Dawn Balusik Acupuncture

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 # (last 4 digits)

Street Address	City	State	Zip

Home Phone	Cell Phone	Permission to text your appointment reminders? Yes No	Age	Sex	Date of Birth

Marital Status	Employer & Occupation	Emergency Contact: Name & Phone

Height	Weight	Blood Pressure	Date of BP Reading	Blood Type

E-mail Address (for newsletters & appointment reminders)	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?

Check if you have a FAMILY HISTORY of any of these:

☐ Allergies	☐ Diabetes	☐ Kidney disease
☐ Arthritis	☐ Epilepsy / Seizures	☐ Mental illness
☐ Asthma	☐ Glaucoma	☐ Stroke
☐ Bleeding disorders	☐ Heart disease	☐ Thyroid disease
☐ Cancer	☐ High blood pressure	☐ 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.

Past	Now	
☐	☐	Abdominal / stomach pain
☐	☐	Abnormal appetite
☐	☐	Nausea / vomiting
☐	☐	Belching
☐	☐	Heartburn / reflux
☐	☐	Gas
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Black stool
☐	☐	Blood in stool
☐	☐	Mucous in stool
☐	☐	Undigested food in stool
☐	☐	Rectal pain / hemorrhoids
☐	☐	Regular laxative use
☐	☐	Unusually thirsty
☐	☐	Overweight
☐	☐	Weight changes
☐	☐	Bleeding / bruising easily
☐	☐	Bleeding gums
☐	☐	Poor circulation
☐	☐	Dizzy spells or fainting
☐	☐	Chest pain / pressure
☐	☐	Irregular heart beat
☐	☐	Palpitations / chest fluttering
☐	☐	Pounding heart beat
☐	☐	Racing heart beat
☐	☐	Chronic cough
☐	☐	Coughing blood
☐	☐	Frequent chest colds
☐	☐	Shortness of breath
☐	☐	Tightness of chest
☐	☐	Wheezing
☐	☐	Coughing up Phlegm
		Color of Phlegm______________
☐	☐	Chronic or recurrent infection
☐	☐	Fatigue or tiredness
☐	☐	Sudden energy drop at ______
☐	☐	Frequent antibiotic use

Past	Now	
☐	☐	Chills
☐	☐	Fever
☐	☐	Excessive sweating
☐	☐	Lack of perspiration
☐	☐	Hot flashes
☐	☐	Night sweats
☐	☐	Cold Hands/Feet/Nose
☐	☐	Tendency to be too hot
☐	☐	Tendency to be too cold
☐	☐	Dry eyes
☐	☐	Eye pain
☐	☐	Itchy eyes
☐	☐	Tearing eyes
☐	☐	Poor vision
☐	☐	Night or color blindness
☐	☐	Earaches
☐	☐	Ringing or sounds in ears
☐	☐	Hearing problems
☐	☐	Sinus problems
☐	☐	Sneezing
☐	☐	Snoring
☐	☐	Nose bleeds
☐	☐	Dry mouth or throat
☐	☐	Sore throat
☐	☐	Swollen glands
☐	☐	Frequent hoarseness
☐	☐	Mouth or lip sores
☐	☐	Many cavities or root canals
☐	☐	Unusual taste in mouth
☐	☐	Teeth grinding or clenching
☐	☐	Jaw Problems or TMJ
☐	☐	Facial pain
☐	☐	Headaches
☐	☐	Blood in urine
☐	☐	Burning or painful urination
☐	☐	Difficult urination / retention
☐	☐	Frequent or urgent urination
☐	☐	Frequent urination at night
☐	☐	Loss of bladder control

