Confidential Patient Health Record ***Today's Date*:____/_____/_____**

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Advertisement ☐ Hospital ☐ Insurance Plan

Personal Information

Last:_____ First:_____ Middle: _____

Birth Date: ____ /____/_____ Age:_____ Sex: Male / Female Social Security #: _____-_____-_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ ext _____

Cell Phone: (_____) _____-_____ Fax #: (_____) _____-_____

Email Address: _____ Spouses Name: _____

Children (Names and Ages): _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Current Health Condition

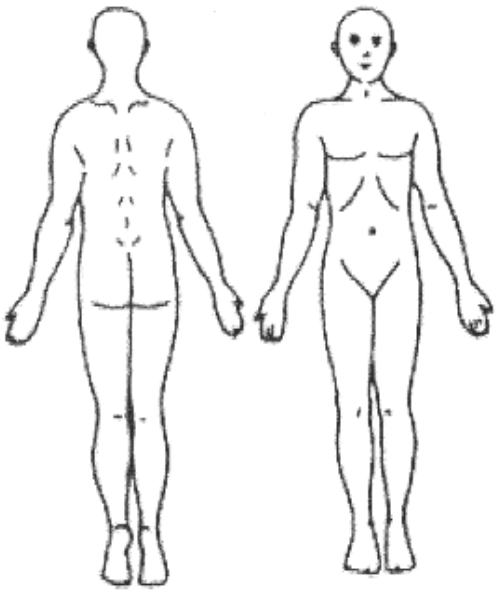
Unwanted Condition (Why you are here today?):_____

_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT
→→→→→→→→

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN? _____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No. When? _____

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

_____

Date of Accident: _____

Time of Accident: _____ am /pm

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____
_____
_____
_____
_____

Condition: ☐ **New →☐ Acute or ☐ Chronic**
☐ **Recurrence (Acute)** ☐ **Exacerbation (Acute)** ☐ **Chronic**

Description of Onset of Complaint: _____

Current Symptoms: ☐ Pain ☐ Numbness ☐ Stiffness ☐ Weakness

Location: ☐LEFT ☐ RIGHT ☐Bilateral

Quality: ☐ Burning ☐ Diffuse ☐ Dull/Aching ☐ Localized ☐ Radiating ☐ Sharp ☐ Shooting
☐ Stabbing ☐ Throbbing ☐ Tightness ☐ Tingling ☐ Other _____

Level of Impairment Due to Symptoms (Resting):
0 1 2 3 4 5 6 7 8 9 10

Level of Impairment Due to Symptoms (With Activity):
0 1 2 3 4 5 6 7 8 9 10

Timing: ***Worse*:** ☐ Morning ☐ Afternoon ☐ Night ☐ with Activity; ☐ Constant ☐ Intermittent

Context: ***Better with:*** ☐ Warm Temp ☐ Cold Temp ***Worse with:*** ☐ Warm Temp ☐ Cold Temp ☐ Damp

Assoc Signs and Symptoms: ☐ Blurred Vision ☐ Depression ☐ Dizziness ☐ Irritability/Mood Swing ☐ Localized Tingling ☐ Nausea
☐ Ringing in Ears ☐ Sleep Disturbance ☐ Stiffness

Radiation: ☐Left☐Right☐Bilateral **Weakness: ☐Left☐Right☐Bilateral**

Other Assoc Signs and Symptoms: _____

Modifying Factors:

Symptoms Better With:

☐ nothing helps	☐ activity	☐ bending	☐ applying cold	☐ applying heat
☐massage	☐ movement	☐ OTC meds	☐ Rx meds	☐ rest
☐ stretching	☐ sitting	☐ standing	☐ twisting	☐ walking

Symptoms Worse With: (as noted in Social History)

Since condition began, has anything permanently helped you? ☐ YES ☐ NO
Has anything that you have done, thus far, fixed your problem? ☐ YES ☐ NO

Employment:

