New Patient Information Form For All Services Performed By Serenity Holistic Wellness

2703 Egret Way, Frederick, Md. 21701 410-967-1773

Acupuncture treats the whole person. It is important to have a complete picture of your health. Please take the time to fill out this questionnaire accurately. All answers are confidential. Please use ink. Print this out on 1 side only-- Not double sided.

Name_____Date_____Date of Birth_____Age_____

Address_____City_____ State_____Zip_____

Telephone:
Home_____Work_____Cell_____

E-Mail Address_____
Occupation_____Employer_____

Would you like to receive and informative monthly acupuncture newsletter by e-mail?_____

Is there another insurance company? _____Is this an accident case involving attorneys or workers comp?___

Single____Married_____Divorced_____Widowed_____Living with_____

Referred by: _____

Have you had acupuncture before? _____How long ago_____

Current reason for seeking help_____

Other concerns_____

Initial cause_____

How long have you had this condition? _____ Have you experienced this before? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother your: Sleep_____Work_____Other_____

Other therapies you have tried for this condition_____

In case of emergency: Person to contact _____Phone_____

Physicians name _____Phone_____Date last seen_____

Medicines:

Prescription drugs you are currently taking	For what condition?
_____	_____
_____	_____
_____	_____
_____	_____

Over the counter medications and vitamins.	What condition are you taking it for?
_____	_____
_____	_____ _____
_____	_____

Major hospitalizations and Surgeries:
Year Operation or Illness

_____
_____
_____
_____

Lifestyle (How much, how many, how often)
Coffee/tea_____ Alcohol_____Glasses of water per day_____ What do you usually

drink during the day?_____ Cola: diet or regular_____Marijuana_____Other recreational drugs_____ Cigarettes_____

Exercise_____ How often? _____

What non-work activities do you enjoy doing? (reading, meditation, TV, music, etc.)_____

_____

Diet: any dietary restrictions_____ Food cravings_____

What might you eat on a typical day?
Breakfast_____
Lunch_____
Dinner_____
Snacks_____

PLEASE CHECK ALL THAT APPLY:

__Anxiety, uneasiness
__Agitated
__Irritable/ angry/frustrated
__Often feeling lonely, sad, isolated
__Feel as if carrying a heavy burden
__Worrying a lot
__Tendency to be shy or sensitive
__Do you feel a lot of grief or regret
__Difficulty relaxing, hard to sit still
__Easily startled
__Feeling clingy or needy
__Do you cry often?
__Do you feel depressed?
__Do you feel overwhelmed?
__ Are you afraid of the unknown?
__Are you frightened a lot?
__ Trouble making decisions?
__Have you ever considered suicide?
__ Are you seeing a therapist?
__Sense of Hopelessness
__Do you get sick easily?
__Fatigued a lot
__Trouble falling asleep routinely
__Trouble staying asleep
__Tired when you wake in the morning
__ Frightening dreams or thoughts?
__ Hot more than others?
__ Cold more than others?
__Forgetfulness/ poor memory
__Trouble focusing/ easily distracted
__Disturbed by work or family problems
__ Seasonal Affective Disorder?
__Mood swings
__Can you easily let go of things
__ Same thoughts often churning in the mind?
__ Are you passionate about things?
__ Is there enough fun in your life?
__ Are you a thrill seeker?
__ Would you like to learn to meditate?
___Winter Blues(SADD)

PLEASE PUT A "C" IF THE CONDITION IS CURRENT OR A "P" IF THE CONDITION IS PAST. IF YOU ARE NOT SURE HOW TO ANSWER, PLEASE CIRCLE. IF THE CONDITION DOES NOT APPLY LEAVE BLANK.

