PATIENT ADMISSIONS FORM
PATIENT INFORMATION:

Patient Name: _____Birth Date: _____

Address: _____

Last 4 Digits of Social Security #: _____

Primary Phone Number:_____[ ]Home [ ]Mobile [ ]Work Sex: **M / F**

Secondary Phone Number:_____[ ]Home [ ]Mobile [ ]Work Email: _____

Place of Employment:_____Occupation: _____

Address:_____City:_____State:_____Zip: _____

Please list the family members or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**

Name:_____Telephone Number: _____

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation)：

Name:_____Telephone Number: _____

How do hear about us? ☐ Web ☐ Friends / Relative ☐ Ad ☐ Other

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If you or family member has had any following, please circle:

ADHA ☐ Anemia ☐ Allergies/Hay Fever ☐ Asthma ☐ Arthritis ☐ Anxiety/Depression Diabetes ☐
High Blood pressure ☐ High Cholesterol ☐ Heart Attack ☐ Kidney Disease ☐ Liver Disease ☐
HIV ☐ Respiratory Disease ☐ Skin Disease ☐ Stomach/Colon Disease ☐ Stroke ☐ Seizure Disorder ☐
Thyroid Disorder ☐ Other ☐

CURRENT HEALTH HISTORY

Main purpose of this appointment:

_____

_____

Other health concerns: _____

_____

Other treatments you have received for these conditions: (please circles):

Acupuncture Chiropractic Homeopathic MD Massage Naturopathic Osteopathy Shiatsu

Are there others in your family with the same conditions? _____

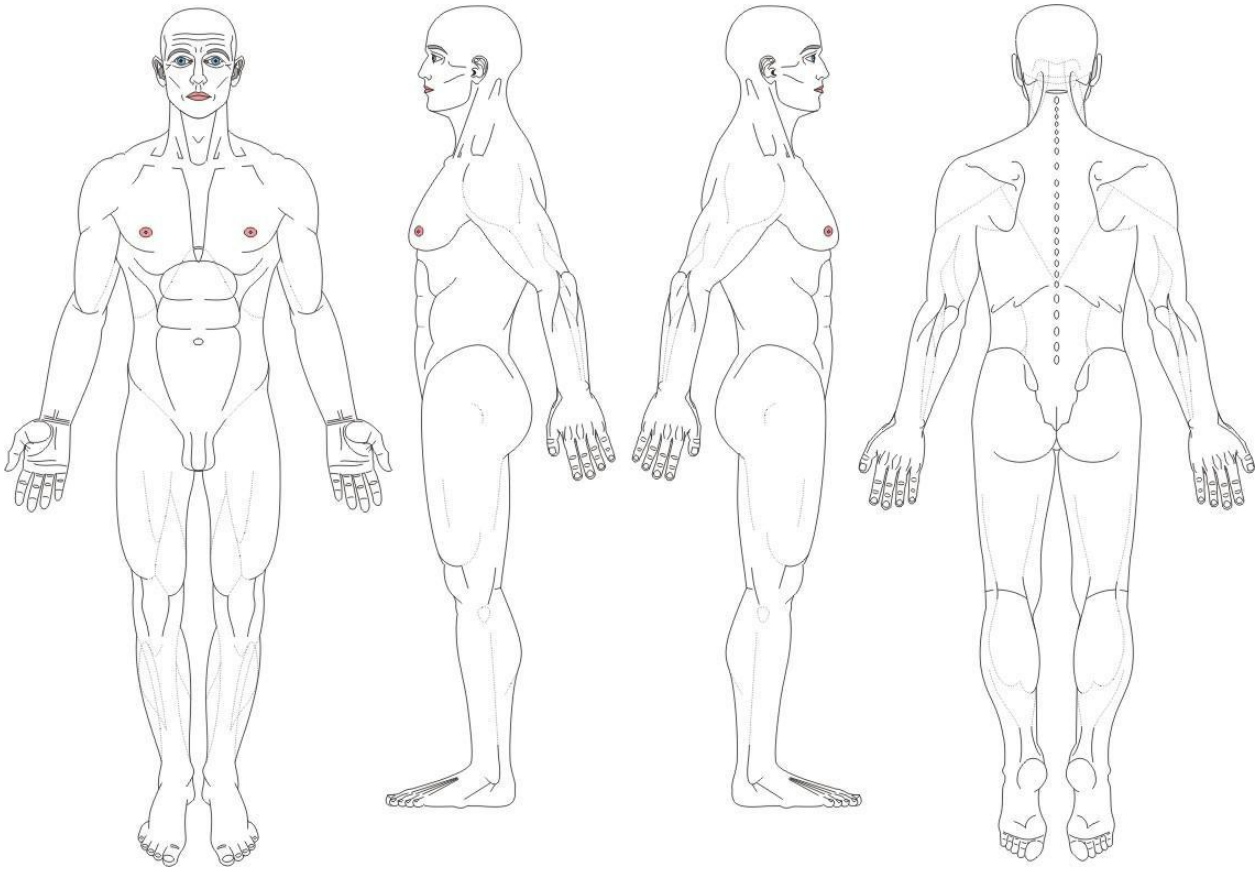
To what extent does this problem interfere with your daily activities (e.g. sleep, sex, work)? _____

