Patient Intake Form

Name:	Phone: Home	Work
Street	Age Ht.	Wt.
City	Birthdate	Sex
State Zip	Occupation:	
Physician:	Referred By:	Emerg. #:
Main Problem:		Onset:
Other Concurrent Therapies		

Past Medical History (include date):

Significant Illnesses: ___ Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___ Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ Other.

Surgeries:

Significant Trauma (auto accidents, falls, etc.)

Birth History: (prolonged labor, forceps delivery, etc.)

Allergies: (drugs, chemicals, foods.)

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses (Chemical, physical, psychological,etc.)

Exercise:

Comments:

Average daily diet:

Morning *Afternoon* *Evening*

Habits: Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt Other ___

Family Medical History: ___Diabetes ___Cancer ___ High Blood Pressure ___ Heart Disease ___Stroke ___ Seizures ___ Asthma ___Allergies ___Alcoholism ___ Other ___

Notes ___

GENERAL

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Insomnia
- ☐ Fatigue
- ☐ Tremors
- ☐ Vertigo
- ☐ Cold hands
- ☐ Cold feet
- ☐ Cold back
- ☐ Cold abdomen
- ☐ Fevers
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Cravings
- ☐ Localized weakness
- ☐ Poor coordination
- ☐ Change in appetite
- ☐ Sudden energy drop at _____ (time)
- ☐ Peculiar tastes/smells ___
- ☐ Strong thirst (cold/hot drinks) ___
- ☐ Bleed or bruise easily (where) ___

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Loss of hair
- ☐ Change in hair/skin texture
- ☐ Purpura
- ☐ Other hair or skin problem ___

HEAD, EYES, EARS, NOSE, AND THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glassses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Mucus
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Copius saliva
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Grinding teeth
- ☐ Facial pain
- ☐ Gum problems
- ☐ Spots in eyes
- ☐ Recurrent sore throats _____/month
- ☐ Sores on lips or tongue
- ☐ Headaches (where and when) ___
- ☐ Other head or neck problems

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest Pain ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feet ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Difficulty in breathing when lying down ☐ Tight chest
☐ Production of phlegm _____what color _____ ☐ Other lung problems

GASTROINTESTINAL

☐ Nausea ☐ Vomiting ☐ Diarrhea Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools _____Frequency
☐ Bad Breath ☐ Rectal pain ☐ Hemorrhoids _____Color
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen _____Odor
☐ Pain or cramps ☐ Laxative use:_____ /week; type _____ _____Texture/form

GENITO-URINARY

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate
☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency
☐ Wake up to urinate How often_____/night; time:_____ ☐ Other G/U problems

PREGNANCY AND GYNECOLOGY

☐ Number pregnancies ☐ Number births ☐ Premature births ☐ Miscarriages
☐ Age at first menses ☐ Period (days) ☐ Duration ☐ Irregular periods
☐ Flow (describe) ☐ Clots Last PAP_____ Last menses _____
☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps Menopause _____
☐ Birth control type and duration _____ ☐ Changes in body/psyche prior to menstruation

MUSCULOSKELETAL

☐ Neck pain ☐ Mucscle pains ☐ Back pain(where) ☐ Joint pains(where)
☐ Other joint or bone problems? _____ _____

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion
☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed
☐ Treated for emotional problems ☐ Considered/attempted suicide
☐ Other neurological or psychological problems?

CLASSICAL

Preference	Most Liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Temperature		

Body type: _____
Color: _____
Tone: _____
Odor: _____
Yin/Yang: _____
Firm/Weak: _____
Hot/Cold: _____
Surface/Interior _____

COMMENTS

□ ♀: Do you have fibrocytic breasts?

♀For Women

Age of first period _____ Date of last period _____ Number of children (live births) _____

Number of days between periods (your cycle) _____Number of days of flow_____

♀ Check All that Appply:

Color of flow: □ pale/light red □ red □ bright red □ dark red □ dark red/brown □ dark red/purple

# of pads you use per day: 1st day ___2ND day __3RD day ___4th day ___

Pain and Cramping: □ No / □ Yes □ mild □ moderate □ severe
1st day ___2ND day __3RD day ___4th day ___Before flow ___After flow

Amount of flow:

□ even throughout

□ clots	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow
□ spotting	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow
□ light	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow
□ heavy	□ No / □ Yes	1st day	___2ND day	__3RD day	___4th day	___Before flow	___After flow

Other symptoms related to menses: □ Discharge □ PMS □ Headache □ Nausea

□ Constipation □ Diarrhea □ Swollen Breasts □ Mood Swings □ Increased Appetite □ Decreased Appetite □ Insomnia

Have you ever been diagnosed with: □ fibroids □ fibrocystic breasts □ endometriosis □ ovarian cysts □ PID

□ polycystic ovary syndrome □ STD _____

Fertility Information

# of IVF procedures_____ # of IUI procedures_____

Has a physician diagnosed a difficulty with fertility due to: □ Female Factor □ Male Factor □ Unexplained

□ Other _____

□ Do you have heart palpitations, especially when anxious?

