IVELISSE DEJONGH, A.P., FABORM
2929 SW 3RD AVE SUITE 610 MIAMI, FL 33129
PHONE:305-677-3214 FAX:786-329-5692 Email:admin@miamiacupunctureclinic.com

Postpartum

Date:

Last name /	First name /	Circle: Miss Ms. Mrs. Dr.

Birth date /	Age /	Circle # of preferred contact

Address /		Phone (home) /
City /		Phone (work) /
Province /	Postal Code /	Phone (cell) /
Email /		Occupation /
Height /	Weight /	Emergency Contact /

Reason for Visit /

Have you had Acupuncture before? Yes No
Chinese herbal medicine? Yes No

Family Physician name /	Family Physician phone /

Western Medical diagnosis (if applicable) /

Other medical treatment received (circle) / Physiotherapy Massage Naturopathy Chiropractic Other:

Please indicate with a '**P**' (past) '**C**' (current) '**F**' (family) if any of the conditions below apply:

	Heart conditions		Stroke		High blood pressure		Low blood pressure
	Diabetes		Deep vein thrombosis		Neurological condition		Spinal or head injury
	Respiratory condition		Kidney disorder		Cancer		Hepatitis
	HIV / AIDS		Sprain/strain/fracture		Osteoporosis		Headaches/migraines
	Jaw pain		Arthritis		Dizziness/fainting		Contagious illness
	Skin condition		Digestive problems		Haemophiliac		Wear a pacemaker
	Lung condition		Epilepsy				Upcoming surgeries

On the figures below, please circle the areas of concern/pain;

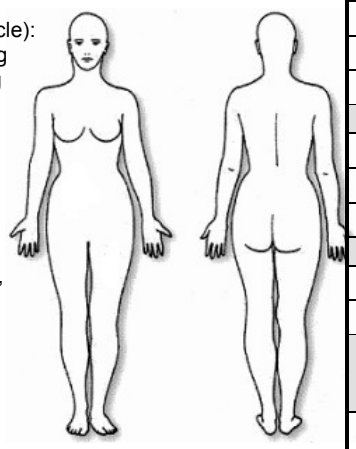
Sensations/pain characteristics (circle):
Sharp Burning Moving Tingling
Dull Severe Stabbing Shooting
Throbbing Numbness

What relieves the pain (ice, rest, activity, massage, heat…)?

_____
_____

What aggravates the pain (weather, heat, cold, rest, activity…)?

_____
_____



Please list any prescription medication or over the counter drugs currently taking:

1.	2.
3.	4.
5.	6.

Please list herbal medicine and other supplements currently taking:

1.	2.
3.	4.
5.	6.

Please list any allergies (food, drugs, environmental, etc.):

1.	2.
3.	4.

Have you been hospitalized and/or treated for any infectious/serious conditions or surgeries? If yes, briefly explain for what condition or reasons and the year (below).

Do you use the following? If so how often? Cigarettes: _____ Alcohol: _____ Drugs:_____Coffee:_____Pop: _____

Do you participate in the following physical activities? If so, please indicate how often:			
Yoga:	Running:	Fitness Class:	Gym:
Biking:	Swimming:	Walking:	Other:

How did you hear about DeJongh Acupuncture Clinic? (Internet, Friend, Doctor, Seminar, Magazine, TV, News, etc.) _____

Please print, complete, and email forms before your initial appointment. Thank you.

DEJONGH ACUPUNCTURE CLINIC
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For each symptom below that you currently have, rate its severity from 1-5 (5 being worst). Leave blank if N / A.

