

# Dawn Balusik AP, DOM

[www.AcupunctureByDawn.com](http://www.AcupunctureByDawn.com)

## Confidential Health History Questionnaire

Date: \_\_\_\_\_

We look forward to helping you achieve your health goals. Please help us learn more about you so that we may provide you with the most effective care. On this questionnaire, you will find many in-depth questions; each answer provides important information that allows us to optimize your health care results. Thank you for your thorough responses.

Last Name		First Name		Middle Initial	Social Security #	
Street Address			City		State	Zip
Home Phone	Cell Phone		Date of Birth	Age	Sex	Marital Status
Work Phone	Employer & Occupation		Emergency Contact: Name & Phone			
Height	Weight	Blood Pressure		Date of BP Reading	Blood Type	
E-mail Address (for articles and newsletters)			How did you hear about us?			
Are you currently under Doctor's care?		MD's Name		MD's Phone		
List your reasons for today's visit, in order of importance.						
What treatments have you tried or are you currently doing for these conditions?						
<b>Check if you have a <u>FAMILY HISTORY</u> of any of these:</b>						
<input type="checkbox"/> Allergies		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Kidney disease		
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Epilepsy / Seizures		<input type="checkbox"/> Mental illness		
<input type="checkbox"/> Asthma		<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Stroke		
<input type="checkbox"/> Bleeding disorders		<input type="checkbox"/> Heart disease		<input type="checkbox"/> Thyroid disease		
<input type="checkbox"/> Cancer		<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Other inheritable disease		

**Please identify current symptoms by marking the box under the “Now” column.  
Mark the “Past” column only if a past condition was particularly severe or significant.**

