

Blue Q Health & Wellness

Name: _____ Today's Date: _____

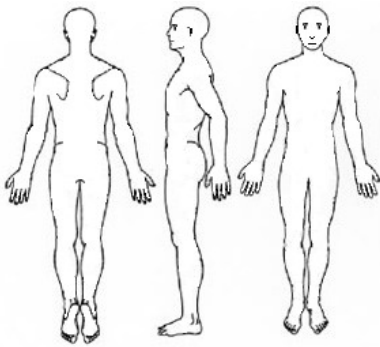
Address: _____ City/State/Zip: _____

Insurance: _____ Date of birth: _____

Phone: _____ Email: _____

Main Complaint/Reason for Visit: _____

Area(s) of complaint (circle on diagram); Please describe in the blank space to the right of the diagram:



Stiffness Soreness Numbness Tingling Weakness Swelling Dull Achy Sharp Stabbing Burning

If you are experiencing pain, please circle a number: (No Pain) **0-1-2-3-4-5-6-7-8-9-10** (Severe)

When did your symptom(s) begin? _____

How often do symptoms occur? (Circle One) Occasional Intermittent Frequent Constant Is the complaint getting: (Circle One) Better Worse Same/Not Changing N/A

Affected Activities of Daily Living: _____

What makes the problem(s) better? _____

What makes the problem(s) worse? _____

Medical History:

Have you treated elsewhere for this condition? N or Y (Date of last visit: _____)

Name/Location/ Phone: _____

Do you have a Family Physician? N or Y (Do we have your permission to contact them: Y or N)

Name/Location: _____

Blue Q Health & Wellness

Have you been hospitalized last 5 yrs? N or Y (explain) _____

Have you had Surgery last 5 yrs? N or Y (explain) _____

Have you had a serious Accident/Injury last 5 yrs? N or Y (explain) _____

Do you have any Allergies? N or Y (list) _____

Are you currently taking any Medication? N or Y (list) _____

WOMEN ONLY:
 Are you currently pregnant? Y or N (Yes, due date: _____)
 Date of Last Physical Exam: _____ Where? _____

REVIEW OF SYMPTOMS: Which of the following conditions do you now have or have you previously had? (circle)

- | | | | | |
|-----------------------|----------|-------------------|---------------|----------------|
| Arthritis | Asthma | Sinus Issues | Blood Clotts | Allergies |
| Tuberculosis | Diabetes | Vertigo | ADD/ADHD | Epilepsy |
| Migraine/HA's | Thyroid | High BP | Low BP | Heart Trouble |
| Pacemaker | HIV/AIDS | Cancer | Polio | Scoliosis |
| Mental/Emotional | | Prostate Trouble | Hormonal | Dislocation |
| Disc Herniation/Bulge | | Rheumatic Fever | Bone Fracture | Osteoporosis |
| Kidney Disease | | Digestive Trouble | Acid Reflux | Sleep Disorder |

Family History:

	Cancer	Diabetes	Blood Pressure	Heart Attack	Stroke	Osteoporosis	Arthritis	Scoliosis	Other
Father									
Mother									
Sibling (s)									
Child/Children									
Grandparent(s)									

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I understand that my health information will remain private and will not be shared with anyone without my written or verbal approval. I have received a copy of Blue Q Health and Wellness PLLC Notice of Privacy Practices. I understand that Blue Q Health and Wellness PLLC has the right to change its Notice of Privacy Practices from time to time and that I may contact Blue Q Health and Wellness PLLC at any time to obtain a current copy of the Notice of Privacy Practices. I authorize the sharing of my health information with the following party or parties listed below:

(List any names of lawyers, doctors, or family members who may contact us for your health information)

 Patient Name (or Guardian)

 Date

 Representative of Blue Q Health and Wellness

 Date

Blue Q Health & Wellness

ACUPUNCTURE

Name: _____ DOB: _____ Today's Date: _____

Have you been to an Acupuncturist? **N** or **Y** Date or year of last treatment: _____

Type of Acupuncture and outcome: _____

<p style="text-align: center;"><u>Main Complaints</u></p> <p>Please write in your top 3 health complaints/concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1= no symptoms, 10=worst ever).</p>	<p><u>Questions/Comments/Concerns:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>1 _____</p> <p>When did this start? _____ ago</p> <p>Heat makes it: better no change worse</p> <p>Cold makes it: better. No change. Worse</p> <p>Damp weather: better. No change. Worse</p> <p>Exercise/activity: better. No change. Worse</p> <p>0 1 2 3 4 5 6 7 8 9 10</p>	<p><u>Goals of Treatment:</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>2 _____</p> <p>When did this start? _____ ago</p> <p>Heat makes it: better no change Worse</p> <p>Cold makes it: better. No change. Worse</p> <p>Damp weather: better. No change. Worse</p> <p>Exercise/activity: better. No change. Worse</p> <p>0 1 2 3 4 5 6 7 8 9 10</p>	<p style="text-align: center;"><u>Habits</u></p> <p>Amount/Week. If Quit, Year?</p> <p>Coffee/Tea _____</p> <p>Soda _____</p> <p>Tobacco _____</p> <p>Alcohol _____</p> <p>Drugs _____</p>
<p>3 _____</p> <p>When did this start? _____ ago</p> <p>Heat makes it: better no change worse</p> <p>Cold makes it: better. No change. Worse</p> <p>Damp weather: better. No change. Worse</p> <p>Exercise/activity: better. No change. Worse</p> <p>0 1 2 3 4 5 6 7 8 9 10</p>	<p>MISCELANEOUS INFO:</p> <p>_____</p> <p>_____</p> <p>_____</p>