Gan
___ Irritability / frustration / impatience
___ Depression
___ Stress
___ Emotional eating
___ Unfulfilled desires
___ Visual problems / floaters
___ Blurred vision / poor night vision
___ Red / dry / itchy eyes
___ Headaches / migraines
___ Dizziness
___ Feeling of lump in throat
___ Muscle twitching / spasm
___ Neck / shoulder tension
___ Brittle nails
___ Sighing
___ Sensation or pain under rib cage
___ PMS
___ Genital itching / pain / rashes

Xin
___ Palpitations
___ Chest pain / tightness
___ Insomnia / sleep problems
___ Restless / easily agitated
___ Vivid dreams
___ Lack of joy in life
___ Forgetful
___ Aversion to heat
___ Bitter taste in mouth
___ Tongue / mouth ulcers / cankers

Shen
____ Frequent urination
____ Bladder infection
____ Lack of bladder control
____ Wake to urinate
____ Feel cold easily
____ Cold hands / feet
____ Night sweats / hot flushing
____ Low sex drive
____ High sex drive
____ Loss of head hair
____ Hearing problems
____ Crave salty food
____ Fear
____ Poor long term memory
____ Ankle swelling
____ Tinnitus

Fei
____ Dry cough
____ Cough with phlegm
____ Nasal discharge / drip
____ Sinus infection / congestion
____ Itchy / painful throat
____ Dry mouth / throat / nose
____ Skin rashes / hives
____ Snoring
____ Grief / sadness
____ Shortness of breath
____ Allergies / asthma
___ Weak immune system
Alternate fever / chills

Pi
___ Heaviness in the head / body
___ Fatigue after eating
___ Difficult getting up in morning
___ Water retention
___ Muscular tired / weak
___ Bruise easily
___ Unusual bleeding (stool, nose, etc)
___ Bad breath
___ Poor appetite
___ Increased appetite
___ Crave sweets
___ Poor digestion
___ Nausea / vomiting
___ Bloating / gas
___ Hemorrhoids
___ Constipation
___ Loose stool
___ Alternate constipation / loose
___ Abdominal pain
___ Intestinal pain / cramping
___ Heartburn
___ Pensive / over-thinking
___ Overweight
___ Foggy mind
___ Yeast infection
___ Aversion to cold
___ Cold nose
___ Increased thirst
___ Prefer warm / cold drinks
___ Sweat easily

List your main health concerns in order of importance to you:	1.	2.
	3.	4.

On a scale of 1-10, how would you rate your daily energy level (10 being best)?

How many times (approx.) in your life have you taken antibiotics? How many times have you taken oral steroids?

What is your occupation? Do you enjoy your work? How many hours per week do you work? Is it stressful? What are your duties?

Please describe in general what you eat, and what you crave. (sweet, spicy, salty, organic, wheat, dairy, meat, veggies, fruit, pasta, sandwiches, soups, etc.)

Are your bowel movements regular? How many times per day/week? Are they formed, loose, constipated, or do they alternate from loose to difficult to pass?

Do you have trouble falling asleep? Are you a light sleeper? How many hours per night? Do you have vivid dreams? If so, what are they about? Do you wake and have difficulty falling back to sleep?

Do you experience urinary frequency, urgency, burning, dribbling, retention? What colour/shade of yellow is it? Do you have a history of urinary tract infections?

If you were asked to describe yourself from an emotional standpoint, what would you say (i.e. irritable, worrier, anxious, sad, impatient, stressed, etc.)?

How many glasses of water do you drink in a day?

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Baby's name:_____ Baby's age: _____

Date of delivery:_____ Vaginal birth or C-section? _____

How many weeks pregnant at time of delivery?_____ Baby's birth weight: _____

Were you under the care of a midwife or doctor? _____

Caregiver's name: _____

How was the delivery? _____

_____

_____

_____

Was the delivery medicated or non-medicated? _____

Were any medical interventions used? ☐☐ Yes ☐☐ No

If yes, what intervention(s)? _____

Were there any complications or trauma? ☐☐ Yes ☐☐ No

If yes, please explain: _____

_____

_____

Tearing? ☐☐ Yes ☐☐ No Hemorrhaging? ☐☐ Yes ☐☐ No

Current bleeding? ☐☐ Yes ☐☐ No How long did you experience lochia (postpartum bleeding)? _____

Breastfeeding:

How many times per day?_____ How many times per night? _____

Any complications with breastfeeding? ☐☐ Yes ☐☐ No

If yes, please describe: _____

_____

_____

How are you feeling emotionally? _____

_____

_____

Do you have other children? ☐☐ Yes ☐☐ No If yes, name(s) and age(s): _____

Do you have a strong support system? ☐☐ Yes ☐☐ No

Please describe: _____

_____

_____

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OFFICE AND FINANCIAL POLICIES

FEES: The fees charged in this office are comparable to those charged by other healthcare providers in these areas, with similar qualifications. We accept cash, credit cards and personal checks. Please note there is a $25 charge for checks with insufficient funds.

