

Patient Medical History

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_

State your MAIN problem: \_\_\_\_\_

\_\_\_\_\_

When did it start? What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

State any SECONDARY problems: \_\_\_\_\_

\_\_\_\_\_

List ALL CURRENT or PAST DISEASES: \_\_\_\_\_

List all PRESCRIPTION DRUGS you have ever taken and are currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rate your sleep: \_\_deep & restful \_\_light \_\_restless \_\_nightmares \_\_trouble falling \_\_wake up a lot

Rate your appetite: \_\_excessive eating \_\_cravings \_\_moderate \_\_low appetite

Rate your energy: \_\_great \_\_good \_\_O.K. \_\_low

Rate your work stress: \_\_high \_\_moderate \_\_low; Rate your home stress: \_\_high \_\_moderate \_\_low

What is your occupation?: \_\_\_\_\_

\_\_\_\_\_

Check all mental/emotional traits you exhibit 50% or more of the time in a 24-hour day:

controlling angry impatient depressed irritable excessive laughing passionate

loving anxious sad diplomatic tolerant grounded worry obsessive intolerant

intellectual methodical organized aloof melancholy easygoing courageous creative

strong willed evasive lazy fearful rigid

In Chinese Medicine particular emotional traits are associated with the condition of your internal organs.

Please describe your bowel movements: Check all that relate -

regular irregular irritable loose constipated dry little balls large light dark

unusually bad odor bloody mucus watery fully formed difficult 1x day up to 3x day

every other day few times a week only with laxatives

Please describe your urination: Check all that relate

frequent infrequent lose when cough or sneeze lose when laugh lose when exercise wear pads

get up during sleep burning bad odor cloudy bloody light color dark color

\_\_\_\_\_

**LADIES MENSTRUATION:** Check all that relate

Menopause: \_\_Yes \_\_No Length of period: \_\_\_\_\_ days Amount of blood: \_\_Light \_\_Moderate \_\_Hvy

Quality of blood: \_\_Thick/Clotty \_\_Rich/Smooth \_\_Pale/Thin Cycle Pattern \_\_\_\_\_

Bleed out of cycle: \_\_Yes \_\_No Any and All Body Pains during Period: \_\_\_\_\_

Other problems during Period: \_\_nausea \_\_diarrhea \_\_edema Growths: \_\_ovarian cysts \_\_fibroids

endometriosis

\_\_\_\_\_

**MEN'S GENITAL FUNCTION:** Check all that relate

premature ejaculation impotence cold semen textured semen testicle problems low sperm count

prostate problems

**Please Review the Following Carefully and Check All that Relate To You:**

**EYES:** \_\_strain \_\_dryness \_\_pain \_\_blurry \_\_nearsighted \_\_farsighted \_\_infections \_\_floaters  
\_\_cataracts \_\_glaucoma

**EARS:** \_\_loss of hearing \_\_aches & pain \_\_ringing \_\_infections

**NOSE:** \_\_stuffy \_\_nasal drip \_\_dry mucus \_\_thick mucus \_\_can't breath \_\_nose bleeds

**NAILS:** \_\_brittle \_\_infections \_\_ridged \_\_white spots \_\_hangnails

**SKIN:** \_\_pimples \_\_itching \_\_rashes \_\_moles \_\_spots \_\_dryness \_\_thin/delicate \_\_spider veins &  
location:\_\_\_\_\_ varicose veins & location:\_\_\_\_\_

**HAIR:** \_\_loss \_\_dryness \_\_itchy scalp **HEAD:** \_\_pain & location\_\_\_\_\_ flushed face \_\_injury \_\_bumps  
\_\_dizziness \_\_heavy / full sensation **MOUTH:** \_\_jaw clicks \_\_sores on lips \_\_sores on tongue \_\_grind teeth  
\_\_gum problems \_\_teeth problems \_\_tmj \_\_dry throat

**LUNGS:** \_\_short breath \_\_heavy sensation \_\_pain on breath \_\_chest phlegm \_\_cough \_\_asthma \_\_bronchitis  
\_\_pneumonia \_\_lose breath when exercising

**HEART:** \_\_low pressure \_\_high pressure \_\_palpitations \_\_chest tightness \_\_rapid rate \_\_slow rate \_\_  
chest pain \_\_irregular beat \_\_blood clots \_\_surgeries \_\_vessel blocks \_\_strokes \_\_heart attacks

**SPLEEN & STOMACH:** \_\_edema \_\_nausea \_\_belching \_\_hiccups \_\_ulcer \_\_indigestion \_\_bloating \_\_  
bruise easy \_\_easy weight gain \_\_muscle ache \_\_tire after eating \_\_difficult weight loss

**LIVER / GALLBLADDER:** \_\_gallbladder pain \_\_stones \_\_pain under ribs \_\_breast distension  
\_\_genital infections \_\_groin pain \_\_hepatitis A B C \_\_enlarged liver \_\_ligament pain anywhere in body

**KIDNEY:** \_\_stones \_\_frequent urination \_\_burning urination \_\_painful urination  
\_\_difficult or incomplete urination \_\_urine leaks \_\_low back pain \_\_knee joint / cap pain  
\_\_bone pain anywhere in body \_\_memory loss

**LARGE INTESTINE:** \_\_polyps \_\_worms \_\_bleeding \_\_constipation \_\_diarrhea \_\_surgeries \_\_prolapse  
\_\_hemorrhoids \_\_appendicitis \_\_cramping