Past	Now	
☐	☐	Anger
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Fear
☐	☐	Frustration
☐	☐	Grief or sadness
☐	☐	Irritability
☐	☐	Mood swings
☐	☐	Obsession
☐	☐	Panic Attacks
☐	☐	Stress
☐	☐	Worry
☐	☐	Victim of Child Abuse
☐	☐	Victim of Domestic Abuse
☐	☐	Victim of Sexual Abuse
☐	☐	War Veteran
☐	☐	Acne pimples
☐	☐	Dry skin / Oily Skin
☐	☐	Itching or burning skin
☐	☐	Skin rash or sores
☐	☐	Tendency to get hives
☐	☐	Scalp itching or flaking
☐	☐	Early graying of hair
☐	☐	Loss of hair
☐	☐	Nail fungus
☐	☐	Weak / brittle nails
☐	☐	Numbness or tingling
☐	☐	Poor concentration
☐	☐	Poor memory
☐	☐	Seizures or convulsions
☐	☐	Shaking or trembling
☐	☐	Stuttering or stammering
☐	☐	Difficulty falling asleep
☐	☐	Waking up frequently
☐	☐	Wake up still tired
☐	☐	Many dreams
☐	☐	Nightmares

LIFESTYLE & DIET

☐ Tobacco ☐ E-Cigarettes ☐ Marijuana	☐ Recreational Drugs ☐ High Stress ☐ Occupational Hazards	Exercise: (describe)
☐ Coffee (amt): ______________ ☐ Tea (amt):_______________ ☐ Soft Drinks (amt):___________ ☐ Energy Drinks (amt) ________ ☐ Alcohol (amt): _____________ ☐ Water (amt): _______________	☐ Artificial Sweeteners ☐ Fast Food ☐ Vegetarian/ Vegan ☐ High Protein ☐ Gluten-free ☐ Low Fat ☐ Crave Sugar ☐ Crave Salt	Herbs/Vitamins/Supplements: (list)

FOR MEN	
Past Now	**Past Now**
☐ ☐ Genital pain, swelling or itching	☐ ☐ Low sperm count / motility / morphology
☐ ☐ Abnormal sex drive [ ] high [ ] low	☐ ☐ Penile discharge
☐ ☐ Erectile dysfunction	☐ ☐ Prostate problem (PSA reading:__________)

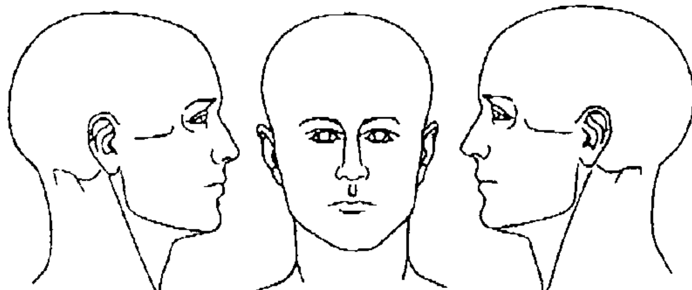
FOR WOMEN		
Past Now	**Past Now**	**Past Now**
☐ ☐ Abnormal PAP smear	☐ ☐ Endometriosis	☐ ☐ Ovaries removed
☐ ☐ Abnormal sex drive	☐ ☐ Fibroids	☐ ☐ Pain with intercourse
☐ ☐ Abortion history	☐ ☐ Genital pain, swelling or itching	☐ ☐ Painful periods
☐ ☐ Bleeding between periods	☐ ☐ Heavy bleeding with periods	☐ ☐ Pelvic inflammatory disease
☐ ☐ Breast lumps / tenderness	☐ ☐ Hysterectomy	☐ ☐ Polycystic ovary disease
☐ ☐ Clots in menstrual blood	☐ ☐ Menopausal symptoms	☐ ☐ Premenstrual tension / PMS
☐ ☐ Difficulty conceiving	☐ ☐ Miscarriage	☐ ☐ Vaginal discharge or dryness

