

PATIENT HISTORY

			ADDRESS:	ADDRESS:			
CITY: ZIP:		STATE:	STATE:		BIRTHDATE:		
	NESS: blem		y of thes	e illness/problems or "F" if a fam	ily me	embe	r has had any of these illness /
Υ	F	ILLNESS / DISEASE	Υ	ILLNESS / DISEASE	Υ	F	ILLNESS / DISEASE
		Alcoholism		Eye Problems			Rheumatic Fever
		Anemia		Glaucoma			Rubella, German Measles
		Anesthetic Reaction		Heart Disease			Stroke
		Asthma		High Blood Pressure			Suicide Attempt
		Cancer, Tumor		Kidney / Bladder Problems			Thyroid Disease
		Diabetes		Liver Disease (Hepatitis,			Ulcer (Stomach /
				Jaundice)			Duodenum)
		Drug Abuse		Lung Disease, Tuberculosis			Uncontrolled Bleeding
		Depression		Mumps, Measles, Chicken Pox			Venereal Disease
		Eczema, Hives, Rashes		Nervous Breakdown, Mental Illness			Other
		Epilepsy		Phlebitis			
	MEDICINE ALLERGIES: List those medicines to which you are allergic and the type of reaction for each.						
		TIONS YOU ARE TAKING: ist all prescription and non-pre	escriptior	n medications.			

HOSPITALIZATIONS:

Please list all illness / injuries / operations and the approximate year.

YEAR	ILLNESS / INJURY / OPERATION	HOSPITAL	CITY / STATE



Have you ever had a blood transfusion? Yes or No?						
Any reaction to the transfusion? Ye	Any reaction to the transfusion? Yes or No?					
Do you smoke?	If yes, how many p	If yes, how many packs per day? For how many years?				
What about alcohol consumption? Yes or No?		If yes, how many drinks pe	er day / week?			

PREGNANCY HISTORY

Please enter the number of:

TIMES PREGNANT	PREMATURE BIRTHS	
MISCARRIAGE	ABORTION	
LIVE BIRTHS	LIVING CHILDREN	
LIST ANY COMPLICATIONS:		

REVIEW OF SYSTEMS CHECKLIST:

Please check all that apply.

CONSTITUTIONAL		
night sweats	recent illness	malaise
anorexia	fatigue	weight gain / obesity
chills	fever	
sweating	insomnia	
EYES		
blindness	eye foreign body	eyelid swelling
eye discharge	eye pain	eyelid pain
eye redness	eye tearing	vision change
eye floaters	eye trauma	cataract
EARS / NOSE / THROAT / NECK		·
cancer	facial weakness	allergies
ear wax	headache	nasal pain
cosmetic deformity	hearing loss	polyps
dental pain	hoarseness	neck pain
dizziness	jaw pain	oral pain
facial fracture	lacerations of head or neck	sinus congestion
facial pain	nose bleeds	sleep apnea
snoring	sore throat	
CARDIOVASCULAR		
arrhytmia	fatigue	palpitations
chest pain	high blood pressure	fainting
swelling		
RESPIRATORY		
asthma	cigarette smoke	snoring
congestion	cough	vomiting
chest tightness		
GASTROINTESTINAL		
hemorrhoids	constipation	nausea
hepatitis	diarrhea	vomiting
abdominal pain	gas and bloating	



anorexia	jaundice	
GENITOURINARY / NEPHROLOGY		1
breast complaint	menstrual irregularity	testicular mass
flank pain	night urination	testicular pain
genital lesson	pap smear abnormality	urinary urgency
blood in urine	pelvic pain	urinary frequency
impotence	penile pain and discharge	urinary incontinence
menopausal symptoms	pregnancy	vaginal discharge
MUSCULOSKETAL	·	
stiffness	bone fracture	muscle weakness
swelling	bone pain	muscle pain
pain in joints	carpal tunnel syndrome	neck pain
back pain	joint complaint	osteoporosis
sciatica	shoulder pain	
DERMATOLOGIC	· ·	
eczema	sores	skin cancer
mole change	acne	skin lesion
pigmentation change	cyst	
rash	melanoma	
NEUROLOGIC		•
dizziness	back pain	speech difficulty
headache	limp pain	fainting
hearing loss	neck pain	weakness
memory loss	facial pain	spasms
mental status change	seizure	
PSYCHIATRIC		•
alcohol abuse	disturbance of consciousness	eating disorder
drug abuse	disturbance of emotion	hallucinations
anxiety	disturbance of memory	mania
depression	disturbance of thinking	
psychosis	suicidally	
ENDOCRINE	•	•
diabetes	hyperthyroidism	Chills
elevated blood sugar	hypothyroidism	
elevated cholesterol	obesity	
HEMATOLOGIC / LYMPHATIC	· ·	•
abnormal bleeding	abnormal bruising	anemia
ALLERGY / IMMUNOLOGY	,	
nasal discharge	food allergies	