**BACK / SPINE:** *Upper Middle Lower*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_joint pain \_\_numbness \_\_cold \_\_hot \_\_swollen \_\_stiff \_\_tight

**HAND:** *Right Left Both*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_wrist pain \_\_vessel pain \_\_numbness \_\_tingling \_\_cold \_\_hot  
\_\_swollen \_\_stiff \_\_tight

**FINGERS:** *Right Left Both*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_joint pain \_\_vessel pain \_\_numbness \_\_tingling \_\_cold \_\_hot  
\_\_swollen \_\_stiff \_\_tight \_\_top of hand \_\_bottom of hand

**ARM:** *Right Left Both*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_shoulder pain \_\_elbow pain \_\_vessel pain \_\_numbness  
\_\_tingling \_\_cold \_\_hot \_\_swollen \_\_stiff \_\_tight

**LEG:** *Right Left Both*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_hip pain \_\_knee pain \_\_vessel pain \_\_numbness \_\_tingling  
\_\_cold \_\_hot \_\_swollen \_\_stiff \_\_tight

**FOOT:** *Right Left Both*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_ankle pain \_\_vessel pain \_\_numbness \_\_tingling \_\_cold \_\_hot  
\_\_swollen \_\_stiff \_\_tight \_\_top of foot \_\_bottom of foot

**TOES:** *Right Left Both*

\_\_bone pain \_\_muscle pain \_\_ligament pain \_\_joint pain \_\_vessel pain \_\_numbness \_\_tingling \_\_cold \_\_hot  
\_\_swollen \_\_stiff \_\_tight

**Please Check All Food Items That You Eat and Mark Frequency:**

<b>FOOD ITEM</b>	<b>Daily</b>	<b>Weekly</b>	<b>Monthly</b>	<b>Yearly</b>
Chicken				
Seafood				
Shellfish				
Beef				
Pork				
<i>Other Meat:</i>				
<b>Wheat*</b>				
Rye				
Oat				
Other Grain:				
Apples				
<b>Oranges*</b>				
<b>Strawberries*</b>				
Bananas				
Berries				
<i>Other Fruit:</i>				
Broccoli				
Green Beans				
<b>Corn</b>				
Potato				
<i>Other Vegetable:</i>				
<b>Cow Milk*</b>				
<b>Soy Milk*</b>				
Goat Milk				
Rice Milk				
<b>Yogurt*</b>				
<b>Cheese*</b>				
<b>Pudding*</b>				
<b>Ice Cream*</b>				
<b>Eggs*</b>				
<b>Peanuts*</b>				
<b>Tree Nuts* (Circle Items)</b>				
Cashews, Pecans, Macadamia,				
Almonds, Pistachios, Brazil, Pine,				
Hazelnut, Walnut				
<b>Alcohol (Wine, Beer, Hard Liquor</b>				
<b>Yeast Products* (Baked Goods)</b>				
<b>Packaged / Preserved Foods*</b>				
<b>Restuarant / Fast Food</b>				
<i>* These items tend to cause allergic reactions</i>				

INSURANCE VERIFICATION SHEET

Please fill out the following form to collect and verify insurance coverage. (You may call the provider yourself if you choose to do so.)

Insurance Company Name

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Insurance Company Claim Submission Address

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Customer Service Phone Numbers

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Name of Person Insured on the Plan

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Your Relationship to the Insured (Self, Spouse, or Other?)

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Patient Membership No. \_\_\_\_\_ Group Policy No \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_ Social Security No \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

QUESTIONS TO ASK INSURANCE REPRESENTATIVE

It is **very important** that all of the following questions are asked to **ensure coverage**. Remember insurance companies are **in the business of not paying if they can get around it**.

Has my **deductible been met?** \_\_\_\_\_ **How many** acupuncture treatments are allowed on this plan? \_\_\_\_\_

**Who** may perform these treatments? \_\_\_\_\_

May a **licensed acupuncture physician perform** these treatments? \_\_\_\_\_

What **kinds of diseases** may be treated with acupuncture **for coverage?** \_\_\_\_\_

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Will you cover acupuncture treatments performed by a physician **out of network?** \_\_\_\_\_

**What percentage** of the acupuncture treatment will you cover? \_\_\_\_\_

# HUNGERFORD MEDICAL INC

2609 SW 33rd Street • Unit 103 • Suite 1  
Ocala, Florida 33471

IQLIA HUNGERFORD, A.P., M.S.

## STATEMENT OF PRIVACY POLICIES

Hungerford Medical Inc. is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

This office gathers personal information and health information in several ways:

- Information received from you;
- Information received from other healthcare providers;
- Information received from third party payers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship with you I will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize me to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have for your protected health information.

### ***Marketing***

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletter and appointment reminder, by calls, post cards or letters.

### ***Disclosure***

This office may use or disclose your Protected Health Information when required by this law.

### ***Patient Rights***

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that this office amends your Protected Health information; the request must be in writing.
5. You have a right to receive all notices in writing.

You may send a written complaint to the U.S. Department of Health and Human Services.

If you have questions, complaints or want more information, contact this office.

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ACKNOWLEDGEMENT  
OF RECEIPT OF  
STATEMENT OF PRIVACY PRACTICES

I, \_\_\_\_\_, have read, reviewed, understand and agree to the Statement of the Privacy Policy for healthcare services in the office of Hungerford Medical Inc. This practice has provided me with a Statement of Privacy Policies.

\_\_\_\_\_  
*Please Print* Patient's Name or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Provider's Original Signature

\_\_\_\_\_  
Date