



IVELISSE DEJONGH, AP, FABORM
2929 SW 3RD AVE SUITE 610 MIAMI, FL 33129

PHONE: 305-677-3214 FAX: 786-329-5692 Email: admin@miamiacupunctureclinic.com

Women's General Gynecology

Date: _____

Last name / _____ First name / _____

Circle: 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:

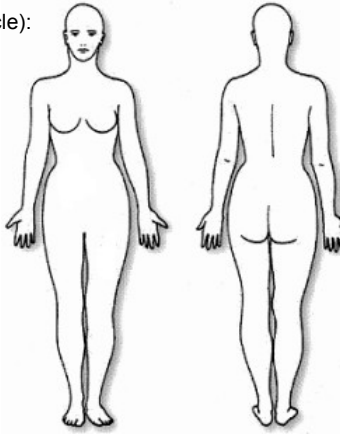
<input type="checkbox"/>	Heart conditions	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Deep vein thrombosis	<input type="checkbox"/>	Neurological condition	<input type="checkbox"/>	Spinal or head injury
<input type="checkbox"/>	Respiratory condition	<input type="checkbox"/>	Kidney disorder	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	Sprain/strain/fracture	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Headaches/migraines
<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Dizziness/fainting	<input type="checkbox"/>	Contagious illness
<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	Haemophilic	<input type="checkbox"/>	Wear a pacemaker
<input type="checkbox"/>	Lung condition	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Possibility of pregnancy	<input type="checkbox"/>	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.



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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.		
<p>Gan</p> <p><input type="checkbox"/> Irritability / frustration / impatience</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Emotional eating</p> <p><input type="checkbox"/> Unfulfilled desires</p> <p><input type="checkbox"/> Visual problems / floaters</p> <p><input type="checkbox"/> Blurred vision / poor night vision</p> <p><input type="checkbox"/> Red / dry / itchy eyes</p> <p><input type="checkbox"/> Headaches / Migraines</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Feeling of lump in throat</p> <p><input type="checkbox"/> Muscle twitching / spasm</p> <p><input type="checkbox"/> Neck / shoulder tension</p> <p><input type="checkbox"/> Brittle nails</p> <p><input type="checkbox"/> Sighing</p> <p><input type="checkbox"/> Sensation or pain under rib cage</p> <p><input type="checkbox"/> PMS</p> <p><input type="checkbox"/> Genital itching / pain / rashes</p> <p>Xin</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Chest pain / tightness</p> <p><input type="checkbox"/> Insomnia / sleep problems</p> <p><input type="checkbox"/> Restless / easily agitated</p> <p><input type="checkbox"/> Vivid dreams</p> <p><input type="checkbox"/> Lack of joy in life</p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Aversion to heat</p> <p><input type="checkbox"/> Bitter taste in mouth</p> <p><input type="checkbox"/> Tongue / mouth ulcers / cankers</p>	<p>Shen</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Wake to urinate</p> <p><input type="checkbox"/> Feel cold easily</p> <p><input type="checkbox"/> Cold hands / feet</p> <p><input type="checkbox"/> Night sweats / hot flushing</p> <p><input type="checkbox"/> Low sex drive</p> <p><input type="checkbox"/> High sex drive</p> <p><input type="checkbox"/> Loss of head hair</p> <p><input type="checkbox"/> Hearing problems</p> <p><input type="checkbox"/> Crave salty food</p> <p><input type="checkbox"/> Fear</p> <p><input type="checkbox"/> Poor long term memory</p> <p><input type="checkbox"/> Ankle swelling</p> <p><input type="checkbox"/> Tinnitus</p> <p>Fei</p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Cough with phlegm</p> <p><input type="checkbox"/> Nasal discharge / drip</p> <p><input type="checkbox"/> Sinus infection / congestion</p> <p><input type="checkbox"/> Itchy / painful throat</p> <p><input type="checkbox"/> Dry mouth / throat / nose</p> <p><input type="checkbox"/> Skin rashes / hives</p> <p><input type="checkbox"/> Snoring</p> <p><input type="checkbox"/> Grief / sadness</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Allergies / asthma</p> <p><input type="checkbox"/> Weak immune system</p> <p><input type="checkbox"/> Alternate fever / chills</p>	<p>Pi</p> <p><input type="checkbox"/> Heaviness in the head / body</p> <p><input type="checkbox"/> Fatigue after eating</p> <p><input type="checkbox"/> Difficult getting up in morning</p> <p><input type="checkbox"/> Water retention</p> <p><input type="checkbox"/> Muscular tired / weak</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Unusual bleeding (stool, nose, etc)</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Increased appetite</p> <p><input type="checkbox"/> Crave sweets</p> <p><input type="checkbox"/> Poor digestion</p> <p><input type="checkbox"/> Nausea / vomiting</p> <p><input type="checkbox"/> Bloating / gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Loose stool</p> <p><input type="checkbox"/> Alternate constipation / loose</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Intestinal pain / cramping</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Pensive / over-thinking</p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Foggy mind</p> <p><input type="checkbox"/> Yeast infection</p> <p><input type="checkbox"/> Aversion to cold</p> <p><input type="checkbox"/> Cold nose</p> <p><input type="checkbox"/> Increased thirst</p> <p><input type="checkbox"/> Prefer warm / cold drinks</p> <p><input type="checkbox"/> Sweat easily</p>