_____

Please list all medications, herbs, supplements, home remedies, etc. that you currently take:_____

_____

PLEASE INDICATE YOUR AREAS OF DISCOMFORT OR PAIN



HEALTH HISTORY

Have you been treated for any health conditions in the past year? _____yes ____ no. If yes, Please explain:

_____

_____

Major illnesses/Injuries/Trauma (include dates) _____

_____

Your birth history, if known, premature, forceps delivery, prolonged labor, etc. _____

_____

Allergies (drug, chemical, foods, etc.) _____

_____

Family history of cancer, who/type: _____

CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH APPLY TO YOU (Now or recent past)

MUSCULOSKELETAL

__Low back pain
__Upper back pain
__Neck pain
__Arm pain
__Joint pain/stiffness
__Walking problems
__Difficult chewing
__Jaw clicking/popping
__Cold/Tingling extremities

NERVOUS SYSTEM

__Numbness
__Paralysis
__Dizziness
__Forgetfulness
__Confusion
__Depression
__Fainting
__Convulsions

GENERAL

__Allergies
__Difficulty sleeping
__Fever
__Headaches
__Migraines

CARDIOVASCULAR

__Chest pain
__Shortness of breath
__Irregular blood pressure
__Heart problems
__Lung problems
__Lung congestion
__Varicose veins
__Ankle swelling

GENITO-URINARY

__Bladder trouble
__Painful/excessive urination
__Discolored urine
__Urine leakage

EENT

__Vision problems
__Dental problems
__Sore throat
__Earaches
__Hearing difficulty
__Stuffed sinuses

GASTROINTESTINAL

__Poor/excessive appetite
__Vomiting
__Hemorrhoids
__Weight problems
__Gas/bloating after meals
__AM or __PM Bowel movements

__Excessive thirst
__Diarrhea
__Liver trouble
__Abdominal cramps
__Heartburn/indigestion

__Frequent nausea
__Constipation
__Bladder issues
__Bloody stools
__Colitis

MALE ONLY

__Prostate concerns
__Discolored urine

__Painful/excessive/decreasing urination
__Impotence

FEMALE ONLY

__Menstrual irregularity
__Vaginal pain/infections
__Discharge between cycles
__Sexual dysfunction

__Menstrual cramping
__Genital herpes
__PMS
__Breast limps/pain

__Vaginal dryness

__Age Menstruation started
__Days between cycles
__Usual days of low
__Light ___Medium ___Heavy flow

___ _ _ Date of last Pap
___ _ _ Date of last mammogram
___ _ _ Date of last menstruation

Contraception methods used_____

Current method _____

Ever use birth control pills? _____ yes _____ no

___# of pregnancies ___# of live births ___# of abortions

___# of D&C's ___# of Cesareans

___Hysterectomy, date of surgery_____

Any other female concerns not addressed: _____

Yin Acupuncture & Integrative Healing Center

1900 N. Mills Ave. Orlando, FL 32803
Phone: (407)256-3542 Fax: (407)790-4260

I hereby consent to the following provisions deemed necessary by Yin Acupuncture & Integrative Healing Center:

Patient's Name: (PLEASE PRINT):_____

A. **Treatment**: Any and all health care and treatment, which may include acupuncture, herbal formulas, TuiNa, cupping therapy, moxibustion, therapeutic exercises and/or nutritional counseling, I understand that needling and cupping therapy may cause bruising in some cases.

B. **Financial information**: All professional fees are due in full at the time services are rendered. I hereby acknowledge and accept full responsibility for any and all costs incurred. .

C. **Authorization of Compensation**: Payment is made directly to Yin Acupuncture & Integrative Healing Center for the amount due after services have been rendered. Payment can be made by major credit cards, cash or check.

D. **Authorization to Use and Disclose Health Information**: I authorize Yin Acupuncture & Integrative Healing Center to use all of my medical data for educational purposes. **Confidentially will be maintained.**

I authorize the release of any of my medical information to my insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care. Unless revoked earlier, this authorization will expire 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient Signature: _____ Date: _____

Witness Signature:_____ Date: _____

(YAIH) REPRESENTATIVE)

Yin Acupuncture & Integrative Healing Center

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures, we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____ Date: _____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____ Witness: _____

Date: _____

Printed Name (YAIH REPRESENTATIVE)