GENERAL
__AIDS/ HIV
__Alcoholism
__Cancer
__Diabetes
__Tumors
__Seizures
__Osteoporosis
__Emphysema
__Liver disease
__Drug Abuse
__Polio
__Rheumatic Fever
__Tuberculosis
__Hepatitis
__Thyroid Disorders
__Epilepsy
__Anemia
__Bleeding disorders
__Kidney disorders
__Trouble focusing/concentrating
__Fatigue
__Generalized weakness
__Stroke

SKIN & HAIR
__Rashes
__Hives
__Eczema
__Psoriasis
__Acne
__Hair loss
__Fungal infections
__Itching
__Night sweating
__Excess sweating
__No sweating
__Dry skin
__Changes in moles/lumps
__Feeling cold a lot
__Feeling hot a lot
__Change in hair or skin

RESPIRATORY
__Short of breath
__Tightness in chest
__Difficulty Breathing
__Environmental Allergies
__Seasonal Allergies
__Wheezing
__Asthma
__Wet cough
__Dry cough
__Chronic Cough
__Phlegm
Color of phlegm
_____
__Post nasal drip
__Coughing blood
__Pneumonia

GASTROINTESTINAL
__Acid reflux
__Recent weight gain/ loss
__Gas
__Bad breath
__Bloating
__Diarrhea
__Irritable Bowel
__Crones disease
__Constipation
__Laxative use
__Cramping/ pain
__Gurgling
__Intestinal pain
__Poor appetite
__Excessive hunger
__Nausea
__Vomiting
__Mucus in stools
__Bloody stools
__Strongly Prefer cold drinks
__Strongly prefer hot drinks
__Indigestion/ Heart burn
__Gall bladder disorder
__Bowel movement formed
__Bowel movement in pellets
Frequency of bowel movements a week_ _____

CARDIOVASCULAR
__Anemia
__Blood clots
__Shortness of breath
__Chest pain
__Chest tightness
__Phlebitis
__Heart palpitations
__Swelling in legs, ankles, feet
__Poor circulation
__Fainting
__Irregular heartbeat
__High blood pressure
__Low blood pressure
__Cold hands or feet
__Bleed or bruise easily
__History of heart attack
__Racing heart rate

NOSE, THROAT, MOUTH
__Grinding teeth
__TMJ
__Frequent sore throat
__Mouth / tongue ulcers
__Frequent colds
__Nosebleeds
__Dry nose
__Nasal congestion
__Loss of voice
__Thirst
__Facial problems
__Dry mouth
__Sinus infections
__Sinus Pressure/ Headaches
__Feeling lump in throat
__Dry, brittle fingernails
__Snoring
__Sleep Apnea

HEAD and NECK
__Headaches
Frequency_____
Duration_____
Location_____
__Migraines
Frequency_____
Duration_____
__Cause of HA or migraines
_____
__Other Head problems
_____
__Neck pain
__Neck stiffness
__Degenerative cervical disease
__Dizziness

GENITO-URINARY
__Pain with urination
__Frequent urination
__Urgent urination
__Blood in urine
__Incomplete urination
__Wake to urinate
How often?_____
__Kidney stones
__Burning with urination
__Burning or itching
around anus
__Hemorrhoids
__Increased libido
__Decreased libido
__Clear urine
__very yellow or dark urine
__Bedwetting

EYES
__Red eyes
__Itchy eyes
__Blurred vision
__Pain behind eyes
__Spots/ floaters
__Glaucoma/ cataracts

EARS
__Ringing in ears (tinnitus)
__Vertigo
__Hearing difficulty
__Earache/ infection

MUSCULAR- SKELETAL
__Knee pain
__Shoulder
__Neck pain
__Joint pain
__Muscle cramps or
Spasms
__Hand pain
__Low back
__Upper back
__Limited range of motion
__Hip pain
__Foot pain
__Arm Pain
__Muscular pain
__Pain changes in response
To weather
__Numbness
__Carpal Tunnel Syndrome
__Other_____
_____
__Swelling of feet/ hands

NEUROLOGICAL
__Seizures
__Tremors or tics
__Paralysis
__Other_____

MEN ONLY
__Impotence
__Premature ejaculation
__Nocturnal emission
__Pain/itching /redness
of genitalia
__Lumps in testicles
__Prostrate problems
__Burning on urination

INFECTION SCREENING
__Venereal disease
__HIV risks-self or partner
__TB self or household
__Hepatitis risk self or other
__Genital warts
__Herpes-oral or genital