□ Do you have nightmares?

□ Do you seem low in spirit or lacking vitality?

□ Are you prone to agitation or extreme restlessness?

□ Do you fidget?

□ Do you sweat excessively, especially on your chest?

Excess Heat

□ Are your mouth and throat usually dry?

□ Are you often thirsty for cold drinks?

□ Do you often feel warmer than those around you?

□ Do you wake up sweating or have hot flashes?

□ ♀: Do you breakout with red acne, especially pre-menstrually?

□ ♀: Do you have a short menstrual cycle?

□ ♀: Do you have vaginal irritation?

Dampness

□ Do you feel tired and sluggish after a meal?

□ Do you have cystic or pustular acne?

□ Do you have urgent, bright, or foul-smelling stools?

□ Are you overweight?

□ Do you have a wet, slimy tongue?

□ Does your body feel like a barometer? Can you sense when it will rain?

□ ♀: Does your menstrual blood contain stringy tissue or mucus?

□ ♀: Are you prone to yeast infections and vaginal itching?

□ ♀: Have you been diagnosed with endometriosis or uterine fibroids?

□ ♀: Do you have piercing or stabbing menstrual cramps?

□ ♀: your menstrual flow ever brown or black in color?

□ ♀: Do you feel mid-cycle pain around your ovaries?

□ ♀: Do you have painful, unmovable breast lumps?

Liver Qi Stagnation

□ Are you prone to emotional depression?

□ Are you prone to anger and/or rage?

□ Are your pupils usually dilated and large?

□ Do you have difficulty falling asleep at night?

□ Do you experience heartburn or wake up with a bitter taste in your mouth

□ ♀: Do you become irritable pre-menstrually?

□ ♀: Do you feel bloated or irritable around ovulation?

□ ♀: Does it feel as if your ovulation lasts longer than it should?

□ ♀: Are your breasts sensitive/sore at ovulation?

□ ♀: Do you experience nipple pain or discharge from your nipples?

□ ♀: Do you have a lot of pre-menstrual breast distension or pain?

□ ♀: Do you become bloated pre-menstrually?

□ ♀: Are your menses painful?

□ ♀: Do you feel your menstrual cramps in the external genital area?

□ ♀: Is your menstrual blood thick and dark, or purplish in color?

Heart-

□ Do you wake up early in the morning and have trouble getting back to sleep?

□ ♀: Is your menstruation thin, watery, profuse, or pinkish in color?

□ ♀: Are you more tired around ovulation or menstruation?

□ ♀: Do you ever spot a few days or more before your period comes?

□ ♀: Have you ever been diagnosed with uterine prolapse?

□ ♀: Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Xu-

□ Do you have dry, flaky skin?

□ Are you prone to getting chapped lips?

□ Are your fingernails or toenails brittle?

□ Is your hair brittle or dry?

□ Do you have diminished nighttime vision?

□ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

□ ♀: Do you get dizzy or light-headed around your period?

□ ♀: Are you losing hair on your head?

□ ♀: Are your menses scant or late?

Blood Stasis

□ Do you experience periodic numbness of your hands and feet, especially at night?

□ Do you have varicose or spider veins?

□ Do you have red cherry spots (hemangiomas) on your skin?

□ Do you have chronic hemorrhoids?

□ Do you have dark spots in your eyes?

□ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

□ ♀: Does your menstrual blood contain clots?

□ Do you wake up at night or early in the morning because you have to urinate?

□ Do you urinate frequently, and is the urine diluted and/or profuse?

□ Do you have early morning loose, urgent stools?

□ ♀: Do you have low back pain pre-menstrually?

□ ♀: Do you have profuse vaginal discharge?

□ ♀: Do you feel cold cramps during your period that respond to a heating pad?

Spleen Qi – Xue – Yang Xu

□ Are you often fatigued?

□ Do you have poor appetite?

□ Is your energy low after a meal?

□ Do you feel bloated after eating?

□ Do you crave sweets?

□ Do you have loose stools, abdominal pain, or digestive problems?

□ Are your hands and feet cold?

□ Are you prone to feeling sluggish?

□ Are you prone to heaviness or grogginess in the head?

□ Do you have varicose veins?

□ Are you prone to worry?

□ Have you been diagnosed with low blood pressure?

□ Do you sweat a lot without exerting yourself?

□ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?

□ Are you often sick, or do you have allergies?