Occupation/Job Title: _____ Work: _____ hrs / day or week

Description of Work: _____

Condition's Effect On Job Performance:

☐**Mild** Painful (Can do) ☐**Mod** Painful (limited ability) ☐**Mod/Severe** Limited Duty ☐**Severe** No Limited Duty ☐**Severe** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Bending:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod**Painful (Limited)	☐**Severe**Unable to Perform
Change Posn–Sit-Stand:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe**Unable to Perform
Driving:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod**Painful (Limited)	☐**Severe** Unable to Perform
Extended Computer use	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe**Unable to Perform
Household Chores:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe**Unable to Perform
Lift Children:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod**Painful (Limited)	☐**Severe**Unable to Perform
Lifting:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod**Painful (Limited)	☐**Severe**Unable to Perform
Reading -Concentration	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod**Painful (Limited)	☐**Severe**Unable to Perform
Sitting:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe**Unable to Perform
Standing:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe**Unable to Perform
Walking:	☐**No Effect**	☐**Mild** Painful (Can do)	☐**Mod**Painful (Limited)	☐**Severe**Unable to Perform
Yard Work:	☐**No Effect**	☐**Mild**Painful (Can do)	☐**Mod** Painful (Limited)	☐**Severe**Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

_____ ☐**No Effect** ☐**Mild**Painful (Can do) ☐**Mod**Painful (Limited) ☐**Severe** Unable to Perform

_____ ☐**No Effect** ☐**Mild** Painful (Can do) ☐**Mod** Painful (Limited) ☐**Severe** Unable to Perform

PAST HEALTH HISTORY – Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

☐**I have not previously seen a doctor for this condition OR Fill in the information BELOW**

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____

Type of Treatment: _____ Were you satisfied with the results of your treatment? ☐ Yes ☐ No

Explain: _____

Current Medication (s) and vitamins, minerals or herbs **- List ANY/ALL you are CURRENTLY taking. Be Specific.**

_____

_____

_____

_____

Injury (ies): **List All Injuries. Write the DATE of the Injury immediately afterward.**

_____

_____

_____

Non-Drug Allergies: **Please list any known non-drug allergies below.**

_____

_____

Adult Illness (es): **LIST all health conditions.**

_____

_____

Surgery (ies): **LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.**

_____

_____

_____

REVIEW OF SYSTEMS-Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall course of care.***Check what may apply to you; if none apply, check the "I DENY" box.***

Constitutional (General): ☐ **I DENY having or have had any of the symptoms or problems listed below.**

☐ chills ☐ fever ☐ fatigue ☐ weight loss ☐ weight gain ☐ daytime drowsiness ☐ night sweats

Eyes/Vision: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ blindness ☐ eye pain ☐ change in vision ☐ field cuts ☐ photophobia ☐ itching

☐ blurred vision ☐ double vision ☐ glaucoma ☐ tearing ☐ cataracts

Ears, Nose and Throat: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ bleeding ☐ nasal congestion ☐ hearing loss ☐ nosebleeds ☐ sore throat

☐ dentures ☐ ear pain ☐ ear drainage ☐ history of head injury ☐ postnasal drip ☐ tinnitus

☐difficulty swallowing ☐ fainting ☐ headaches ☐ hoarseness ☐ snoring ☐ rhinorrhea ☐ TMJ problems

☐ discharge ☐ frequent sore throats ☐ loss of sense of smell ☐ sinus infections ☐ dizziness

Respiration: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ asthma ☐ coughing up blood ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ angina (chest pain or discomfort) ☐ shortness of breath with exertion or exercise ☐ heart problems
☐ paroxysmal nocturnal dyspnea ☐ low blood pressure ☐ high blood pressure ☐ swelling of legs
☐ claudication (leg pain/ache) ☐ orthopnea (difficulty breathing lying down) ☐ ulcers ☐ varicose veins
☐ heart murmur ☐ palpitations