<b>Past</b>	<b>Now</b>	<b>Past</b>	<b>Now</b>	<b>Past</b>	<b>Now</b>
<input type="checkbox"/> <input type="checkbox"/> Abdominal / stomach pain <input type="checkbox"/> <input type="checkbox"/> Abnormal appetite <input type="checkbox"/> <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> <input type="checkbox"/> Belching <input type="checkbox"/> <input type="checkbox"/> Heartburn / reflux <input type="checkbox"/> <input type="checkbox"/> Gas <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Black stool <input type="checkbox"/> <input type="checkbox"/> Blood in stool <input type="checkbox"/> <input type="checkbox"/> Mucous in stool <input type="checkbox"/> <input type="checkbox"/> Undigested food in stool <input type="checkbox"/> <input type="checkbox"/> Rectal pain / hemorrhoids <input type="checkbox"/> <input type="checkbox"/> Regular laxative use <input type="checkbox"/> <input type="checkbox"/> Unusually thirsty <input type="checkbox"/> <input type="checkbox"/> Overweight <input type="checkbox"/> <input type="checkbox"/> Weight changes	<input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Excessive sweating <input type="checkbox"/> <input type="checkbox"/> Lack of perspiration <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> Night sweats <input type="checkbox"/> <input type="checkbox"/> Cold Hands/Feet/Nose <input type="checkbox"/> <input type="checkbox"/> Tendency to be too hot <input type="checkbox"/> <input type="checkbox"/> Tendency to be too cold	<input type="checkbox"/> <input type="checkbox"/> Anger <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Fear <input type="checkbox"/> <input type="checkbox"/> Frustration <input type="checkbox"/> <input type="checkbox"/> Grief or sadness <input type="checkbox"/> <input type="checkbox"/> Irritability <input type="checkbox"/> <input type="checkbox"/> Mood swings <input type="checkbox"/> <input type="checkbox"/> Obsession <input type="checkbox"/> <input type="checkbox"/> Panic Attacks <input type="checkbox"/> <input type="checkbox"/> Stress <input type="checkbox"/> <input type="checkbox"/> Worry	<input type="checkbox"/> <input type="checkbox"/> Dry eyes <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> Itchy eyes <input type="checkbox"/> <input type="checkbox"/> Tearing eyes <input type="checkbox"/> <input type="checkbox"/> Poor vision <input type="checkbox"/> <input type="checkbox"/> Night or color blindness <input type="checkbox"/> <input type="checkbox"/> Earaches <input type="checkbox"/> <input type="checkbox"/> Ringing or sounds in ears <input type="checkbox"/> <input type="checkbox"/> Hearing problems <input type="checkbox"/> <input type="checkbox"/> Sinus problems <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> Snoring <input type="checkbox"/> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> <input type="checkbox"/> Dry mouth or throat <input type="checkbox"/> <input type="checkbox"/> Sore throat <input type="checkbox"/> <input type="checkbox"/> Swollen glands <input type="checkbox"/> <input type="checkbox"/> Frequent hoarseness <input type="checkbox"/> <input type="checkbox"/> Mouth or lip sores <input type="checkbox"/> <input type="checkbox"/> Many cavities or root canals <input type="checkbox"/> <input type="checkbox"/> Unusual taste in mouth <input type="checkbox"/> <input type="checkbox"/> Teeth grinding or clenching <input type="checkbox"/> <input type="checkbox"/> Jaw Problems or TMJ <input type="checkbox"/> <input type="checkbox"/> Facial pain <input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Victim of Child Abuse <input type="checkbox"/> <input type="checkbox"/> Victim of Domestic Abuse <input type="checkbox"/> <input type="checkbox"/> Victim of Sexual Abuse <input type="checkbox"/> <input type="checkbox"/> War Veteran	<input type="checkbox"/> <input type="checkbox"/> Acne pimples <input type="checkbox"/> <input type="checkbox"/> Dry skin / Oily Skin <input type="checkbox"/> <input type="checkbox"/> Itching or burning skin <input type="checkbox"/> <input type="checkbox"/> Skin rash or sores <input type="checkbox"/> <input type="checkbox"/> Tendency to get hives <input type="checkbox"/> <input type="checkbox"/> Scalp itching or flaking <input type="checkbox"/> <input type="checkbox"/> Early graying of hair <input type="checkbox"/> <input type="checkbox"/> Loss of hair <input type="checkbox"/> <input type="checkbox"/> Nail fungus <input type="checkbox"/> <input type="checkbox"/> Weak / brittle nails
<input type="checkbox"/> <input type="checkbox"/> Bleeding / bruising easily <input type="checkbox"/> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> <input type="checkbox"/> Poor circulation <input type="checkbox"/> <input type="checkbox"/> Dizzy spells or fainting <input type="checkbox"/> <input type="checkbox"/> Chest pain / pressure <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> <input type="checkbox"/> Palpitations / chest fluttering <input type="checkbox"/> <input type="checkbox"/> Pounding heart beat <input type="checkbox"/> <input type="checkbox"/> Racing heart beat	<input type="checkbox"/> <input type="checkbox"/> Chronic cough <input type="checkbox"/> <input type="checkbox"/> Coughing blood <input type="checkbox"/> <input type="checkbox"/> Frequent chest colds <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/> Tightness of chest <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Coughing up Phlegm Color of Phlegm _____	<input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> Burning or painful urination <input type="checkbox"/> <input type="checkbox"/> Difficult urination / retention <input type="checkbox"/> <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> <input type="checkbox"/> Loss of bladder control	<input type="checkbox"/> <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> <input type="checkbox"/> Poor concentration <input type="checkbox"/> <input type="checkbox"/> Poor memory <input type="checkbox"/> <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> <input type="checkbox"/> Shaking or trembling <input type="checkbox"/> <input type="checkbox"/> Stuttering or stammering	<input type="checkbox"/> <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> <input type="checkbox"/> Waking up frequently <input type="checkbox"/> <input type="checkbox"/> Wake up still tired <input type="checkbox"/> <input type="checkbox"/> Many dreams <input type="checkbox"/> <input type="checkbox"/> Nightmares	
<b>LIFESTYLE &amp; DIET</b>					
<input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Marijuana	<input type="checkbox"/> Recreational Drugs <input type="checkbox"/> High Stress <input type="checkbox"/> Occupational Hazards	Exercise: (describe)			
<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks <input type="checkbox"/> Energy Drinks <input type="checkbox"/> Sugar <input type="checkbox"/> Fast Food <input type="checkbox"/> Alcohol (amt):	<input type="checkbox"/> Artificial Sweeteners <input type="checkbox"/> Salty Foods <input type="checkbox"/> Vegetarian/ Vegan <input type="checkbox"/> Low Carb <input type="checkbox"/> Low Fat <input type="checkbox"/> Crave Sugar <input type="checkbox"/> Crave Salt	Herbs/Vitamins/Supplements: (list)			