□ Have you ever been diagnosed with hypothyroid or anemia?

□ Do you have hemorrhoids or polyps?

□ Therapeutic massage □ Assisted Stretching/Yoga □ Relaxation techniques □ Tai Chi and/or Qi gong health exercises

□ Relaxation techniques □ Nutritional consultation

Other

Please indicate if the following pertain to you:
NOTE: This Symbol ♀: before a question, indicates that it is for Women only.

Kidney Yin Xu-

□ Do you have lower back weakness, soreness or pain?

□ Do you have ringing in your ears?

□ Is your hair prematurely gray?

□ Do you have dark circles under your eyes?

□ Do you have night sweats?

□ Are you prone to hot flashes?

□ Would you describe yourself as "afraid" frequently?

□ Do you have dizziness?

□ Do you have knee problems?

□ ♀: Do you have vaginal dryness?

□ ♀: Is your mid-cycle cervical mucus scanty or missing?

Kid Y ng Xu-

□ Is your back sore or weak?

□ Are your feet cold, especially at night?

□ Are you typically colder than those around you?

□ Is your libido low?

□ Are you often fearful?

PAIN PATIENTS, please indicate on the figures below the areas of the body you experience your pain:

How would you characterize your pain: □ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical

What would you like to achieve with acupuncture treatment?

Symptom Survey

Please "check" the symptoms or conditions you experience frequently:

Sp/St	Ht/P	Lu/LI	Ki/UB	Liv/GB
___ excessive appetite	__ insomnia	__ cough	__ low back pain	__ eye problems
__ loose stool/diarrhea	__ palpitations	__ shortness of breath	__ knee problems	__jaundice
__ digestive problems, indigestion	__ cold hands and feet	__ decreased sense of smell	__ hearing impairment	__ difficulty digesting oily foods
__ vomiting	__ nightmares	__ nasal problems	__ ear ringing	__ gall stones
__ belching, burping	__ mentally restless	__ skin problems	__ kidney stones	__light-colored stool
__ heartburn/reflux	__ laughing for no reason	__ claustrophobia	__ decreased sex drive	__ soft or brittle nails
__ stomach bloating	__ chest pains	__ colitis/diverticulitis	__ hair loss	__ easily angered
__ obsession in work,	__ poor memory	__ constipation	__ urinary problems	__ difficult relationships
__ blood in stool	__ sadness	__ allergies	__ dental problems	__ difficulty making decisions
__ lack of appetite	__ Depression	__asthma	__ fatigue	____dizziness
__ hemorrhoids	__ Anxiety	__ get sick easily	__edema	__headaches
__easily bruised				

__ I usually feel warm __ I usually feel chilled

Conclusion

Are you interested in additional health services besides acupuncture? □ No □ Yes

Please check which services you might be interested in: □ Chiropractic Services □ Chinese herbal medicine

LAKOTA Wellness
A Whole Health Clinic

Elyse Saltalamachia, DC
2910 Maguire Road Suite 1009
Ocoee, FL 34761
407.877.8707 phone
407.877.7464 fax

CONSENT TO ACUPUNCTURE TREATMENT

I understand that

1. Acupuncture treatments involve the insertion of needles at one or several points in the body, and methods of treatment can vary as follows, depending on the acupuncturist's judgment.
   A. Needle or multiple needles with or without twirling
   B. Needle or multiple needles attached to low current (electro-stimulation), replacing manual twirling
   C. Local heat, either by heat lamp or moxa

2. That acupuncture is a procedure which was developed thousands of years ago and has been used in Asian countries and other parts of the world, but at present is not universally taught in medical schools in the United States. However, advance acupuncture training is taught in four-year graduate schools of Oriental Medicine and is authorized by the Board of Medical Quality Assurance, the licensing body of the state of Florida.

3. I understand that the administration of acupuncture could directly or indirectly result in minor adverse effects to my body including, but not restricted to, lightheadedness, minor bleeding, bruising, soreness, pain and general relaxation.

4. I further acknowledge that I am not seeking or undergoing acupuncture as a result of any indictment or representation or promises made by the acupuncturist or any other person in the office. I wish to proceed freely and voluntary with such treatment and authorize Dr. Elyse Saltalamachia to proceed with such treatment with the full and informed consent on my part of all the relevant facts as set forth in this consent form. This consent shall apply to all my initial and all subsequent acupuncture treatments.