PACKAGE AGREEMENTS: The packages that are offered in this office are at a discounted rate from the price per treatment. **The packages are non-refundable and can not be shared.** If you suspend or terminate your care at any time, your portion of all charges on your package agreement will be immediately due and charged to this office to the credit card that's on file.

INSURANCE COVERAGE: Many insurance policies cover Acupuncture care, but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductibles and percentage of coverage for Acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

VOLUNTARY TERMINATION OF CARE: If you suspend or terminate your care at any time, your portion of all charges for profesional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimatley will be personally responsible for payment regardless of your insurance coverage.

APPOINTMENT POLICY

Welcome to DeJongh Acupuncture Clinic. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Many of our clients are pleased to find out that we are usually on time. This is because **a treatment room has been reserved for you**, whereas most medical offices overbook by appointing several patients at the same time. That kind of scheduling provides the practitioner with a steady flow of patients but does not respect the patient's time. Occasionally, there is a problem with patients who are not used to staying on schedule themselves. With that in mind, **if you are going to be more than 15 minutes late, please call to confirm availability. If arriving late to appointment, patient will receive a treatment for remainder of the allotted time.**

CANCELLATION POLICY

As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance for any reschedule or cancellations in order to avoid the cancellation fee. This allows us time to schedule another patient that would also benefit from treatment. This appointment policy allows us to develop a mutual consideration and respect for our time and yours. **No emails or rescheduling notice will be accepted as cancellation, you must call the office to notify one of our staff members or leave a detailed voicemail.**

A valid credit card must be on file for all Booked appointments. For any cancellations or no show given less than 24 hours which will be charged the full price of treatment scheduled as a cancellation fee and consultations will inquire a $100 fee.

_____ _____

Patient's name (please print) Date

_____

Patient's signature

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Patient Information Release Request Form

Acupuncture Clinic's effort to provide me with the highest standard of integrated care, they may consult freely with other physicians and healthcare professionals, whose care I am under, regarding any of my medical treatments or relevant information. This could include the exchange of both verbal and written communications (including lab work).

I give full consent so that DeJongh Acupuncture Clinic may share personal information and my confidential treatment plan with my other healthcare providers to better my care. _____
(Initial)

(*to be filled out by your DeJongh Acupuncture Clinic practitioner*)

The following is an authorization to provide DeJongh Acupuncture Clinic with the following information:

- ○ All recent lab work results
- ○ All medical records
- ○ All semen tests
- ○ Other: _____

Medical Services Plan (MSP) #: _____

Doctor's Name:_____Clinic Name: _____

Clinic Phone #:_____Clinic Fax #: _____

I am nineteen years of age or older:

- ○ Yes
- ○ No

Client/Patient Signature:_____ Date: _____

Signature of parent or guardian (if applicable): _____

Thank you for your prompt attention to this request. Please send information via email to admin@miamiacupunctureclinic.com or by fax to 786-329-5692. If you have any questions, please feel free to contact us.

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Notice of Patient Privacy
Health Insurance Portability & Accountability Act (HIPPA)

DeJongh Acupuncture Clinic is dedicated to preserving your personal health information. We are required, by law, to protect your personal medical information and to provide you with a notice describing how your medical information may be used, disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities supporting your treatment. We may be required by law, to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to request and receive a copy of your medical information that we maintain, amend or correct that information, obtain an accounting and/or disclosure of your medical information, and/or complain if you think, your rights have been violated in any way.

We have available, a detailed, NOTICE OF PRIVACY PRACTICES, which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date, at the bottom of this page, indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE, in effect. If you have not received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

If you have any questions or concerns about the NOTICE or your medical information, please contact DeJongh Acupuncture Clinic at (305) 677-3214. You may also send a write complaint to the US Department of Health and Human Services.

_____ _____
Patient's name (please print) Date

_____
Patient's signature

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