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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Date last menses began /

Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?	How many days do you bleed in total? /
	Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___ **Consistency of blood:** Watery ___ Thick ___ Average ___
Does your blood contain clots? Yes ___ No ___...and... **At which point during the cycle?** Start ___ Mid ___ End ___
Describe the colour of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ___ No ___	Before menses ___ During _____ (please specify which days) After ___
What relieves the pain?	Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.
 Breast tenderness ___ Cramps ___ Acne ___ Change in bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___
 Fatigue ___ Night sweats ___ Sleep disturbances ___
Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? _____	Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva
Do you experience pain around ovulation? Yes ___ No ___	Do your breasts get tender around ovulation? Yes ___ No ___
Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes ___ No ___	

How many times have you been pregnant? _____ **How many times have you given birth?** _____
 Ages of children _____ Sex of Children _____ Given names _____
 Have you had any miscarriages? Yes ___ No ___
 If yes, how many, at how many weeks pregnant, and in what year(s)? _____

 How many times have you had a D&C preformed? _____
 How many abortions have you had? _____ In what year(s)? _____
 Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with: STD? Yes ___ No ___ Pelvic inflammatory disease? Yes ___ No ___ Uterine fibroids? Yes ___ No ___ Polyps? Yes ___ No ___ Pelvic adhesions? Yes ___ No ___ Prolapsed uterus? Yes ___ No ___ Unique shape of uterus? Yes ___ No ___ Endometriosis? Yes ___ No ___ PCOS (polycystic ovarian syndrome)? Yes ___ No ___	Date of last pap smear: _____ / _____ / _____ (dd/mm/yyyy) Have you ever had an abnormal pap smear? Yes ___ No ___ Have you ever had a cervical biopsy or operation? Yes ___ No ___ Do you get yeast infections regularly? Yes ___ No ___ Do you get bladder infections regularly? Yes ___ No ___ If answered yes, list STDs: _____
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Do you experience vaginal discharge? Yes ___ No ___
If yes, what colour?
 White ___ Yellow ___ Green ___ Pinkish ___ Red ___
If yes, what consistency?
 Watery / thin ___ Thick ___ Sticky ___
If yes, does it have foul odour? Yes ___ No ___

Have you taken oral contraceptives? Yes ___ No ___
If yes, for how long? _____
When did you stop? _____
Have you ever had an IUD? Yes ___ No ___
Have you ever taken Depo-Provera? Yes ___ No ___

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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 professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately 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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**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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Patient Information Release Request Form

I, _____ (please print name) understand that as part of DeJongh 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
- 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.

DeJongh Acupuncture Clinic.