Gastrointestinal: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ abdominal pain ☐ diarrhea ☐ nausea ☐ indigestion ☐ abnormal stool caliber ☐ vomiting blood
☐ vomiting ☐ jaundice ☐ abnormal stool color ☐ hemorrhoids ☐ difficulty swallowing ☐ constipation

Endocrine: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ cold intolerance ☐ excessive hunger ☐ excessive thirst ☐ goiter ☐ diabetes ☐ unusual hair growth
☐ heat intolerance ☐ abnormal frequency of urination ☐ hair loss ☐ voice changes

Skin: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ changes in nail texture ☐ hair loss ☐ hair growth ☐ history of skin disorders ☐ skin lesions / ulcers
☐ changes in skin color ☐ hives ☐ itching ☐ rash ☐ paresthesias ☐ varicosities

Nervous System: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ dizziness ☐ limb weakness ☐ numbness ☐ slurred speech ☐ tremor
☐ facial weakness ☐ loss of consciousness ☐ seizures ☐ stress ☐ loss of balance
☐ headache ☐ loss of memory ☐ sleep disturbance ☐ strokes

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anhedonia ☐ loss or change in appetite ☐ behavioral change ☐ convulsions ☐ memory loss
☐ anxiety ☐ confusion ☐ insomnia ☐ bi-polar disorder ☐ depression ☐ mood change

Allergy: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anaphylaxis ☐ food intolerance ☐ acute nasal congestion ☐ chronic nasal congestion ☐ sneezing

Hematological: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ anemia ☐ bleeding ☐ fatigue ☐ blood clotting ☐ bruising easily ☐ lymph node swelling

Male: ☐ **I DENY having any of the symptoms or problems listed below.**

☐ burning urination ☐ frequent urination ☐ prostate problems ☐ urine retention
☐ erectile dysfunction ☐ hesitancy/dribbling

Female: ☐ **I DENY having any of the symptoms/problems and/or using any of the items listed below.**

☐ birth control ☐ cramps ☐ hormone therapy ☐ irregular menstruation ☐ vaginal bleeding
☐ breast lumps/pain ☐ frequent urination ☐ pregnancy ☐ urine retention ☐ vaginal discharge

Family History: **Mark all that apply below. List any specific conditions past or present after has/had:**

father ☐ alive ☐ deceased ☐ normally developed ☐ no significant disease ☐ has/had:_____
mother ☐ alive ☐ deceased ☐ normally developed ☐ no significant disease ☐ has/had:_____

Social History: **Mark all that apply below.**

Alcohol: ☐ do not drink alcohol ☐ social consumption only ☐ drink the following regularly (mark below)
Quantity of _____ oz./glasses per ☐ day ☐ week ☐ month

Substance: ☐ never used illegal drugs ☐ has not used illegal drugs since _____ .
☐ never used IV drugs ☐ used illegal drugs for _____ (how long?)

Tobacco: ☐ Do not use ☐ Type_____ Amount_____

SECTION A. PRIVACY PRACTICE INFORMATION (HIPPA)

To obtain more information about your privacy rights or if you have questions you want answered about your privacy rights (as provided by Privacy Rule Section 164.520(b)(2)(vii)), you may contact the Practice's Privacy Officer as follows:

NAME: Nigel Brayer
ADDRESS: 11443 State Road
North Royalton, Ohio 44133
PHONE: (440)877-9440

PRACTICE'S REQUIREMENTS

The Practice is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

a) Under the Privacy Rule, may be required by state law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided under federal law.
b) Is required to abide by the terms of this Privacy Notice.
c) Reserves the reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
d) Will distribute any revised Privacy Notice to you prior to implementation.
e) Will not retaliate against you for filing a complaint.

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notices of Privacy Practice,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or Disclosure that occurred prior to the date I revoke that consent is not affected.

EFFECTIVE DATE

This notice is in effect as of April 15, 2020.