OTHER CONDITIONS THAT APPLY TO YOU THAT ARE NOT LISTED

_____

_____

_____

_____

GYNECOLOGY: EVEN IF YOU HAVE EXPERIENCED MENOPAUSE, PLEASE FILL IN COMPLETE FORM WITH PAST PERIOD INFORMATION

Age first menses_____Date last menstrual period_____Length of flow_____Days between cycles_____

Menopause (date of onset) _____Symptoms from menopause_____

Any breakthrough bleeding since? _____Are you on hormone replacement therapy?_____

How long have you been on HRT? _____Any side effects? _____

Current method of contraception? _____Past method of contraception_____

Any complications from birth control? _____

Are you currently trying to be pregnant? ____ _____How long have you been trying?_____

Any known reason for not conceiving? _____ Has your mate been tested?_____

Are you currently pregnant? _____ If so, how many weeks? _____Any problems?_____

Pap smear: normal abnormal Date of last pap smear_____

Circle the Color of Blood: Pale Bright red Dark red Brown

Consistency of menstrual blood: thick thin watery normal

_____Number of pregnancies
____ Number of live births
_____Number of miscarriages
_____Number of abortions
____ Premature births

____Hysterectomy
____Age at time of hysterectomy
____Cysts
____Fibroids
____Endometriosis

____Vaginal sores/itching, pain
___ _Vaginal discharge
____Vaginal odor
____Uterine prolapse
_ _ __Urinary tract infections
_____ How frequent?

_____Night sweats
_____Regular periods
_____Heavy bleeding

____Spotting between periods
____Irregular periods
____Light bleeding

___ Breast lumps, fibroids

___Days between cycles

SYMPTOMS BEFORE OR DURING THE PERIOD –<u>ANSWER EVEN IF YOU ARE IN MENOPAUSE USING PAST HISTORY</u>

___abdominal distension
___Breast soreness
___Irritability, moodiness
___frequent, pale urination
___Tiredness
___poor sleep
___oppression in chest

___feeling hot, esp. hands and feet
___feeling cold
___ low sexual desire
___dizziness
___clots in the blood
___feeling agitation, aggressiveness
___cramps: how many days _____ When?_____

___poor memory
___Sore back or knees
___depression, sadness

INDICATE PAINFUL OR DISTRESSED AREAS AND ANY SCARS, EVEN IF THEY ARRE MINOR.

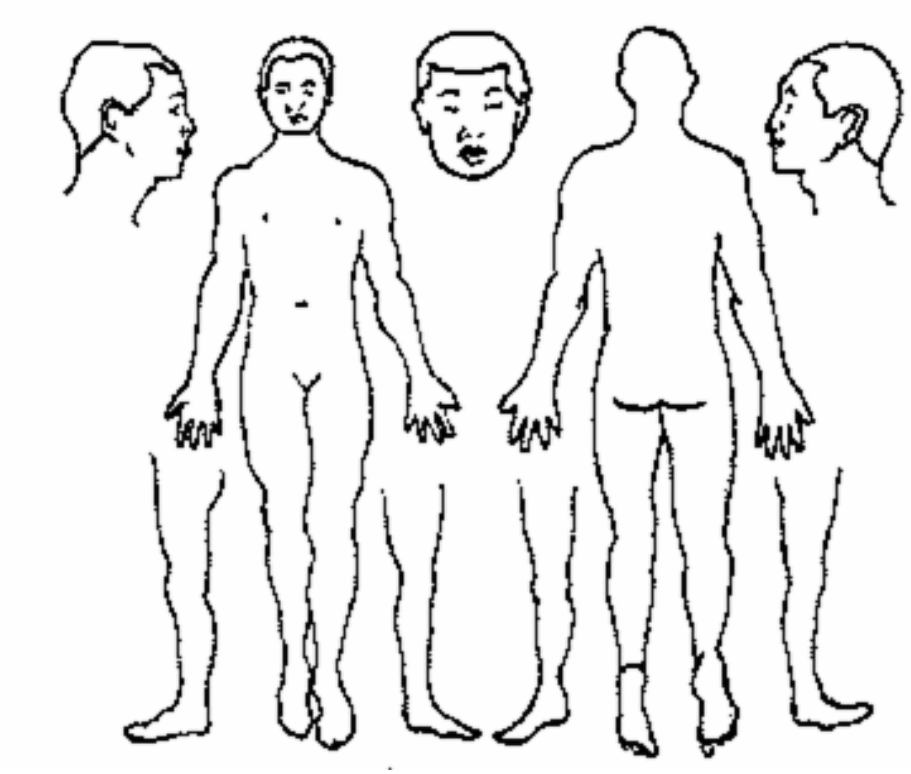
Use P for pain, D for discomfort, T for tightness, A for ache, and S for scar

