_ Rashes
- \_\_\_ Eczema/psoriasis
- \_\_\_ Night sweating
- \_\_\_ Excess sweating
- \_\_\_ Dry skin
- \_\_\_ Easy Bruising
- \_\_\_ Changes in moles/lumps
- \_\_\_ Itching

**Respiratory**

- \_\_\_ Difficulty Breathing
- \_\_\_ Difficulty breathing when lying down
- \_\_\_ Wheezing
- \_\_\_ Asthma
- \_\_\_ Chronic Cough
- \_\_\_ Wet cough
- \_\_\_ Dry cough
- \_\_\_ Coughing up Phlegm
- \_\_\_ Coughing up blood
- \_\_\_ Shortness of breath
- \_\_\_ Tight chest
- \_\_\_ Pneumonia

**Ears**

- \_\_\_ Ringing
- \_\_\_ Hearing Loss
- \_\_\_ Infections
- \_\_\_ Earache
- \_\_\_ Hearing aids
- \_\_\_ Vertigo

**Eyes**

- \_\_\_ Glasses/Contact Lenses
- \_\_\_ Blurred Vision
- \_\_\_ Poor night vision
- \_\_\_ Spot and floaters
- \_\_\_ Eye inflammation
- \_\_\_ Double vision
- \_\_\_ Glaucoma
- \_\_\_ Cataracts

**Cardiovascular**

- \_\_\_ High Blood Pressure
- \_\_\_ Low Blood Pressure
- \_\_\_ Chest pain or tightness
- \_\_\_ Palpitation
- \_\_\_ Rapid heart beat
- \_\_\_ Irregular heart beat
- \_\_\_ Poor circulation
- \_\_\_ Swollen ankles
- \_\_\_ Phlebitis
- \_\_\_ Anemia
- \_\_\_ History of heart attack

Please put a "C" if the condition is current or a "P" if you had it in the past.

Initial \_\_\_\_\_

**Musculoskeletal**

- \_\_\_ Joint pain/disorder
- \_\_\_ Sore Muscles
- \_\_\_ Weak Muscles
- \_\_\_ Difficulty walking
- \_\_\_ Neck/shoulder pain
- \_\_\_ upper back pain
- \_\_\_ lower back pain
- \_\_\_ rib pain
- \_\_\_ limited range of motion
- \_\_\_ other(Describe)\_\_\_\_\_

**Nose, Throat & Mouth**

- \_\_\_ TMJ
- \_\_\_ Facial Pain
- \_\_\_ Gum problems
- \_\_\_ Dry mouth
- \_\_\_ Sinus infection
- \_\_\_ Hay fever/Allergies
- \_\_\_ Frequent sore throat
- \_\_\_ Difficulty swallowing
- \_\_\_ Mouth and tongue ulcers
- \_\_\_ Frequent colds
- \_\_\_ Nosebleed
- \_\_\_ Dry nose
- \_\_\_ Nasal congestion
- \_\_\_ Loss of voice
- \_\_\_ Thirst
- \_\_\_ Excessive Phlegm

**Genito-urinary**

- \_\_\_ Pain on urination
- \_\_\_ Frequent urination
- \_\_\_ Urgent urination
- \_\_\_ Blood in urine
- \_\_\_ Unable to hold urine
- \_\_\_ Incomplete urination
- \_\_\_ Bedwetting
- \_\_\_ Wake to urinate
- \_\_\_ Increased libido
- \_\_\_ Decreased libido
- \_\_\_ Kidney stones
- \_\_\_ Impotence
- \_\_\_ Premature ejaculation
- \_\_\_ Nocturnal emission
- \_\_\_ Pain/itching genitalia
- \_\_\_ Lumps in testicles

**Infection Screening**

- \_\_\_ HIV risks: self or partner
- \_\_\_ TB: self or household
- \_\_\_ Hepatitis risk: self or partner
- \_\_\_ History of sexually transmitted disease: self or partner
- \_\_\_ Gonorrhea
- \_\_\_ Chlamydia
- \_\_\_ Syphilis
- \_\_\_ Genital warts
- \_\_\_ Herpes: oral/genital

**Gastrointestinal**

- \_\_\_ Nausea
- \_\_\_ Indigestion
- \_\_\_ Stomach pain
- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Poor appetite
- \_\_\_ Excessive hunger
- \_\_\_ Vomiting
- \_\_\_ Gas
- \_\_\_ Hiccups
- \_\_\_ Acid regurgitation
- \_\_\_ Bloating
- \_\_\_ Bad breath
- \_\_\_ Laxative use
- \_\_\_ Bloody stool
- \_\_\_ Mucus in stool
- \_\_\_ Hemorrhoids
- \_\_\_ Gall bladder disorder

**Other**

\_\_\_\_\_  
\_\_\_\_\_

**For Women Only**

Initial \_\_\_\_\_

**Gynecology**

Age of first menses? \_\_\_\_\_ Date of last menstrual period? \_\_\_\_\_ Duration of flow? \_\_\_\_\_

