Ashley Herrin, D.O.M.,A.P.
Infinite Health and Wellness Center
2717 E. Oakland Park Blvd
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""""""NEW PATIENT INTAKE

Today's Date ____/____/____

Name ______________________________________ Birthdate ____/____/____ Age ________
First Middle Last

Sex Male□ Female□ Height ________ Weight ________ Any significant weight change in last year?___ How? _________

Occupation _________________ Occupational Hazards _________________ Marital Status _________ Children (#) ______

Address ____
Street or P.O. Box City State Zip Code

Home Phone (____)_____-_______ Work Phone (____)_____-_______ Cell Phone (____)_____-_______

Email ______________________________________""""""""""""""""Uqekcn'Ugewtkv{ "%'aaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaaa

Emergency Contact _________________________ (___)_____-_______ _____________________
Name Phone Relationship to Patient

How did you hear about us? ____

Have you had acupuncture before? Yes□ No□ Chinese Herbal Medicine? Yes□ No□

Reason for visit today: ___________________________________ Any other concerns you'd like to address?__________________

How long have you had this condition?______________ Is it getting worse? _____

Does it bother your: Sleep□ Work□ Other□? Describe ____

What seemed to be the initial cause? ____

What seems to make it better? ____

What seems to make it worse? ____

Do you have a pacemaker? ____

WOMEN: are you or might you be pregnant? ____

Are you under the care of a physician now? Yes□ No□ If yes, for what?____Who is your physician? ____________________________
Physician's Phone (___)_____-____
Doctor's diagnosis? ____________________________
Describe any lab work done________________________________ Can you obtain copies? Yes□ No□

Family Medical History (List who on line below):

- ☐ Allergies
- ☐ Asthma
- ☐ Arteriosclerosis
- ☐ Cancer
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Kidney Disease
- ☐ Lung Disorder
- ☐ Heart Disease
- ☐ Seizures
- ☐ Substance abuse
- ☐ Liver Disease
- ☐ Stomach Disorder
- ☐ High Blood Pressure
- ☐ Strokes
- ☐ Mental illness
- ☐ Other

Your Past Medical History (Check any of the following conditions you currently have, or have had in the past.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Any unusual childhood illness______________
- ☐ Diabetes
- ☐ Frequent Ear Infections
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lung Disorder
- ☐ Liver Disease
- ☐ Measles
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rashes
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Disorder
- ☐ Strokes
- ☐ Substance Abuse
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (specify)
- ☐ Surgery (list type, date)
- ☐ Major Trauma (accident, injury, etc., list & date)

List all drugs (prescription or not) you are taking. Include the reason taken, amount, length of time taken, and results. List all other drugs you have taken in the past.

Name	Amount	Why Taking	How Long	Results

Antibiotics used in last 2 YEARS (dates and purpose): ______________________________

List any known **allergies** to either food or drugs:______________________________

Do you use/consume any of the following?

	Amount/Frequency		Amount/Frequency		Amount/Frequency
☐ Coffee		☐ Sugar		☐ Alcohol	
☐ Tea		☐ Salty Food		☐ Tobacco	
☐ Soda / Soft Drinks		☐ Artificial sweetener		☐ Marijuana	
☐ Dairy		☐ Laxatives		☐ Other illegal drugs	
☐ Chocolate		☐ Water			

List any foods you crave: (i.e. salty, sweet, sour, spicy, carbohydrates)

____

Do you have a special diet or dietary restrictions? ______ Describe? ______________________________

What 10 foods do you eat most frequently? ______________________________

Describe your **AVERAGE** daily diet:

Breakfast What time?	Snack What time?	Lunch What time?	Snack What time?	Dinner What time?	Snack What time?
________	________	________	________	________	________
________	________	________	________	________	________
________	________	________	________	________	________
________	________	________	________	________	________

List all nutritional supplement products you are taking. Include the name of the company, amount, why you are taking them, and how long you have been taking them.

Name	Company	Amount	Why Taking	How Long

How often do you do exercise or do physical work?