SECTION B. POLICIES FOR PATIENTS

To help you receive our best, all patients are accepted for care based on the following policies by signing you agree to policies below:

- **Appointment Scheduling:** To save you time on each visit we ask that you pre-schedule your appointments in advance and that you refrain from repeatedly rescheduling appointments. In order to keep your progress on schedule, rescheduled appointments should be made up within 48 hours of the original scheduled time.

- **Acupuncture is a self pay service:** We do not bill insurance for acupuncture treatments.

- **Broken Appointments:** **There is a $73 fee for a missed or forgotten Acupuncture appointment**. If you repeatedly miss or reschedule appointments or we must continually call you to reschedule, we will regretfully need to discharge you from our care. **Any massage, acupuncture or nutritional appointment that is not rescheduled or canceled with less than 24 hours notice, the total cost of appointment will still be owed.**

- **Financial Agreements:** It is your payment that allows us to continue providing high levels of professional care, maintain our facility and pay our staff. If for any reason you cannot keep your financial agreement, please inform us

immediately to eliminate any misunderstandings. If you have the desire to receive care in our office, we will make every attempt to make affordable arrangements. Balance in full must be paid upon dismissal unless other arrangements have been made. **A 5% service charge will be added monthly to any unpaid balance**. I understand if I purchase any prepaid or discounted services or treatment plans (these are services additionally discounted when prepaid) these will expire in 2 years from the time of purchase. A refund for any unused funds can be requested in writing at any time within those 2 years. This will be completed by check within 14 days of written request. I understand that after 2 years if no request is made, I forfeit any prepaid plan, or discounted treatment plan monies on account.

By my signature below, I have read and agree to the terms in the above sections A and B of the Living Tree Center for Healings' Confidential Patient Health Record forms, covering Living Tree Center for Healing's, Privacy Practice Information (HIPAA) (Section A) and Policies for Patients (Section C).

Patient Signature_____ Date _____

Parent / Guardian Signature _____ Date_____

Staff Initials: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communications barriers prohibited obtaining that acknowledgement
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (Please Specify)_____

Date: _____ Initials: _____ Explanation: _____

Acupuncture Informed Consent to Treat

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with the information to assist me in making informed choices. This process if often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturist/s named below, including those working at Living Tree Center for Healing, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, dry needling and nutritional counseling.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but as with all types of healthcare interventions, there are some risks to care including, but not limited to: bruising, numbness or tingling near the needling site that may last a few days, dizziness, or fainting. Burns and or scarring are potential risks of moxibustion/cupping, or when treatment involves the use of heath lamps/infrared lamps. Bruising is a common side effect of cupping/acupuncture. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify a staff member of the acupuncturist who is caring for me if I am or becoming pregnant or nursing.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinic staff to exercise judgement during the course of treatment. I understand that as with all healthcare, results are not guaranteed and there is no promise of a cure.

I understand that I must inform and continue to fully inform this office of any medical history, medications, and or supplements being taken currently (prescription/over the counter). I understand the Clinical and administrative staff my review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition, other than acupuncture procedures. These options may include, but not limited to: self-administered care, over the counter pain relievers, physical measures, and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.
By voluntarily signing below I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of my treatment for my present condition and for any future conditions for which I seek treatment.

Patient Name:_____Date_____

Patient Signature_____

Acupuncturist name: Dr Nigel Brayer, Dr Harish Rai Living Tree Center for Healing

Acupuncture Cancellation Policy

Due to limited appointments and high demand for acupuncture services, patients MUST give **24 HOURS NOTICE** to cancel Acupuncture/Cupping appointments.

Any missed or late cancelled appointments will be assessed with our regular session fee of $73 dollars, or 1 pre-pay visit will be surrendered.

We appreciate your cooperation in ensuring you receive the highest quality care.

I HAVE READ AND UNDERSTAND THE ACUPUNCTURE/CUPPING CANCELLATION POLICY

Patient Name:_____Date:_____

Patient Signature:_____