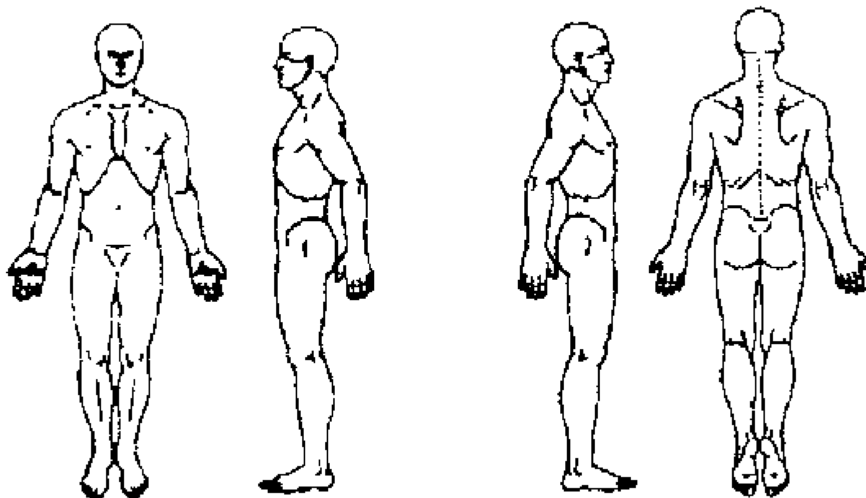
Are you currently pregnant or trying to become pregnant?	
Duration of periods:	Number of pregnancies you've had:
Interval between periods (onset to onset):	Number of births you've had:
Dates of last period:	Ages of your children:
Past birth control methods:	Current birth control method:

Check if you have or had any of these:		
Past Now	**Past Now**	**Past Now**
☐ ☐ Addiction (to _____________)	☐ ☐ Epilepsy / Seizure disorder	☐ ☐ Multiple sclerosis
☐ ☐ AIDS / HIV	☐ ☐ Gall bladder disease / stones	☐ ☐ Osteoporosis / osteopenia
☐ ☐ Allergies (to ______________)	☐ ☐ Glaucoma	☐ ☐ Pacemaker
☐ ☐ Anemia	☐ ☐ Gout	☐ ☐ Parkinson's
☐ ☐ Arthritis	☐ ☐ Gum disease	☐ ☐ Pneumonia
☐ ☐ Asthma	☐ ☐ Heart disease	☐ ☐ Polio
☐ ☐ Bleeding disorder	☐ ☐ Hepatitis or jaundice	☐ ☐ Rheumatic or Scarlet fever
☐ ☐ Blood clots	☐ ☐ Herpes	☐ ☐ Shingles
☐ ☐ Bronchitis	☐ ☐ High / Low blood pressure	☐ ☐ Spinal meningitis
☐ ☐ Cancer / tumor	☐ ☐ High cholesterol	☐ ☐ Stroke
☐ ☐ Cataracts	☐ ☐ Kidney stones	☐ ☐ Tuberculosis
☐ ☐ Chicken pox	☐ ☐ Kidney or bladder infection	☐ ☐ Thyroid trouble or goiter
☐ ☐ Chronic fatigue syndrome	☐ ☐ Liver disease	☐ ☐ Ulcer
☐ ☐ Colon / bowel disease	☐ ☐ Lupus	☐ ☐ Varicose veins
☐ ☐ Diabetes	☐ ☐ Malaria	☐ ☐ Venereal disease
☐ ☐ Emotional / mental illness	☐ ☐ Measles, Mumps or Rubella	Other:
☐ ☐ Emphysema	☐ ☐ Mononucleosis	

Surgeries, hospitalizations & dates:	Accidents, injuries & dates:	Medications, reasons & dosages:
		______________________________
		______________________________
		______________________________
		______________________________
		______________________________
		______________________________
		______________________________

Please Indicate Areas of Pain or Discomfort:





		Severity			Severity
☐	Back pain or trouble -------------	1 2 3 4 5	☐	Spinal disc problems ------------	1 2 3 4 5
☐	Muscle pain, spasm, cramping -	1 2 3 4 5	☐	Stiff or painful neck ------------	1 2 3 4 5
☐	Muscle weakness -----------------	1 2 3 4 5	☐	Swelling ---------------------------	1 2 3 4 5
☐	Restless or nervous legs ---------	1 2 3 4 5	☐	Tendonitis (where:________________________)	

Please describe your pain/discomfort:

____

____

____

____

____

By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I understand that if I wish to change the dosages of my medications, D. Balusik recommends that this happen gradually and with consent of my prescribing physician(s). I know D. Balusik does not treat cancer or epilepsy.

