

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

1 Worman's Mill Court, Suite 11/ Office #3, Frederick, Maryland 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
- Crohns 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	____ Hysterectomy	____ Vaginal sores/itching, pain
____ Number of live births	____ Age at time of hysterectomy	____ Vaginal discharge
____ Number of miscarriages	____ Cysts	____ Vaginal odor
____ Number of abortions	____ Fibroids	____ Uterine prolapse
____ Premature births	____ Endometriosis	____ Urinary tract infections
____ Night sweats	____ Spotting between periods	____ How frequent?
____ Regular periods	____ Irregular periods	____ Breast lumps, fibroids
____ Heavy bleeding	____ Light bleeding	____ Days between cycles

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

____ abdominal distension	____ feeling hot, esp. hands and feet	____ poor memory
____ Breast soreness	____ feeling cold	____ Sore back or knees
____ Irritability, moodiness	____ low sexual desire	____ depression, sadness
____ frequent, pale urination	____ dizziness	
____ Tiredness	____ clots in the blood	
____ poor sleep	____ feeling agitation, aggressiveness	
____ oppression in chest	____ cramps: how many days _____ When? _____	

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

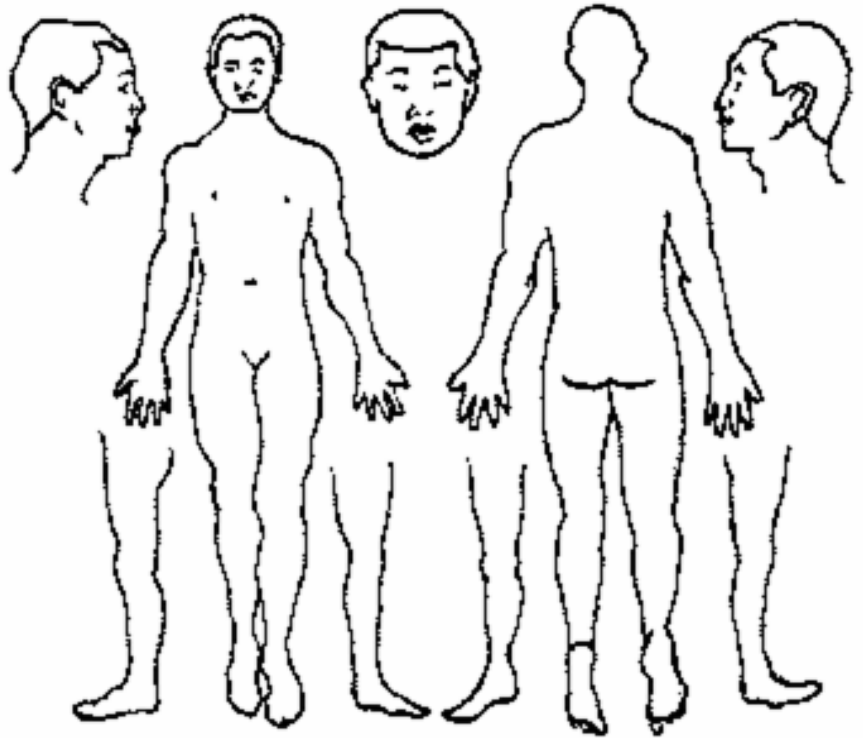
Use P for pain, D for discomfort, T for tightness, A for ache, and S for scar

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

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.