☐ Never ☐ Once in a while ☐ Several time per month ☐ Several times per week ☐ Daily

Describe type of activity: ____

Have you had to cut down on exercise or recreation because of your health? ______________________

Describe your hobbies and interests: ________________________________

What is your overall level of satisfaction with life? ______________________

Would you say that you are under a lot of stress? _______ Describe? ______________

What methods do you use to alleviate or cope with stress? __________________

Do you suffer from exhaustion or fatigue? _______ If yes, describe how you feel? __________

____

How often do you feel fatigue? _______________ What time of day do you feel most tired? _________

Do you experience undue worry, difficulty concentrating, or forgetfulness?_____ Describe? __________

____

General Symptoms

☐ Poor appetite	☐ Prefer cold drinks	☐ Frequent Colds	☐ Shortness of breath	☐ Muscle cramps
☐ Heavy appetite	☐ Prefer hot drinks	☐ Lack of strength	☐ Fever or heat sensation	☐ Vertigo or dizziness
☐ Lack of taste	☐ Poor sleep	☐ Bodily heaviness	☐ Chills or cold sensation	☐ Bleed or bruise easily
☐ Peculiar taste in mouth	☐ Heavy sleep	☐ Cold hands/feet	☐ Night sweats	☐ Low Blood Pressure
Describe______________ ____________________	☐ Dream-disturbed sleep	☐ Poor circulation	☐ Sweat easily	☐ High Blood Pressure

Head, Eyes, Ears, Nose, Throat

☐ Glasses
☐ Eye pain
☐ Hearing loss
☐ Red eyes
☐ Itchy eyes
☐ Dry eyes
☐ Spots in eyes
☐ Poor vision

☐ Blurred vision
☐ Night blindness
☐ Glaucoma
☐ Cataracts
☐ Teeth problems
☐ Grinding teeth
☐ TMJ
☐ Facial pain

☐ Gum problem
☐ Sores on lips or tongue
☐ Dry mouth
☐ Excessive salivation
☐ Sinus problems
☐ Excessive phlegm
Color of phlegm________
☐ Recurrent sore throat

☐ Swollen glands
☐ Lumps in throat
☐ Enlarged thyroid
☐ Nose bleeds
☐ Ringing in ears
☐ Earaches
☐ Headaches
☐ Migraines

☐ Concussions
Other head or neck problems:
____
____
____
☐ Runny Nose
☐ Difficulty Swallowing

Respiratory

☐ Difficulty breathing when lying down
☐ Shortness of breath

☐ Tight chest
☐ Asthma / wheezing
☐ Bronchitus

☐ Cough
Wet or dry?____________
Thick or thin?__________

Color of phlegm
____

☐ Coughing blood
☐ Pneumonia

Cardiovascular

☐ High blood pressure
☐ Blood clots
☐ Low blood pressure

☐ Fainting
☐ Chest pain
☐ Difficulty breathing

☐ Tachycardia
☐ Heart palpitations
☐ Heart murmur

☐ Mitral valve prolapse
☐ Phlebitis
☐ Irregular heartbeat

☐ Chest Tightness
Other:_________________
____

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating
☐ Bad breath
☐ Intestinal Gas

☐ Diarrhea
☐ Constipation
☐ Laxative use
☐ Black stools
☐ Bloody stools
☐ Mucous in stools
☐ Incontinence
☐ Frequent Hunger

☐ Intestinal pain or cramping
☐ Itchy anus
☐ Buring anus
☐ Rectal pain
☐ Hemorrhoid
☐ Anal fissures
☐ Pain After Eating
☐ Excess Thirst

Bowel movements: # times a day
____
Color________________
Texture/form (hard, loose, sticky, watery)
____
Odor_______________
☐ Stomach Pain
☐ Hard to Lose Weight

Any undigested food in stool?_______________
Any particular foods affect quality of stool?
____
____
____
____
☐ Hard to Gain Weight