Sign:	**Date:**

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

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 Acupuncture

OFFICE POLICIES

Welcome to our Practice! We have implemented certain office policies and procedures to ensure safety and the highest level of care:

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1. We do not dispense any herbal medicine or supplement to people who are not active patients of Dawn Balusik (meaning you have been seen for treatment within the last year.)

2. We are available for communication primarily via phone and secondarily via e-mail. Please do not text, instant message, Facebook, Twitter, or otherwise attempt communication, as these may not be received. Likewise, if you e-mail and do not receive a return e-mail within 24 hours, please call the office; phone is the most reliable route of communication for our office.

3. Dawn Balusik is available for communication with active patients for quick questions that can be answered briefly. If you have a more complex question or lengthy explanation, or if your question requires an in-depth answer, we may ask that you schedule an appointment, either in-office or on-phone.

4. We try to return phone calls and e-mails within a few hours, but sometimes that is not possible. However, we will always return phone calls by 8pm on Monday, Wednesday, and Friday. We may not be in the office on Tuesday, Thursday, Saturday, Sunday, and may not be available for communication on those days.

5. We **do not** practice emergency medicine. If you have an emergency, please call 911 or report to your local emergency room or urgent care clinic. If you have an urgent situation that you think does not require an emergency room visit, and you think Dawn Balusik may be able to help, please phone us. We will do what we can for you, but if your situation worsens or if you do not hear back from us within a time-frame that is appropriate for your situation, please call 911 or report to your local emergency room or urgent care.

6. We keep your health information private. If you would like a copy of our Privacy Practices, please let us know.

I have read and agree to the above Office Policies:

____ ________________

Signature **Date**

Dawn Balusik Acupuncture

FINANCIAL POLICIES

(revised 07/17)

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Payment Methods Accepted: Cash, Check, Visa, Mastercard, Discover & American Express are accepted.

Returned Checks: Each returned check will incur a fee of $35.

Cancellations or Missed Appointments: We require a notice of 24 hours if you need to cancel an appointment, or you will be billed at the rate of *$65 for your missed appointment*.

If you have a Health Savings Account: Acupuncture treatment is allowable under all HSA's. You will need to check with your specific HSA to find out if herbal medicine prescribed by a health professional is an allowable expense.

If Your Health Insurance Policy Covers Acupuncture: We do not bill insurance. At your request, we will provide you a superbill/receipt form which contains all the procedure & diagnostic codes prudent to your visit. You can submit a copy of this form to your insurance company for them to reimburse you directly.

If You are an Auto Injury Patient: Unfortunately, Florida PIP does not cover acupuncture services, but you may submit your paid receipts to your PI attorney for reimbursement from your eventual settlement or lawsuit.

If You are a Medicare Patient: At this time, Medicare does not cover acupuncture services.

Fee Schedule:

New Patient (60-90 mins):	$150 - $175 (depending on severity)
Acupuncture Follow-up (45-60 mins):	$85 (see package discounts below)
Childbirth Preparation (60 mins):	$100 initial, then same as Follow-up
Herbal / Nutritional Only Follow-up (30 mins):	$65
Pediatric (12 & under) Follow-Up:	$65
Phone Consult (for active patients only):	$35 per 15 minute increment
Herbal Formulas / Supplements:	varies

Discounts for Follow-Up Acupuncture Visits:

- $5 off your visit when paying by Cash.
- Packages: *** *Packages must be purchased with Check or Cash only.****
  3 visits for $240 (This is $5 off each visit.)
  6 visits for $450 (This is $10 off each visit.)

Note: If you request a refund on a partially used package, the fees for the completed treatments reverts back to the usual $85 fee, and your refund will be calculated accordingly.

I have read and agree to the above Financial Policies.

______________________________ ______________________

Signature **Date**