Absolute Integrated Medicine
1575 Indian River Blvd Suite C-136
Vero Beach, FL 32960
772-770-6184

Please fill in the following information as completely as possible. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME_____**DATE**_____

ADDRESS_____

CITY/STATE_____ **ZIP**_____

HOMEPHONE_____ **CELL PHONE**_____

EMAIL_____

DATE OF BIRTH_____**AGE**_____**TIME OF BIRTH**_____**AM/PM**

PLACE OF BIRTH _____ **MARITAL STATUS**_____**CHILDREN**_____

PLACE OF EMPLOYMENT_____

WORK PHONE_____**BEST # TO REACH YOU**_____

How did you learn about our office?_____

Major Medical Complaint:_____

Medications:_____

_____

_____

_____

_____

Surgical History: _____

_____

_____

_____

_____

PATIENT PROFILE

NAME: _____ DATE: _____

It is very important in Chinese Medicine to know how long patient has experienced his/her symptoms. It is essential to indicate time on the symptoms.
Please indicate with one check (X) any conditions that you sometimes experience; use two checks for those which often occur and three (XXX) for symptoms that are a major concern.

WATER ELEMENT

_____Hearing Loss
_____Dizziness
_____Lower Back Pain/Neck Pain
_____Sinus Congestion
_____Edema
_____Rapid Weight Change
_____Darkness Under the Eyes
_____Emotional Instability
_____Aversion to Cold
_____Pre-Mature Aging
_____Frequent Urination
_____Kidney Stones
_____Perspire very easily
_____Weakness of the legs/knees
_____Reduced Sexual Energy
_____Thyroid Problems
_____Diabetes
_____Hair Thinning or Loss
_____Asthmatic Cough

WOOD ELEMENT

_____Ear Infections
_____Headache
_____Bitter Taste in Mouth
_____Migraines
_____Nose Bleeds
_____Ulcer
_____Gum Problems
_____Ringing in the Ears
_____Indecisiveness
_____Vomiting
_____Gallstones
_____Constipation
_____Hemorrhoids
_____Hepatitis
_____Poor eyesight
_____Eye Infections
_____Dry Eyes
_____Eczema
_____Shingles
_____Herpes Simplex
_____Nervousness

WOOD ELEMENT CONT.

_____Fullness Below Ribs
_____Shoulder/Neck Tension
_____Insomnia 11pm- 3 am
_____Warts
_____Convulsions/Spasms
_____Irritability
_____Painful Menstruation

FIRE ELEMENT

_____Dry Scalp
_____Skin Eruptions/Rashes
_____Cysts/Tumors
_____Sore Throat/Tonsillitis
_____Lymphatic Swelling
_____Hot Palms and Soles
_____Heart Palpitations
_____Aversion to Heat
_____Facial Redness
_____Itching/Burning Skin
_____Hot Hands/Feet
_____Thirst
_____Dark Urine
_____Night Sweats

EARTH ELEMENTS

_____Indigestion
_____Strong Appetite
_____Flatulence
_____Food Allergy
_____Stomach Ache/Ulcer
_____Diarrhea
_____Anemia
_____Halitosis
_____Mouth Sores
_____Heartburn
_____Weak Appetite
_____Nausea
_____Abdominal Bloating
_____Low Body Weight

METAL ELEMENT

_____Bronchitis
_____Asthmas
_____Shallow Breathing
_____Cough
_____Sinus Congestion
_____Nasal Infections

OTHER

_____Fatigue
_____Arthralgia
_____Sciatica
_____Nerve Pain
_____Cold Hand/Feet
_____Tendonitis
_____Bursitis

Pain (please describe):