Informed Consent for Acupuncture and Chinese Medicine Treatments

I, _____, voluntarily consent to be treated with acupuncture and other procedures within the scope of practice of acupuncture administered by a Florida licensed provider at Blue Q Health and Wellness.

I understand that acupuncture is performed by the insertion of sterile, disposable needles through the skin at certain points on or near the surface of the body. I understand that such treatment is intended to improve body function and to relieve pain. I understand that the methods of treatment may include, but are not limited to: acupuncture, moxibustion, heat lamp, bloodletting, cupping, gua sha, Tui-Na (Chinese medical massage/body work), Chinese herbal medicine, electrical stimulation (e-stim) applied to acupuncture needles, and nutritional counseling.

I understand that while rare, side effects may result. These could include, but are not limited to, temporary pain or discomfort, some local bruising, hematoma, slight bleeding, fainting, nausea, burns, pneumonia, spontaneous miscarriage, strong emotional response, and the temporary aggravation of pre-existing conditions. Bruising/red marks are a common side effect of cupping, and usually last several days to one week in most cases.

Any recommended herbs (which are from plant, animal, and mineral sources) are traditionally considered safe in the practice of traditional Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify my acupuncturist if I am or become pregnant. Some of the possible side effects of taking Chinese herbs are nausea, gas, stomachache, headache, diarrhea, rashes and hives. I will immediately notify my acupuncturist of any unpleasant effects associated with the consumption of herbs.

I understand that if my condition worsens, or if it does not improve in the time estimated by my acupuncturist, or if a new condition arises, that I should consult my personal physician. I accept that no guarantee is made concerning the results of my treatment and that I am free to discontinue treatment at any time.

I consent to the use and disclosure of my protected health information for treatment, payment and/or clinic operations. 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.

I have carefully read and understand all the above information and fully aware of what I am signing. I have felt free to ask any questions. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Signature of Patient (Or Guardian)

Date Signed

Office Signature

Date Signed

Cancellations and Missed Appointment Policy

Appointments canceled same day or missed (no call/no show) will incur either a **\$30 charge, the full service amount, or count toward the service package.** All appointments must be canceled or rescheduled by the close of the day prior (7:00pm the day before) in order to avoid the charge or package deduction.

I acknowledge and understand the policy and have been given a copy for my records (if requested).

Signature

Date

(Please complete if verifying insurance benefits)

ASSIGNMENT OF BENEFITS

I, _____, assign all of the rights and benefits of any applicable health insurance policies, personal injury protection, medical payments, or other coverage provided by any insurance policy issued pursuant to Florida Statutes §627.730 - §627.7405, to Blue Q Health and Wellness PLLC, for services and supplies provided to me. I agree to pay any co-payment or deductible not covered by the applicable health insurance policy, personal injury protection, medical payments, or other insurance coverage.

This assignment includes, but is not limited to:

- all rights to collect benefits directly from any insurance carrier obligated to provide
- benefits for services and supplies I have received;
- all rights to take legal or other action against any insurance carrier obligated to provide
- benefits if for any reason the insurance carrier fails to pay any benefits due; and
- all rights to recover attorney fees, legal assistant fees, costs, and any interest on fees
- and costs, for any legal or other action taken by Blue Q Health and Wellness PLLC as my assignee.

This is an assignment of rights only, and is not a delegation of any of my duties under the subject insurance policy. I agree that Blue Q Health and Wellness PLLC or health provider may retain any attorney it chooses to bring legal action against any insurance carrier obligated to provide benefits for services and supplies I have received, and that the attorney chosen may be different than any attorney I may have handling any claim I may have for personal injuries. I have been given a copy of this assignment to retain for my records; I have read this assignment and I am satisfied that I fully understand the purpose and implications of executing this assignment and do so freely and voluntarily.

Patient Name (or Guardian)

Date

The undersigned, as authorized representative of Blue Q Health and Wellness PLLC accepts the assignment of benefits as set forth above.

Representative of Blue Q Health and Wellness

Date

We hope that you enjoy your treatment and tell others!

*If there is anything else that we can do here at blue Q Health and Wellness to make your treatment even better, please let our front desk know :)