Blood clots: yes  no  When? \_\_\_\_\_ Length of cycle? \_\_\_\_\_

Color of menstrual blood? Pale  Bright  Red  Dark Red  Brown  Other  \_\_\_\_\_

Texture of menstrual blood? Thick  Thin  Watery  Normal

Pain: yes  no  When? \_\_\_\_\_

Irregular period (describe): \_\_\_\_\_

PMS (Please describe): \_\_\_\_\_

Current method of contraception? \_\_\_\_\_ Past method? \_\_\_\_\_

Are you currently pregnant? Yes  no

Number of pregnancies? \_\_\_\_\_ Number of live births? \_\_\_\_\_

Number of miscarriages? \_\_\_\_\_ Number of abortions? \_\_\_\_\_

Any premature Births? \_\_\_\_\_

Breast (lumps, cysts, tenderness, etc): \_\_\_\_\_

Urinary Tract infection? \_\_\_\_\_ How frequent? \_\_\_\_\_

Vaginal infections/discharges (describe color) \_\_\_\_\_

Pain/itching of genitalia: \_\_\_\_\_

Pap smear: Normal  Abnormal  Date of last pap smear? \_\_\_\_\_

Uterine fibroids  Endometriosis  Other

Menopause (date of onset) \_\_\_\_\_ Symptoms? \_\_\_\_\_

Any bleeding since Menopause? Yes  No  Explain \_\_\_\_\_

Are you currently on Hormone Replacement Therapy(HRT)? Yes  No  Dose? \_\_\_\_\_

How long have you been on HRT? \_\_\_\_\_ Any side effects? \_\_\_\_\_

Other information: \_\_\_\_\_

**For Men Only**

Date of last Prostate check up? \_\_\_\_\_ PSA result \_\_\_\_\_

Digital rectum exam result? \_\_\_\_\_

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Reduced Libido       | <input type="checkbox"/> Back pain          | <input type="checkbox"/> premature ejaculation   |
| <input type="checkbox"/> Discharge            | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Prostatitis             |
| <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> Excessive Libido   | <input type="checkbox"/> Groin Pain              |
| <input type="checkbox"/> Retention of urine   | <input type="checkbox"/> Impotence          | <input type="checkbox"/> Genital/testicular pain |
| <input type="checkbox"/> Prostate cancer      | <input type="checkbox"/> Incontinence       | <input type="checkbox"/> Other _____             |

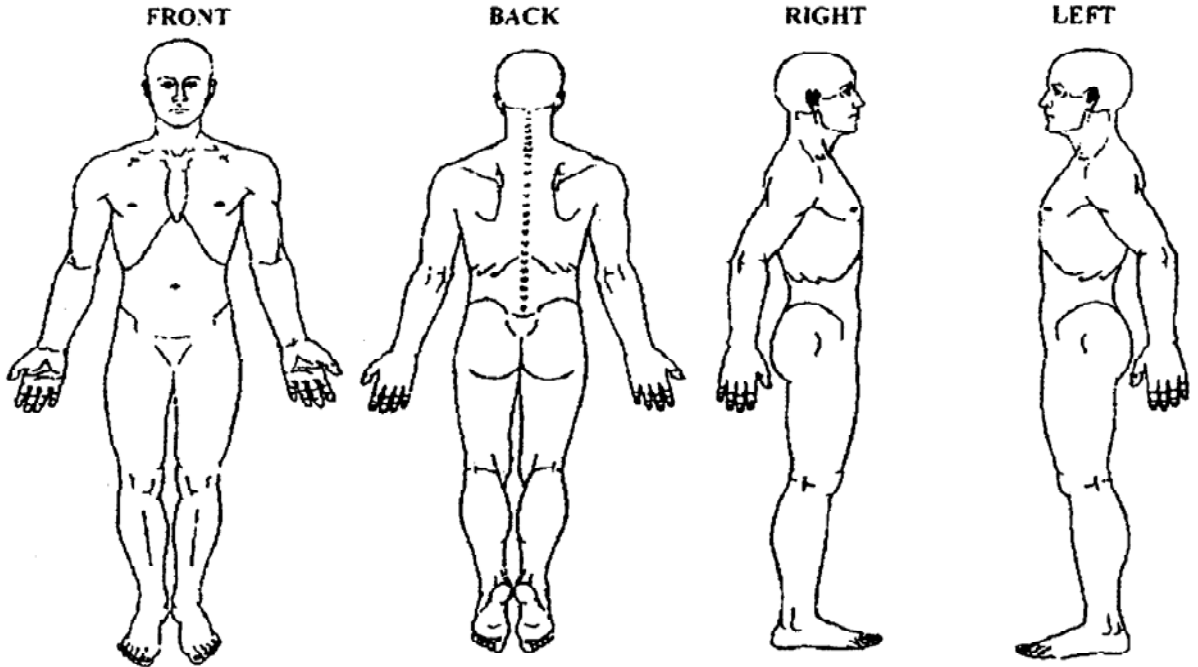
Frequency of urination: Day time \_\_\_\_\_ Night time \_\_\_\_\_

Urine Odor? \_\_\_\_\_

Color of Urine? Clear  Murky  Dark yellow  Blood in urine

**Initial** \_\_\_\_\_

**Pain Patients Only**



How would you describe your pain: Dull/achy  Sharp/stabbing  Burning  Tingling   
Throbbing  Soreness  Numbness  Electrical  Other  \_\_\_\_\_

Please write down the area of pain and the pain level on a scale of 1 to 10, 10 being the highest level of pain.

\_\_\_\_\_ ☺1  2  3  4  5  6  7  8  9  10  ☹

\_\_\_\_\_ ☺1  2  3  4  5  6  7  8  9  10  ☹

\_\_\_\_\_ ☺1  2  3  4  5  6  7  8  9  10  ☹

\_\_\_\_\_ ☺1  2  3  4  5  6  7  8  9  10  ☹

Integrative Acupuncture LLC. 220 Congress Park Dr. Suite #230, Delray Beach, FL. 33445

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