Please rate the pain scale for each area

Is the pain: FIXED MOVING
SHARP DULL ACHY BURNING
CRAMPING OTHER:_____

DO THE FOLLOWING LESSEN
THE PAIN: REST MOVEMENT
HEAT COLD PRESSURE
OTHER:_____

DO THE FOLLOWING WORSEN
THE PAIN: REST MOVEMENT
HEAT COLD PRESSURE
OTHER:_____



How long have you had each condition?

_____

_____

_____

What is your overall energy level 0 to 10_____Best time of day for energy_____Worst time of day for energy_____

Time you go to sleep? _____Time it takes you to fall asleep?_____ Time you wake in the morning?_____How many times do you wake at night?_____ If you wake, how long to fall back asleep?_____ _____How many times do you use the bathroom at night?_____

HIPAA NOTICE OF PRIVACY PRACTICES for SERENITY HOLISTIC WELLNESS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS. If you have any questions about this notice please contact Sara Elijah 410-967-1773

WHO WILL FOLLOW THIS NOTICE

This notice describes our office's practice and that of: Any health care professional authorized to enter information into your medical chart. All employees and staff personnel

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting it. We create a record of care and services you receive in our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of our records of your care generated by our facility. You have the right to request restrictions on how this information is used, to authorize disclosure of your records to others, and be given an account of these disclosures.

We are required by law to:

Make sure that medical information that identifies you is kept private.

Give you this notice of our legal duties and privacy practices with respect to medical information about you

Follow the terms of this notice that is currently in effect.

HOW WE MAY DISCLOSE AND USE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways. Not every use or disclosure category will be listed.

For Treatment: We may use medical information about you to provide you with acupuncture/ healing treatment or services. We may disclose medical information about you to family members or others who play a role in your medical care.

For Payment: We may disclose and use medical information about you so that the treatment and services you receive at this facility may be billed and payment collected from your insurance company and or third party.

Appointment Reminders: We may disclose and use medical information to contact you as a reminder that you have an appointment for treatment.

Treatment Alternatives: We may use and disclose medical information to tell you about health- related benefits and services that may be of interest to you.

As required by law: We will disclose medical information about you when required to do so by federal, state and local law.

To avert Serious Threat to Health and Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health or safety, or the health and safety of another person. Any disclosure would only be to someone able to help prevent the threat.

Workers Compensation: We may release medical information about you for workers compensation or a similar program. These programs provide benefits for work- related illnesses.

Public Health Risks: We may disclose medical information about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including abuse, neglect, or domestic violence. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court order, subpoena, or other lawful process, whether submitted by you or by someone else.

YOUR INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: you have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit your request in writing. We may charge for the cost of copying, mailing, or other associated supplies associated with your request.

Right to amend: if you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request for an amendment if it is not in writing, or does not include a reason to support your request. In addition, we may deny your request if you ask us to amend information that:

Was not created by us, is not part of the medical information kept by us, is not part of the information which you would be permitted to inspect or copy, and is accurate and complete.
You have a right to a paper copy of this notice, at any time.
Changes to this notice: we reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. This notice is dated 7/17/2007.
Complaints: if you believe your privacy rights have been violated, you may file a complaint with this facility or the U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509 F, HHH Building
Washington, D.C. 20201
1- 800- 368- 1019
You may file your complaint with no fear of retaliation.
I have read and agree with the above information

_____ _____
Patient signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT FROM THE OFFICE OF SARA ELIJAH M.AC.

Your signature below confirms that you have received a copy of the "HIPAA notice of privacy practices," regarding your privacy rights and reviewed the HIPAA privacy practices or that you have been provided with an opportunity to review them, but waive your rights to read them.

