

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed, and how you get access to your health information. Copies of this notice are given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you visit this practice. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of your practitioner, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities: This practice is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. The Lyme Research & Healing Center of Frederick, Maryland reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, the Lyme Research & Healing Center and your practitioner agree not to use or disclose your health information without your authorization.

To receive additional information or report a problem: you may contact your practitioner. If you believe your privacy rights have been violated, you have the right to file a complaint with the owner of the Lyme Research & Healing Center, and /or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

"I, _____, understand that the Lyme Research & Healing Center will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment."

Client / Patient Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

- Voluntary:* I hereby voluntarily consent to be treated with acupuncture, herbs, acupressure, cold laser acutherapy, electroacupuncture, cupping, vascular drainage, and Chinese energy healing. I understand that treatment may involve the insertion of needles and/or the application of warmth or herbal formulas to my skin. I understand that treatment may involve gentle hands-on contact with different areas of the body that relate to my conditions that I am coming for treatment. I further understand that any questions I have regarding treatment and procedures will be answered to my satisfaction.
- Possible Side Effects:* I understand that the side effects from treatment, acupuncture, herbs, cupping, and vascular drainage may include temporary pain, slight bleeding, local bruising, or lightheadedness. According to the Law of Cure, it is possible that as healing occurs, certain symptoms may appear aggravated for a short time; this is considered a positive sign.
- Medical Referral:* I understand that if my condition worsens, a new ailment arises, or I do not improve within the time established by my acupuncturist at the beginning of treatment, I should consult a licensed physician.
- Safety:* I am aware that my practitioner uses only sterile, disposable needles or lancets which have never been used before and which are immediately disposed of in a Sharps container after use. My questions regarding safety have been answered and I know future questions would be welcome.
- Returned Checks:* I am aware that I will be charged an additional \$29 processing fee for each returned check.
- Cancellation Policy:* I understand that I may change or cancel an appointment at any time. If I cancel an appointment less than 24 hours before the agreed upon time, I understand that I will be charged the treatment fee. When I want to change or cancel an appointment, I will do so by phone at (301) 228.3764).

Printed name of Client

Signature of Client

Date

Signature of Parent or Guardian

Date

FACT SHEET

Date _____ Birthdate _____ Referred By _____

Patient Name _____

Street Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Male Female Single Married Divorced Widowed Separated Race _____

Height _____ Weight _____ Age _____ Education High School Graduate College degrees _____

Occupation _____ SSN or Medicare Number _____

Physician Name _____

Physician Address _____

Physician Phone Number _____

(For information only, no contact will be made without permission)

Date of last appointment with regular physician: _____

Reason for that appointment _____

Please list all medications, vitamins, and / or food supplements you are currently taking:

Medications _____ Dosage _____

_____ Dosage _____

_____ Dosage _____

_____ Dosage _____

_____ Dosage _____

Vitamins _____ Dosage _____

_____ Dosage _____

_____ Dosage _____

_____ Dosage _____

Food Supplements

Family history (blood or natural relatives, except spouse)																																				
For each member of your family, please check the boxes for																																				
1. Their present state of health																																				
2. Any illness they have had																																				
NAME	Good Health	Poor Health	Deceased	Age or age when deceased	If deceased, write in cause of death. Include fatal accidents and suicides.	Allergies or Asthma	Anemia	Blood clotting problems	Diabetes	Cancer or tumor	Epilepsy	Glaucoma	Genetic disease	Alcoholism	Kidney or Bladder trouble	Stomach or duodenal ulcer	Nervous breakdown	Rheumatism or arthritis	High blood pressure	Heart trouble	Gout	Other														
Father:																																				
Mother:																																				
Brothers/																																				
Sisters:																																				
Spouse:																																				
Child:																																				
Child:																																				
Child:																																				
Child:																																				
Paternal relatives (how many affected with ----->)																																				
Maternal relatives (how many affected with ----->)																																				
Your Health History, have you had =====>																																				
Additional illnesses or problems																																				
Mark an X in the box next to all that you have now or ever had.																																				
<input type="checkbox"/>	eye infections	<input type="checkbox"/>	pneumonia	<input type="checkbox"/>	neuralgia or neuritis	<input type="checkbox"/>	scarlet fever	<input type="checkbox"/>	mononeucleosis																											
<input type="checkbox"/>	thyroid disease	<input type="checkbox"/>	pancreatitis	<input type="checkbox"/>	tension/anxiety	<input type="checkbox"/>	measels	<input type="checkbox"/>	sexually transmitted disease																											
<input type="checkbox"/>	eczema	<input type="checkbox"/>	liver disease	<input type="checkbox"/>	depression	<input type="checkbox"/>	mumps	<input type="checkbox"/>	yellow jaundice																											
<input type="checkbox"/>	hives or rashes	<input type="checkbox"/>	diverticulosis	<input type="checkbox"/>	childhood hyperactivity	<input type="checkbox"/>	polio	<input type="checkbox"/>	tuberculosis																											
<input type="checkbox"/>	bronchitis	<input type="checkbox"/>	hernia	<input type="checkbox"/>	chicken pox	<input type="checkbox"/>	rheumatic fever	<input type="checkbox"/>																												
<input type="checkbox"/>	emphysema	<input type="checkbox"/>	hemorrhoids	<input type="checkbox"/>	German measels	<input type="checkbox"/>	malaria	<input type="checkbox"/>																												
<input type="checkbox"/>	hepatitis	<input type="checkbox"/>	blood transfusion	<input type="checkbox"/>	drug abuse	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>																												
Hospitalizations																																				
If you have ever been hospitalized for any major medical illness, operations, or minor surgeries																																				
Please list your most recent hospitalization first. Please indicate total number of hospitalizations.->																																				
	Year	Reason for Hospitalization			Name of Hospital						City and State																									
1st Hospitalization																																				
2nd Hospitalization																																				
3rd Hospitalization																																				
4th Hospitalization																																				
Tests and immunizations							Medicines																													
Mark an X in the box next to all that you have had.							Mark an X in the box next to all that you are taking,																													
Enter the year you were last given these tests or shots.							or that you are sensitive or allergic to.																													
	Year		Year		Taking	Allergic to:		Taking	Allergic to:																											
<input type="checkbox"/>	chest x-ray	<input type="checkbox"/>	tetanus shots	<input type="checkbox"/>	<input type="checkbox"/>	antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	aspirin																											
<input type="checkbox"/>	kidney x-ray	<input type="checkbox"/>	polio series	<input type="checkbox"/>	<input type="checkbox"/>	penicillin	<input type="checkbox"/>	<input type="checkbox"/>	diet pills																											
<input type="checkbox"/>	G.I. series	<input type="checkbox"/>	typhoid series	<input type="checkbox"/>	<input type="checkbox"/>	sulfa	<input type="checkbox"/>	<input type="checkbox"/>	antacids																											
<input type="checkbox"/>	colon x-ray	<input type="checkbox"/>	flu injections	<input type="checkbox"/>	<input type="checkbox"/>	opiates/ codeine	<input type="checkbox"/>	<input type="checkbox"/>	laxatives																											
<input type="checkbox"/>	gallbladder x-ray	<input type="checkbox"/>	mumps shots	<input type="checkbox"/>	<input type="checkbox"/>	diuretics/ water pills	<input type="checkbox"/>	<input type="checkbox"/>	cold tablets																											
<input type="checkbox"/>	electrocardiogram	<input type="checkbox"/>	measels shots	<input type="checkbox"/>	<input type="checkbox"/>	sedatives	<input type="checkbox"/>	<input type="checkbox"/>	anti-inflammatories																											
<input type="checkbox"/>	TB test	<input type="checkbox"/>	hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	stimulants/ caffeine	<input type="checkbox"/>	<input type="checkbox"/>																												
<input type="checkbox"/>	sigmoidoscopy	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	Demerol	<input type="checkbox"/>	<input type="checkbox"/>																												
<input type="checkbox"/>	mammogram	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>																												