Phone #:		Cellphone:		Work:	
Social Security #:			Occupation:		
E-mail: Age:			Weight:		Height:
Referred by:					
Main Problem:					
Do you have any needs for ski	ng or skin rejuvenatio	on?	o you have	sun spots?	
Are you unhappy with any areas of your body or weight?					



TRADITIONAL CHINESE MEDICINE CHECKLIST

List of herbs:							
Time of day you feel the best?	Time of day you feel the best? Favorite Season:						
Favorite color to wear?	Favorite color to wear?						
Menstrual issues?							
Heavy? Regular? Menopause? Age of first menses?							

DIZZINESS, BALANCE AND HEARING SCREENING

Please check Yes or No for each item.

Name:	Date of birth:	Date:		
	BALANCE DYSFUNCTION SCREENING		YES	NO
1. Do you ever lose your b	alance when standing still?			
2. Do you feel the need to	look for support or grab on to something	when you are moving around?		
3. Do you have problems j	udging distance when walking?			
4. Do you use an assistive	device (cane or walker) to move around?			
5. Have you fallen more th	an once the last year?			
6. Do you ever feel unstea	dy or lose your balance when walking?			
	YES	NO		
1. Do you feel dizzy or ligh	t-headed?			
2. Have you ever suffered	a stroke, head injury or neck trauma?			
3. Do objects appear to bo				
4. Do sudden changes in p	osition make your dizziness worse?			
5. Do you experience visio	n problems such as blurred or double visio	on?		
6. Do you have an increase	ed sensitivity to light and / or sound?			
	HEARING		YES	NO
1. Do you feel pain or pres	sure in your ears when you feel dizzy?			
2. Do you experience a rin	ging or buzzing in your ears?			
3. Have you noticed a decrease in hearing?				
4. Do you ask people to re	peat themselves?			

Speak with your physician about the questions you answered YES to because there are tests and treatments available that may improve your quality of life.



INSURANCE INFORMATION

Date:						
Patient's Name:		Date of Birth:				
Address:		City:	State:	Zip Code:		
Marital Status (Single / Married / Div	vorced / Widowed /	Separated):				
Policy Member ID #:		Group #:				
Policy Holder Name:						
Policy Holder Address (if different fr	om above):					
City:	State:		Zip Code:			
Date of birth of policy holder:		Social Security of	policy holder:			
Insurance Company:						
Address of Insurance Company:						
City:	State:		Zip Code:			
Phone Number of Insurance Compar	ny:					
Relationship to injured:						
I,benefit. I understand that until my in Patient's Signature	I,, authorize to submit a claim to my insurance company for my benefit. I understand that until my insurance company pays for my services I am responsible for the charges.					
Date Legal Guardian	-					
Legai Guardian						



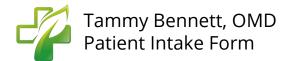
AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS

Date o	of Request:		
Patier	t's Name:	[Date of Birth:
Patier	t Phone:		
1. Info	ormation may be disclosed:	то	FROM
	Tammy Bennett, OMD		
	917 Rinehart Road, Suite 2061 Lake	Mary FI 32746	
	-1 ()	(407) 263-3044	
	rdx.	(407) 203-3044	
2. Inf	ormation may be disclosed:	то	FROM
Name	of Person / Practice:		
Addre	ss:		
Phone	2:	F	Fax:
3. Pur	pose of Disclosure		
	Changing Physicians		Continuity of Medical Care
	Personal Use		Others:
4. Info	ormation to be disclosed:		
	All Medical Records		Progress Notes
	History and Physical		Laboratory Results
	Radiology Results		Consultations
Other	:		
requir about	ed immunodeficiency syndrome (AIDS), or human immunoo and treatment of alco	ude information relating to sexually transmitted disease, odeficiency virus (HIV). It may also include information ohol abuse. This information is being provided to you Federal Law.
and pr	resent my written revocation to the of	fice. I understand tha	ime and further understand that I must do so in writing at the revocation will not apply to information that has horization will automatically expire 90 days from the
notice	·	scribing your rights ur	ise of a patient's Protected Health Information (PHI). The under the law. Patients have the right to access, inspect ons about them.
Patier	t Signature:	Date: _	
\\/itno	cci		



CONSENT TO REVIEW BLOOD WORK

	, hereby voluntarily request that, review my current blood work for the purpose of nutritional evaluation.							
understand that this is not a diagnosis of a specific illness or health condition, but a review of blood work for utritional supplementation and lifestyle counseling based on Traditional Chinese Medicine.								
•	for my health and well-being. It is my duty to be an informed partner in my is end, I will secure the necessary self-knowledge to participate in my healing							
Witness								
Patient's Signature								
 Date								
 Legal Guardian								



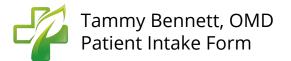
INFORMED CONSENT AND WAIVER

l,	, do hereby voluntarily request to receive clinical services
	I voluntarily consent that these services may
theory and Five Element Stimulati Cold Packs, biofeedback, Kinetic T	onal Chinese Methods, differential diagnosis based in Chinese Medicine on, Therapeutic Massage, Manual Therapy, Lifestyle Counseling, Hot and herapies and Qi Gong therapeutic breathing techniques. I acknowledge that o me as to the effect of such examinations, treatments, therapy or care of my
diagnosis or treatment of disease. produce varied physiologic effects various gates within the Central N	of the above services are meant to be considered by me as the WESTERN. Such treatment and examinations are used as an aid to help my body to heal itself. Several examples of physiologic effects are stimulation of ervous System, production of serotonin, endorphins, norepinephrine and egulation of the autonomic nervous system to name a few.
nature and purpose of the treatm	inning of any treatment procedure, I will receive an explanation of the ent and any probable risks involved. I understand that I may refuse service at consible for my health and well-being. It is my duty to stay informed of my
I understand that payment by cash	h, check or credit card is due at the time of service.
I understand that all the clinical in	formation will be kept confidential.
Witness	
Patient's Signature	
Date	



PATIENT QUESTIONNAIRE

1. Please list the family members of other persons, if any, who and your diagnosis (including treatment, payment and health	· · · · · · · · · · · · · · · · · · ·	
2. Please list the family members or significant others, if any, v IN AN EMERGENCY:	whom we may inform about your medical condition ONLY	
Name:	Phone Number:	
Name:	Phone Number:	
3. Please print the address of where you would like your billing sent, if other than your home:	g statement and/or correspondence from our office to be	
4. Please indicate if you want all correspondence from our officek which applies:	ice sent in a sealed envelope marked "CONFIDENTIAL".	
YES	NO	
5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number:		
6. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine?		
YES	NO	
PATIENT'S SIGNATURE	DATE	
WITNESS	DATE	



PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use 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 chance our Notice, you may obtain a revised copy by contacting our offices.

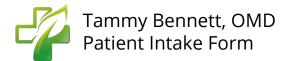
You do have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we are, we shall honor that agreement.

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 revocation shall not affect any disclosures we may have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health 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 the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

PATIENT'S SIGNATURE	DATE
WITNESS	DATE



FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Fees:

Our fees are determined by the complexity of each case and different services used.

Regarding Insurance:

We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document, you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Usual and Customary Rates UCR:

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. All payments are due at the time of service.

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to improve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns.

PATIFNT'S SIGNATURE	DATF

I have read the financial policy and I agree to this financial policy.