PATIENTS NAME (Please Print):_____

Signature:_____ Date:_____

LAKOTA Wellness

Elyse Saltalamachia, D.C.
2910 Maguire Rd Suite 1009 Ocoee FL 34761
P: 407.877.8707 *** F: 407.877.7464

HIPPA ACKNOWLEDGEMENT & AUTHORIZATION

I hereby authorize my insurance company or any other third party payer to pay directly to Lakota Wellness for all charges submitted for services incurred by me. I understand that I will be responsible for any and all charges not paid by my insurance company or third party payer. I authorize Lakota Wellness to release information concerning my chiropractic/medical condition to my insurance company, employer, attorney, or multiple health care providers who may be involved in the treatment directly or indirectly and hereby release this office of any consequence thereof. Furthermore, any risks regarding chiropractic treatment will be explained to me by request. I assign payment directly to Lakota Wellness which may cover in whole or part of the services that I have received. The authorization shall be valid until I notify Lakota Wellness in writing of a cancellation. A photo copy of the authorization shall be valid as the original copy.

I hereby acknowledge that I have read the HIPPA Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Lakota Wellness with my authorization and consent to use and disclose my protected chiropractic/health care information for the purposes of treatment, payment and health care operations as described in the HIPPA Privacy Policy.

Signature of patient/guardian_____ Date_____

OFFICE POLICY

There will be a $50 per hour scheduled for same day or short notice cancellations and missed appointments. There is no charge for cancelations that are made at least 24 business hours before the day of the scheduled appointment. **Our normal business hours are Tuesday thru Thursday 9:30am-6:00pm and Friday and Saturdays 9:30am-4:00pm. Our office is closed Sundays and Mondays. Messages left via voicemail will NOT be counted as an official cancellation notice. THESE FEES ARE NOT COVERED BY INSURANCE CARRIERS; I AGREE TO BE RESPONSIBLE FOR PAYMENT IN FULL.** Payment in full is required before any future appointments can be made. Patients with a chronic history of failed or broken appointments will have to call the day of to see if times are available since our office will no longer be able to reserve appointments in advance.

Signature of patient/guardian_____ Date_____

INSURANCE

In order to meet the needs of our patients, we have enrolled in various insurance programs. As you can imagine, keeping up with all the individual requirements for each of the insurance companies can be practically impossible. Each program may have different requirements or stipulations that dictate which services can be provided and how often they can be provided. These rules can vary even in the same company with various programs being offered. At Lakota Wellness, providing the highest quality in chiropractic care to our patients in an atmosphere of genuine caring is our primary concern. It is possible that your insurance provider may NOT cover every service we provide in our office, and in these cases, we will have no choice but to bill you for the services provided. It is not our sole responsibility to know every detail of your particular insurance company so if we work together, both doing our parts and familiarizing ourselves with your specific policy, we can focus on what we do best – take care of you.

I understand that my insurance company may disallow and not pay fees related to certain procedures and services that I may receive at this office. If these are disallowed, I understand that I am responsible for payment. I understand that I am also responsible for any balance that is not paid by my insurance company after 30 days.

Signature of patient/guardian_____ Date_____

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ASSIGNMENT OF BENEFITS

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this office or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges or professional services rendered by this office.
If in the event my current policy prohibits direct payment to doctor, then I hereby also authorize and direct you to pay directly to:

Lakota Wellness 2910 Maguire Rd. Ocoee FL 34761

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____
Patient Signature **Date**

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

RELEASE OF INFORMATION

I authorize this office to release any information pertinent to my case to any insurance company, adjuster, and attorney involved in this case; and hereby release this office of any consequence thereof.
I understand that if the *Lakota Wellness* accepts me as a patient that I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding chiropractic treatment will be explained to me upon my request.

_____ _____
Patient Signature **Date**

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this office including my insurance deductibles, co-payments and any services or balance **NOT** covered by my insurance company.

_____ _____
Signature of Claimant, if other than Policyholder **Date**

_____ _____
Signature of Policyholder **Witness**

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RECORDS RELEASE AUTHORIZATION

Clinic Name: _____

Clinic Address: _____

Clinic Phone Number: _____

Clinic Fax Number: _____

PATIENT NAME: _____

D.O.B: _____ **Dates of service:** _____

I, _____ hereby authorize _____ to release a copy of my complete medical records, X-Rays, MRIs, CT Scans, Test Results, Doctor Notes, Prescription history, or/and ER Records. This authorization is given pursuant to Florida Statute 456.057 and HIPPA Regulations. I hereby understand that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representative.

_____ _____

Patient or Legal Representative's Signature Date

LAKOTA Wellness
Elyse Saltalamachia, D.C.
2910 Maguire Rd. Suite 1009 Ocoee, FL. 34761
P: 407.877.8707 F: 407.877.7464

AFFIRMATION OF RECEIPT OF PATIENT'S NOTICE OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Patient's Notice of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of personal Health information, as a patient of this practice.

Affirmed,

_____

Patient Name

_____ _____

Patient or Guardian Signature **Date**