Please answer each question by writing an X on either the No or Yes line.			
When a question asks for specific information, write the answer on the line next to the question number.			
If you don't understand a question, or would like to discuss it, circle it's number.			
1. Do you have any skin problems?	No _____	Yes _____	1.
2. Does your skin itch or burn?	No _____	Yes _____	2.
3. Do you have trouble stopping even a small cut from bleeding?	No _____	Yes _____	3.
4. Do you bruise easily?	No _____	Yes _____	4.
5. Do you ever faint or feel faint?	No _____	Yes _____	5.
6. Is any part of your body always numb?	No _____	Yes _____	6.
7. Have you ever had seizures or convulsions?	No _____	Yes _____	7.
8. Has your handwriting changed lately?	No _____	Yes _____	8.
9. Do you have a tendency to shake or tremble?	No _____	Yes _____	9.
10. Are you nervous around strangers?	No _____	Yes _____	10.
11. Do you find it hard to make decisions?	No _____	Yes _____	11.
12. Do you find it hard to concentrate or remember?	No _____	Yes _____	12.
13. Do you usually feel lonely or depressed?	No _____	Yes _____	13.
14. Do you often cry?	No _____	Yes _____	14.
15. Would you say you have a hopeless outlook?	No _____	Yes _____	15.
16. Do you have difficulty relaxing	No _____	Yes _____	16.
17. Do you have a tendency to worry alot?	No _____	Yes _____	17.
18. Are you troubled by frightening dreams or thoughts?	No _____	Yes _____	18.
19. Do you have a tendency to be shy or sensitive?	No _____	Yes _____	19.
20. Do you have a strong dislike for criticism?	No _____	Yes _____	20.
21. Do you lose your temper often?	No _____	Yes _____	21.
22. Do little things often annoy you?	No _____	Yes _____	22.
23. Are you disturbed by any work or family problems?	No _____	Yes _____	23.
24. Are you having any sexual difficulties?	No _____	Yes _____	24.
25. Have you ever considered committing suicide?	No _____	Yes _____	25.
26. Have you ever desired or sought psychiatric help?	No _____	Yes _____	26.
27. Have you gained or lost more than 10 pounds in the last 6 months?	No _____	Yes _____	27.
28. Do you have a tendency to be too hot or too cold?	No _____	Yes _____	28.
29. Have you lost your interest in eating lately?	No _____	Yes _____	29.
30. Do you always seem to be hungry?	No _____	Yes _____	30.
31. Are you more thirsty than usual lately?	No _____	Yes _____	31.
32. Are there any swellings in your armpits or groin?	No _____	Yes _____	32.
33. Do you seem to feel exhausted or fatigued most of the time?	No _____	Yes _____	33.
34. Do you either have difficulty falling asleep or staying asleep?	No _____	Yes _____	34.
35. Do you exercise more than three times a week?	Yes _____	No _____	35.
36. How much do you smoke per day?		_____ Cigarettes	36.
		_____ Cigars/Pipes	
		_____ Don't smoke	

37.	Do you take two or more alcoholic drinks per day?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	37.
38.	Do you drink more than six cups/glasses of coffee, tea, or cola soda per day?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	38.
39.	Are you a regular user of sleeping pills, marijuana, tranquilizers, pain killers, etc.?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	39.
40.	Have you ever used heroin, cocaine, LSD, PCP, etc?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	40.
41.	Do you drive a motor vehicle more than 25,000 miles per year?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	41.
42.	How often do you use seat belts when riding in cars?		<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always	42.
43.	List any country outside the United States you have visited in the past six months			43.
44.	Are you troubled by heartburn?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	44.
45.	Do you feel bloated after eating?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	45.
46.	Are you troubled by belching?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	46.
47.	Do you suffer discomfort in the pit of your stomach?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	47.
48.	Do you easily become nauseated (feel like vomiting)?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	48.
49.	Have you ever vomited blood?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	49.
50.	Is it difficult or painful for you to swallow?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	50.
51.	Are you constipated more than twice a month?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	51.
52.	Are your bowel movements ever loose for more than one day?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	52.
53.	Are your bowel movements ever black or bloody?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	53.
54.	Do you suffer pains when you move your bowels?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	54.
55.	Have you had any bleeding from your rectum?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	55.
56.	Do you frequently get up at night to urinate?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	56.
57.	Do you urinate more than five or six times a day?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	57.
58.	Do you wet your pants or wet your bed?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	58.
59.	Have you ever had burning or pains when you urinate?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	59.
60.	Has your urine ever been brown, black, or bloody?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	60.
61.	Do you have any difficulty starting your urine flow?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	61.
62.	Do you have a constant feeling that you have to urinate?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	62.
	*** FOR MEN ONLY			
63.	Is your urine stream very weak and slow?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	63.
64.	Has a doctor ever told you that you have prostate trouble?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	64.
65.	Have you had any burning or discharge from your penis?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	65.
66.	Are there any swellings or lumps on your testicles?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	66.
67.	Do your testicles get painful?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	67.
	*** FOR WOMEN ONLY			
68.	What was the date of your last menstrual period?		<input type="text"/> / <input type="text"/> / <input type="text"/>	68.
69.	Are you past menopause or have you had a hysterectomy?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	69.
70.	If yes: Have you noticed any vaginal bleeding since? (Please skip to question 74)	No <input type="checkbox"/>	<input type="checkbox"/> Yes	70.
71.	Was your last menstrual period normal?	Yes <input type="checkbox"/>	<input type="checkbox"/> No	71.
72.	Do you have heavy bleeding with your periods?	No <input type="checkbox"/>	<input type="checkbox"/> Yes	72.