You have received the HIPAA form electronically-- whether by reading the privacy practices notice on the website, or by downloading and printing it out from a computer. If you wish to receive a paper copy of this notice, you have the right to request one.

_____ _____
Patient or guardian signature Date

Serenity Holistic Wellness Frederick, Md. 21701 410-967-1773

INFORMED CONSENT FOR CARE

I hereby consent and request treatment by the performance of the services offered by Serenity Holistic Wellness, by Sara Elijah M.Ac. L.Ac. for acupuncture, cupping, and / or spiritual healing. I understand the performance of acupuncture may include, but not be limited to moxibustion, electrical stimulation, cupping, and herbal recommendations. Essential oils may also be recommended for your care.

I have been informed that the treatments are generally safe, but some side effects may occur. These are bruising, slight bleeding, tingling or numbness near a site that was needled that may last for a couple of days, fainting, and dizziness. Bruising also occurs with cupping. Burns can occur from moxibustion or heat lamps. There are low risks with acupuncture of lung puncture (pneumothorax), organ puncture or damage, or spontaneous miscarriage. Infections are very low risk due to a clean and safe environment for treatment, and the use of sterile, disposable needles.

By voluntarily signing below, I acknowledge that I have read, or have had the "Informed consent for care" read to me. I have been told about the risks of the services offered by Sara Elijah. I have also had the opportunity to ask any questions of her. This consent form covers treatment for conditions I am currently seeking treatment for, and for any future conditions that I may seek treatment for.

Patient Signature :_____Date: _____

Patient Name (print): _____ _Date: _____

Patient Representative:_____Date:_____

Relationship to Patient: _____

Serenity Holistic Wellness/ Sara Elijah M.Ac. L.Ac. M.Div.

Cancellation Policy

Your appointments are time set aside just for you. Last minute cancellations or missed appointments mean that someone else who needed the time may have been turned away. I ask that you accept responsibility for each appointment you schedule, and request that you notify me by phone (not email) at least 48 hours in advance of any changes. (24 hours does not give enough time to re-arrange the schedule or call other patients). Any appointment cancelled with less than 48 hours notice will be charged a cancellation fee of $50.00 for my lost time. If the time can be rebooked within 1 week, I will waive the fee. Cancelled/missed appointments are not covered by insurance. Except for emergency cancellations, the cancellation policy will go into effect. If you become ill, please call. I still may want you to be seen, since the treatment may be able to help you.

Financial Agreement

Payment not covered by insurance is appreciated and due at time of service. Although every effort has been made to get correct information from your insurance company, you agree to pay for any charges that are not covered by insurance for acupuncture services rendered. Information provided by your insurance company is not a guarantee of payment. You agree to pay any outstanding balance within 14 days of the invoice date.

By signing below, you acknowledge that you have read, understood, and agree to the cancellation policies and fees.

I (signature) _____(printed name)_____(date)_____

Hereby authorize Serenity Holistic Wellness to keep my credit card information in a locked cabinet, and on file while I am her client. I authorize her to charge my credit/ debit card for treatments, co-pays and co-insurance. I also give permission for her to charge my card for missed appointments, cancellation fees, or payment for services not covered by insurance. You will be notified of any charges by invoice or email.

Please provide a credit card at your appointment and Sara Elijah will fill in the section below:

Credit card #_____CVCnumber_____billing zip_____exp. date____Type____

Commitment to treatment

Your treatments are geared to producing overall good health, and not just treating your symptoms. I hope you will choose to participate in any "homework" I may recommend. Success in treating your condition may also benefit from lifestyle changes.

The progress of your healing depends on your commitment. Better results are achieved with regular appointments. The treatments build upon one another.

Signing this agreement signifies you understand the policies.

_____ _____

Signature of patient Date

I look forward to supporting you on your journey to wellness and wholeness.