Lyme Research & Healing Center

Acupuncture • Herbs • Acupressure • Qi Healing •
Cold Aculaser Therapy • Essential Oil Training Program
Getting Rid of Incredibly Persistent Lyme Disease
4539 Metropolitan Court, Frederick, MD 21704
Phone: 301.228.3764 / 301-238-5270
Treatment@GoodbyeLyme.com

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 your 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: _____

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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

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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
_____ _____
_____ _____

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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.

o eye infections	o pneumonia	o neuralgia or neuritis	o scarlet fever	o mononeucleosis			
o thryoid disease	o pancreatitus	o tension/anxiety	o measels	o sexually transmitted			
o eczema	o liver disease	o depression	o mumps	disease			
o hives or rashes	o diverticulosis	o childhood hyperactivity	o polio	o yellow jaundice			
o bronchitis	o hernia	o chicken pox	o rheumatic fever	o tuberculosis			
o emphysema	o hemorrhoids	o German measels	o malaria	o _____			
o hepatitus	o blood transfusion	o drug abuse	o osteoporosis	o _____			

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

Mark an X in the box next to all that you have had.
Enter the year you were last given these tests or shots.

	Year		Year
o	_____ chest x-ray	o	_____ tetanus shots
o	_____ kidney x-ray	o	_____ polio series
o	_____ G.I. series	o	_____ typhoid series
o	_____ colon x-ray	o	_____ flu injections
o	_____ gallbladder x-ray	o	_____ mumps shots
o	_____ electrocardiagram	o	_____ measels shots
o	_____ TB test	o	_____ hepatitus
o	_____ sigmoidoscopy	o	_____ Lyme disease
o	_____ mammogram	o	_____

Medicines

Mark an X in the box next to all that you are taking, or that you are sensitive or allergic to.

Taking	Allergic to:	Taking	Allergic to:
o	o antibiotics	o	o aspirin
o	o penicillin	o	o diet pills
o	o sulfa	o	o antacids
o	o opiates/ codeine	o	o laxatives
o	o diuretics/ water pills	o	o cold tablets
o	o sedatives	o	o anti-inflammatories
o	o stimulants/ caffeine	o	o _____
o	o Demerol	o	o _____
o	o blood pressure medicine	o	o _____

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	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 you 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 if 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 commiting 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	No____	____**Yes**	27.
	the last 6 months?			
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		

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

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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 you 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	No____	____**Yes**	101.
	in the last two years?			
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 you nose stuffed up when you don't have a cold?	No____	____**Yes**	111.
112.	Does you 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 you 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.

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117.	Has a doctor told you that your tonsils have been enlarged?	No____	____**Yes**	117.
118.	Has your voice ever been hoarse when you didn't have a cold?	No____	____**Yes**	118.
119.	Do you wheeze or have to gasp to breathe?	No____	____**Yes**	119.
120.	Are you bothered by coughing spells?	No____	____**Yes**	120.
121.	Do you cough up a lot of phlegm, mucus, or thick spit?	No____	____**Yes**	121.
122.	Have you ever coughed up blood?	No____	____**Yes**	122.
123.	Do you get chest colds more than once a month?	No____	____**Yes**	123.
124.	Are you sweating more than usual or having night sweats?	No____	____**Yes**	124.
125.	Have you ever been told that you had high blood pressure?	No____	____**Yes**	125.
126.	Have you ever been bothered by a thumping or racing heart?	No____	____**Yes**	126.
127.	Do you ever get pains or tightness in your chest?	No____	____**Yes**	127.
128.	Do you have trouble with dizziness or lightheadedness?	No____	____**Yes**	128.
129.	Does every little effort leave you short of breath?	No____	____**Yes**	129.
130.	Do you wake up at night short of breath?	No____	____**Yes**	130.
131.	Are you using more pillows to help you breathe at night?	No____	____**Yes**	131.
132.	Doyou have trouble with swollen feet or ankles?	No____	____**Yes**	132.
133.	Are you getting cramps in your legs at night or upon walking?	No____	____**Yes**	133.
134.	Have you ever been told that you have a heart murmur?	No____	____**Yes**	134.
135.	Do you have any current spiritual practices	No____	____**Yes**	135.
136.	If Yes, please list/ describe			136.
137.	Please describe your relationship to a Higher Power, God, or your concept of the Divine			137.
138.	Please describe any special issues, problems or			138.
	symptoms that you would like to discuss.			
	Your signature		Date	

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Please list the date(s) or date ranges when you have taken medicines or supplements, or received treatments. For example (Jan 2010 – Nov 2011)	Please describe the name of the medication, herb, or supplement or treatment. For example (Mepron), (Cats claw tincture), or (IVIG)	Please list which physical symptoms, mental abilities, or emotions improved or got worse. For example (Joint pain increased, mental fog decreased, more energy, etc)