73.	Have you had bleeding between your periods?	No ___	___ Yes	73.
74.	Do you ever have bleeding after intercourse?	No ___	___ Yes	74.
75.	Have you had any recent vaginal itching or discharge?	No ___	___ Yes	75.
76.	Do you examine your breasts at least once a month?	Yes ___	___ No	76.
77.	Have you ever noticed any lumps or pain in your breasts?	No ___	___ Yes	77.
78.	Have you had complications with any type of birth control?	No ___	___ Yes	78.
79.	Write in the month and year of your last Pap test		___ / ___ / ___	79.
	Print the following information in the spaces at the right >>>>			
80.	Number of pregnancies		_____	80.
81.	Number of children born alive		_____	81.
82.	Number of premature births		_____	82.
83.	Number of miscarriages		_____	83.
84.	Number of stillbirths		_____	84.
85.	Have you ever had an abortion?	No ___	___ Yes	85.
	*** Questions 86-134 are for both MEN and WOMEN			
86.	Are you troubled with stiff or painful muscles or joints?	No ___	___ Yes	86.
87.	Are your joints ever swollen?	No ___	___ Yes	87.
88.	Are you troubled by pains in the back or shoulder?	No ___	___ Yes	88.
89.	Are your feet often painful?	No ___	___ Yes	89.
90.	Are you handicapped or disabled in any way?	No ___	___ Yes	90.
91.	Do you have headaches more than once a week?	No ___	___ Yes	91.
92.	Does twisting your neck quickly cause pain?	No ___	___ Yes	92.
93.	Have you ever had lumps or swelling in your neck?	No ___	___ Yes	93.
94.	Do you wear glasses or contacts?	No ___	___ Yes	94.
95.	Does your eyesight ever blur?	No ___	___ Yes	95.
96.	Is your eyesight getting worse?	No ___	___ Yes	96.
97.	Do you ever see double?	No ___	___ Yes	97.
98.	Do you ever see colored halos around lights?	No ___	___ Yes	98.
99.	Do you ever have pains or itching in or around your eyes?	No ___	___ Yes	99.
100.	Do your eyes blink or water most of the time?	No ___	___ Yes	100.
101.	Have you ever had any trouble with your eyes in the last two years?	No ___	___ Yes	101.
102.	Do you have difficulty hearing?	No ___	___ Yes	102.
103.	Have you had any earaches lately?	No ___	___ Yes	103.
104.	Have you been troubled by running ears lately?	No ___	___ Yes	104.
105.	Do you have a repeated buzzing or other noises in your ears?	No ___	___ Yes	105.
106.	Do you get motion sickness riding in a car or plane?	No ___	___ Yes	106.
107.	Do you have any problems with your teeth?	No ___	___ Yes	107.
108.	Do you have any sore swellings on your gums or jaws?	No ___	___ Yes	108.
109.	Is your tongue sore or sensitive?	No ___	___ Yes	109.
110.	Has your sense of taste changed lately?	No ___	___ Yes	110.
111.	Is your nose stuffed up when you don't have a cold?	No ___	___ Yes	111.
112.	Does your nose run when you don't have a cold?	No ___	___ Yes	112.
113.	Do you ever have sneezing spells?	No ___	___ Yes	113.
114.	Do you ever have head colds two or more months in a row?	No ___	___ Yes	114.
115.	Does your nose ever bleed for no reason at all?	No ___	___ Yes	115.
116.	Is your throat ever sore when you don't have a cold?	No ___	___ Yes	116.