Muskuloskeletal

☐ Neck/shoulder pain
☐ Muscle pain
☐ Upper back pain
☐ Joint Stiffness

☐ Nerve Pain
☐ Hip Pain
☐ Knee Pain
☐ Bursitis

☐ Low back pain
☐ Joint pain
☐ Rib pain
☐ Muscle Spasms

☐ Numbness
☐ Tingling
☐ Sciatica
☐ Muscle Cramps at night

☐ Limited range of motion
☐ Limited use
☐ Swollen Joints
☐ Arthritis

☐ Lack of Muscle Tone

Other (describe):
____
____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations

☐ Eczema
☐ Psoriasis
☐ Acne

☐ Dandruff
☐ Itching
☐ Hair loss

☐ Change in hair/skin texture
☐ Premature graying of hair (if not familial)
☐ Fungal infections

Other (describe):
____
____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics
☐ Frequent Crying

☐ Poor memory
☐ Depression
☐ Mania
☐ Mood Swings

☐ Anxiety
☐ Irritabililty
☐ Easily stressed
☐ Confusion

☐ Abuse survivor
☐ Considered/attempted suicide
☐ Seeing a therapist
☐ Poor Concentration

☐ ADD/ADHD
Other (describe): __________________
____

Genito-urinary

☐ Painful urination
☐ Burning urination
☐ Frequent urination
☐ Urgent urination
☐ Foul smelling urine
☐ Blood in urine
☐ Milky/cloudy urine
☐ Dark urine
☐ Unable to hold urine
☐ Incomplete urination
☐ Dribbling urine/erratic flow
☐ Bedwetting
☐ Wake to urinate
☐ Kidney stones
☐ Venereal disease
☐ Increased libido
☐ Decreased libido
☐ Impotence
☐ Premature ejaculation
☐ Nocturnal emission
☐ Spontaneous emission
☐ Testicular pain
Age of 1st ejaculation _______
Other (describe): ___________
☐ Thinning Pubic Hair

Gynecology

Age 1st intercourse __________
Age menses began ___________
Age at menopause ___________
Cycle length (day 1 to day 1) ___
Duration of flow _____________
Color (brown, purple, pale red)
____
☐ Blood clots
☐ Irregular periods
☐ Painful periods
☐ PMS
☐ Vaginal discharge
(color)___________
(texture) __________
☐ Vaginal Dryness
☐ Endometriosis
☐ Fibroids
☐ Ovarian cysts
☐ Breast lumps
☐ Breast tenderness
☐ Painful intercourse
Pregnancies _________
Live births _________
Abortions __________
Miscarriages ________
Premature births _____
Date of last PAP:
____
Date last period began:
____
Method of birth control :
____
Other (describe): ______
____
____

Sleep

☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Excessive Dreaming

☐ Light Sleeper ☐ Nightmares How many hours do you sleep each night? __________

☐ Wake up Tired ☐ Wake up Rested ☐ Drowsy during the day or after meals

Patient Signature ____ Date _____________________

Guardian ____ Date _____________________

____ Date _____________________
(If under 18 years old, parent or guardian must also sign here.)

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INFINITE HEALTH & WELLNESS CENTER

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Ft. Lauderdale, FL 33306
Tel: 954-566-5097 Ext. 7/Fax: 954-566-2037
Email: DrAshley@bodymindwell.com

"Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncture physician at Infinite Health and Wellness Center.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to terminate acupuncture treatment at any time.

Chinese Herbs, Homeopathic Remedies, Dietary Supplements: I understand that substances from the Oriental Materia Medica, homeopathy, and/or dietary supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the All One Acupuncture as soon as possible.*

Cupping: I understand that if I receive cupping as part of therapy, there is a risk of local bruising, minor bleeding, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Other Modalities: I understand that I may receive treatment using other modalities (within the scope of practice of licensed acupuncture physicians as permissible by Florida Law), including *but not limited to*: laser, auricular (ear) acupuncture or acupressure, dietary counseling and food therapy, qi gong, etc. I am aware that certain adverse side effects may result. These may include but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse these other modalities.

PRESCRIPTION MEDICATIONS FROM YOUR M.D.: I understand that it is not uncommon for patients to experience beneficial changes in their health that may affect their need for existing prescription medications and dosages. I am aware that in the course of my treatment, it may be necessary to more frequently consult with my prescribing physician(s) regarding medications and dosages. I understand that it is ***absolutely necessary*** to disclose any and all prescription medications and dosages I am taking to my acupuncture physician, as these may affect my treatment.