**FOR MEN**

**Past Now**

- Genital pain, swelling or itching
- Abnormal sex drive [ ] high [ ] low
- Erectile dysfunction

**Past Now**

- Low sperm count / motility / morphology
- Penile discharge
- Prostate problem (PSA:\_\_\_\_\_)

**FOR WOMEN**

**Past Now**

- Abnormal PAP smear
- Abnormal sex drive
- Abortion history
- Bleeding between periods
- Breast lumps / tenderness
- Clots in menstrual blood
- Difficulty conceiving

**Past Now**

- Endometriosis
- Fibroids
- Genital pain, swelling or itching
- Heavy bleeding with periods
- Hysterectomy
- Menopausal symptoms
- Miscarriage

**Past Now**

- Ovaries removed
- Pain with intercourse
- Painful periods
- Pelvic inflammatory disease
- Polycystic ovary disease
- Premenstrual tension / PMS
- Vaginal discharge or dryness

Are you currently pregnant or trying to become pregnant?

Duration of periods:

Number of pregnancies you've had:

Interval between periods (onset to onset):

Number of births you've had:

Dates of last period:

Ages of your children:

Past birth control methods:

Current birth control method:

**Check if you have or had any of these:**

**Past Now**

- Addiction ( to \_\_\_\_\_ )
- AIDS / HIV
- Allergies
- Anemia
- Arthritis
- Asthma
- Bleeding disorder
- Blood clots
- Bronchitis
- Cancer / tumor
- Cataracts
- Chicken pox
- Chronic fatigue syndrome
- Colon / bowel disease
- Diabetes
- Emotional / mental illness
- Emphysema

**Past Now**

- Fibromyalgia
- Gall bladder disease / stones
- Glaucoma
- Gout
- Gum disease
- Heart disease
- Hepatitis or jaundice
- Herpes
- High / Low blood pressure
- High cholesterol
- Kidney stones
- Kidney or bladder infection
- Liver disease
- Lupus
- Malaria
- Measles, Mumps or Rubella
- Mononucleosis

**Past Now**

- Multiple sclerosis
- Osteoporosis / osteopenia
- Pacemaker
- Parkinson's
- Pneumonia
- Polio
- Rheumatic or Scarlet fever
- Shingles
- Spinal meningitis
- Stroke
- Tuberculosis
- Thyroid trouble or goiter
- Ulcer
- Varicose veins
- Venereal disease

Other:

Surgeries, hospitalizations & dates:

Accidents, injuries & dates:

Medications, reasons & dosages:

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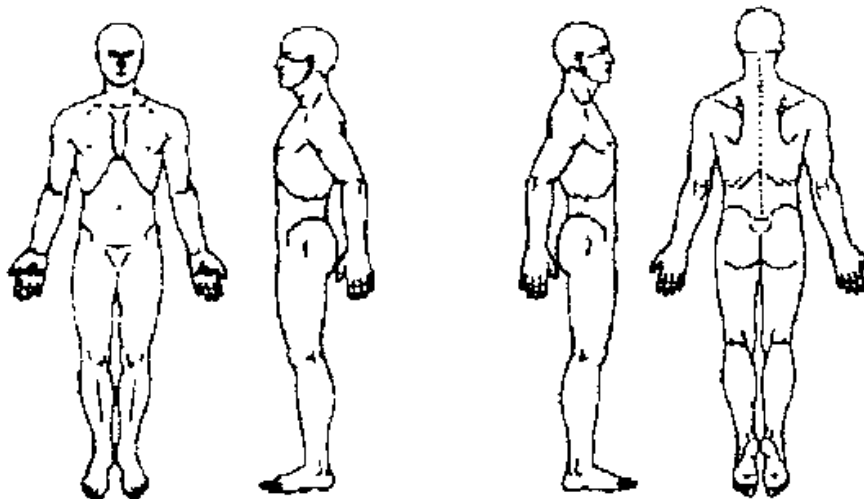
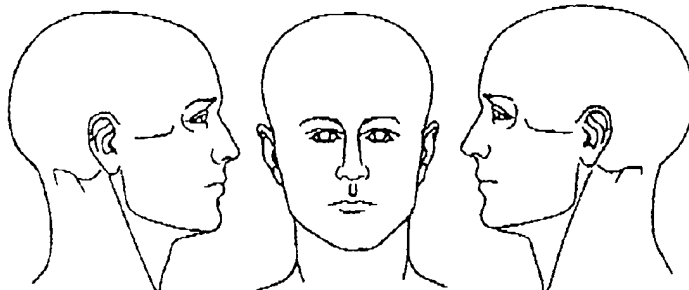