_____
_____
_____
_____
_____
_____
_____
_____
_____

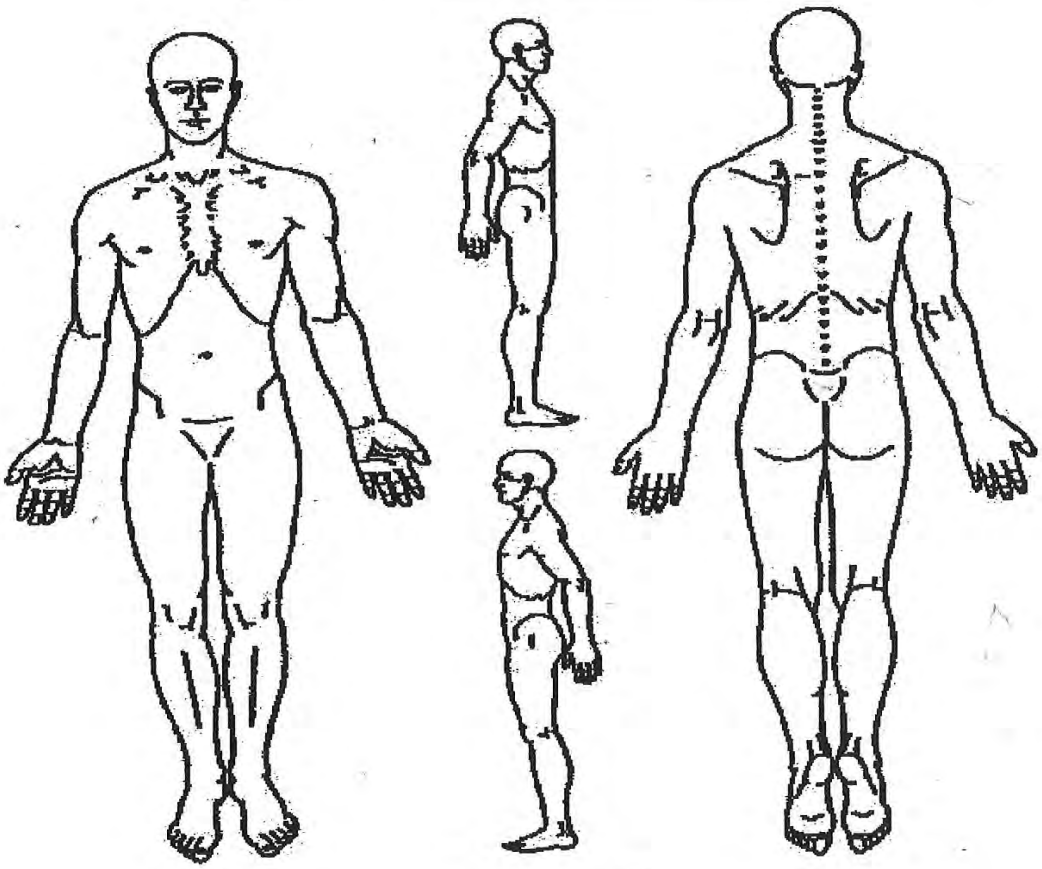
Other comments:

_____
_____
_____
_____
_____
_____
_____
_____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

Are you requesting medical care to treat an injury you received as a result of an accident (auto accident/slip & fall/ work injury)?

YES_____ NO_____

If yes, please answer the questions below. If no, disregard remaining questions and sign below.

Did the accident occur while at work?

YES_____ NO_____

Have you filed a claim with an insurance company?

YES_____ NO_____

If yes, which insurance company and when:_____

Have you filed a worker's compensation claim?

YES_____ NO_____

Are you represented by an attorney?

YES_____ NO_____

If yes, please list name and telephone number of attorney:_____

X_____DATE_____

Signature of Patient or Responsible Party

Absolute Integrated Medicine

PATIENT QUESTIONAIRE

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

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____
Name_____ Phone Number_____

III. 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.

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

_____

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

YES_____ NO_____

PATIENT NAME_____ (guardian if under 18 years)

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

Absolute Integrated Medicine

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND ITEX.

Regarding Insurance Payment

In signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective as the original.

X_____DATE_____

Signature of Patient or Responsible Party

Absolute Integrated Medicine

CONSENT FOR ORIENTAL MEDICINE

Scope of Practice

The "scope of practice" for an acupuncturist is the state of Florida includes but is not limited to the following list of techniques:

- Use of acupuncture needles to stimulate acupuncture points and meridians
- Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians
- Acupressure
- Laserpuncture
- Acupoint injection therapy
- Gua Sha
- Cupping
- Dietary advice based on traditional Chinese medical theory

I recognize the potential risks/side effects and benefits of these procedures as described below:

Potential risks/side effects may include, but are not limited to the following:

- Pain following treatment in insertion area
- Temporary discoloration of the skin
- Aggravation of symptoms existing PRIOR to the treatment
- Minor bruising
- Broken needle
- Infection
- Needle sickness

NOTE: Patients with bleeding disorder, pacemakers, seizure disorders, or women who are currently pregnant, MUST notify the practitioner.

Potential benefits may include, but are not limited to the following:

- Drugless relief of presenting symptoms
- Improved general health
- Elimination of the presenting problem
- Reduction of pain and associated symptoms

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Absolute Integrated Medicine (AIM V) of Vero Beach, regarding cure or improvement of my condition. I hereby release Absolute Integrate Medicine (AIM V) of Vero Beach from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time

_____

PATIENT/GUARDIAN SIGNATURE DATE

Yours in Health,

Jill Jaynes, AP
Beth Myers, AP
Melissa Veaudry, AP

Acupuncture Physicians