I understand that there may be other treatment alternatives, including treatment offered by other types of licensed physicians.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: ____ **Date:** ____________________
(Patient or Legal Guardian)

Printed Name: ____ **Date of Birth:** ______________

Address: ____

City: ______________________ **State:** _____ **Zip Code:** ____________ **Phone:** ____________________

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Email: DrAshley@BodyMindWell.com

"Financial Policy

Our financial policy requires that all payments be made at the time services are rendered. One exception to this is for prepaid treatment packages. In this case, if you have a prepaid credit balance on your account, this will be applied towards payment at the time services are rendered. If there is any amount exceeding your existing credit balance, it must be paid immediately at time services are rendered.

We do accept insurance if your policy has coverage. We will bill for you the appropriate paperwork for reimbursement. *(Note: Some insurance companies will provide reimbursement for acupuncture in part or in full, but it is up to you to research the specifics of your policy with your particular insurance company).* Regardless, full payment is still due at time services are rendered.

REFUND POLICY: Herbal remedies, homeopathics, vitamin and/or nutritional supplements must be returned within 30 days or less, unopened, untampered, original packaging in good condition, for full cash or credit card refund, or credit to your account. This does not apply to chinese herbal formulas/pills that are specially blended for you. (These remedies are individually tailored and made for each person's specific condition and constitution, thus, no two are ever identical, so they cannot be resold). All ***SERVICES*** rendered are non-refundable.

MISSED APPOINTMENTS: We value your time, and will make every attempt to avoid long waits for your scheduled appointments. We ask that you value our time, as well, and keep your appointments in a timely manner. If you cannot make it to your scheduled appointment, we ask that you provide us with notice at least 24 hours prior. ***Otherwise, you will b e assessed a $35 dollar missed appointment fee.*** (If there are extenuating circumstances, we may waive this fee, but this will be the exception and not the norm, and will be determined on an individual, case-by-case basis.) As scheduling permits, if you change the time on the same date of your original appointment, you will not be charged.

I have carefully read and understand the above information and am fully aware of what I am signing. I accept the terms of payment and take full responsibility for payment of services.

________________________________ __________________________

Appointment Cancellations

Less than 24 business hours prior: $35

As scheduling permits, changing time on the same date of original appointment will not be charged.

CANCELLATION POLICY AGREEMENT

I, __________________________, have thoroughly read the Financial Policy and
(Print your name)
understand that should I fail to give 24 hours notice for cancellation of appointments, my credit card (below) will automatically be charged a $35.00 fee for each missed appointment.

______________________________________ __________________________
Signature of Patient or Person Responsible for Payment **Date**

________________________________ __________________________
Printed Name **Relationship to Patient**

CREDIT CARD AUTHORIZATION
For Cancellation Fees

Ashley Herrin, D.O.M., A.P.
Infinite Health and Wellness Center
2717 E. Oakland Park Blvd, St 103
Fort Lauderdale, FL 33306
Phone: 954-566-5097 Ext. 7

Date:________________

Credit Card and Cardholder Information

Cardholder's Name (exactly as appears on the card)-
____

Corporate Name (if a Business card)____

Cardholder's Billing Address____
(Street Address or P.O. Box) (City, State, and Zip Code)

Type of Credit Card Visa'"' '""Mastercard '"""""'American Express'"' '""Discover

Complete Card Number:___________________________________

Expiration Date:_____/_____/_____

***** **CVV/CVC Number**: (last three digits located on the back of the card on the signature line)
'"""""'aaaaaaaaa

I authorize Infinite Health and Wellness Center to bill the above listed credit card in the amount of $35.00 for any cancellations made less than 24 hours prior to scheduled appointments. I am fully aware that my credit card is being charged for this cancellation fee. I am fully aware of the Financial and Cancellation Policy and therefore waive my chargeback/dispute rights for this cancellation fee.

Cardholders Signature:_____________________________

Date:_________________________________