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**Please Indicate Areas of Pain or Discomfort:**



- Back pain or trouble ----- Severity 1 2 3 4 5
- Muscle pain, spasm, cramping - 1 2 3 4 5
- Muscle weakness ----- 1 2 3 4 5
- Restless or nervous legs ----- 1 2 3 4 5

- Spinal disc problems ----- Severity 1 2 3 4 5
- Stiff or painful neck ----- 1 2 3 4 5
- Swelling ----- 1 2 3 4 5
- Tendonitis (where: \_\_\_\_\_)

**Please describe your pain/discomfort:**

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**By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I also understand that if I wish to change the dosages of my medications, Dawn recommends that this happen gradually and with consent of my primary physician.**

**Sign:**

**Date:**

Dawn Balusik AP, DOM

2431 Estancia Blvd, A-2, Clearwater, FL 33761 | (727) 475-4710

**We provide this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA):**

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. Dawn Balusik may employ a third party to do insurance billing. This third party will have access to your billing and medical records. This third party is also bound, by law, to keep information about you confidential, except for the sole purpose of attaining payment.
3. Dawn Balusik Acupuncture has a Notice of Privacy Practices and that the patient has been given a copy of a summary of this Notice, and the patient may request a copy of the entire Notice at any time.
4. Dawn Balusik Acupuncture reserves the right to change the Notice of Privacy Policies.
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

a. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment or payment) if necessary:

\_\_\_\_\_

b. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home address**.

\_\_\_\_\_

c. Please print the telephone number where you want to receive calls about your appointments, or other health care information **if other than your home phone number**.

\_\_\_\_\_

d. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES                      NO

Patient: \_\_\_\_\_

Signature

Printed Name - Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_

Signature

Printed Name - Practice Representative

Date: \_\_\_\_\_

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Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, Tui-na (Oriental massage), oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxabustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE:

(or patient guardian-) \_\_\_\_\_

(-indicate relationship-)

(Date)

OFFICE SIGNATURE: \_\_\_\_\_

# Dawn Balusik AP, DOM

## Financial Policy

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### FULL PAYMENT IS DUE AT THE TIME OF SERVICE

**Payment Methods Accepted:** Cash, Check, Visa, Mastercard, Discover and Debit Cards are accepted.

**Returned Checks:** Each returned check will incur a fee of \$30.

**Cancellations or Missed Appointments:** We require a notice of 24 hours if you need to cancel an appointment, or you will be billed directly at the rate of \$50 for your missed appointments.

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**If your Health Insurance provides acupuncture coverage:** At your request, we will be happy to provide you with a superbill/receipt form which contains all the treatment, procedure and diagnostic codes that the physician is required to provide. You can submit a copy of this form to your insurance company for reimbursement.

**If you are an Auto Injury patient with remaining benefits:** We may bill your insurance for you; each case is considered on an individual basis. If, after verifying your benefits, we determine that we can, we will bill your insurance our "usual and customary" fees in a timely manner. You may view a copy of our "usual and customary" fees upon request. We require that you personally be responsible for the payment of your deductible as well as any unpaid balances in this office. Any unpaid balances will be considered past due 30 days following insurance reimbursement, and will be subject to a 1% monthly interest rate.

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### **Discount for Paying in Full at the Time of Service**

Because paying in full at the time of service frees our office from the administrative costs that would be required in medical billing, we have adjusted our "usual and customary" fees. Your superbill/receipt form will show exam and treatment procedures that occurred during your visit. Depending on the visit and the nature of your treatment, certain procedure codes and/or exam codes may be modified to \$0.00 and you will only be responsible for certain other fees: Your out-of-pocket fees will be as follows:

New Patient: \$125 - \$150  
Acupuncture Follow-up: \$75  
Herbal Follow-up: \$50  
Herbs & Supplements: varies

Acupuncture & Massage Combo: \$100  
Childbirth Labor Induction: \$75  
Pediatric (12 and under): Initial: \$100, Follow-up: \$50  
Stop Smoking: Initial \$100, Follow-up: \$75

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I have read and agree to the above Financial Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date