HEALTH SURVEY

Patient Name: _____ DOB: ____/____/_____ Cell #: _____- _____- _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home #: _____-_____-_____ Work #: _____-_____-____

Occupation: _____ Industry: _____ Hours worked per week: _____

How did you hear about us: TV ☐ Radio ☐ Social Media ☐ Referred by: _____

Please check any of the following symptoms which you have experienced in the last 30 days:

☐ Headaches		☐ Insomnia/Sleep Issue	☐ Sinus Issues/Allergies	☐ Dizziness
☐ Fatigue		☐ Irritability	☐ Fibromyalgia	☐ Weight Concerns
☐ Pain/Tension/Numbness		☐ Digestive Trouble	☐ Asthma	☐ Other _____
☐ Neck	☐ Legs	☐ Constipation	☐ Anxiety/Over Stressed	☐ Other _____
☐ Shoulders	☐ Arms	☐ Diarrhea	☐ Bladder/Urinary Issues	☐ Other _____
☐ Low Back	☐ Hands	☐ Gas	☐ Ringing in Ears	☐ Other _____
☐ Mid-Back	☐ Hips	☐ Bloating	☐ Muscle & Joint Pain	☐ Other _____
☐ Knees	☐ Feet	☐ Acid Reflux	☐ Thyroid Condition	☐ Other _____

Which of the above bothers you the most? _____

How long have you been bothered by this condition? Years _____ Months _____ Days _____

Describe how it feels and affects you when it's at its worst: _____

_____

Hormone Related Symptoms:

☐ Hot Flashes	☐ Loss of Sex Drive	☐ Afternoon Fatigue	☐ Tender Breast
☐ Mood Swings	☐ Anxiety	☐ Water Retention	☐ Sweet Cravings
☐ Trouble Sleeping	☐ Night Sweats	☐ Heart Palpitations	☐ Vaginal Dryness/Infections
☐ Irregular Bleeding	☐ Breast Lumps	☐ Depression	☐ Dry Skin
☐ Hair Loss	☐ Facial Hair Growth	☐ Osteoporosis	☐ Other _____

Does this cause you?	Does this affect your work?	Does this affect your life?
☐ Moodiness	☐ Decision Making	☐ Causes Loss of Patience with Spouse/Family
☐ Irritability	☐ Poor Attitude	☐ Restricts Household Duties
☐ Interrupted Sleep	☐ Decreased Productivity	☐ Reduces Ability to Exercise or Play Sports
☐ Stiffness/Less Flexibility	☐ Exhausted by the End of Day	☐ Interferes with Hobbies or Leisure Activities
☐ Activity Restriction	☐ Unable to Work Long Hours	

Maharajh Acupuncture
& Herb Shoppe

PATIENT CONTACT FORM

Patient Name: _____ DOB: ____/____/_____ Cell Phone: _____- _____- _____

1. Please list the family member or any other person we can inform about your general medical condition and diagnosis (including treatment, payment, and health care operation). If you do not wish your information to be shared with anyone, please check no. Authorized Person(s): YES___ NO___

   Contact Name: _____ Relationship: _____ Phone: _____/_____/_____

   Contact Name: _____ Relationship: _____ Phone: _____/_____/_____

2. Please list the person(s) we can inform about your medical condition *IN AN EMERGENCY :*

   If same as above check here: _____

   Contact Name: _____ Relationship: _____ Phone: _____/_____/_____

   Contact Name: _____ Relationship: _____ Phone: _____/_____/_____

3. Please print the address where you would like billing statements and/or correspondence sent to:

   Street Address: _____

   City: _____ State: _____ Zip: _____

4. Do you want all correspondence to be in a sealed envelope marked confidential? YES _____ NO _____

5. Please list your preferred form of contact for appointments, lab results, or other health care information:

   _____ Email___ Text ___ Call: ___

6. Can confidential messages be left on your voicemail? YES _____ NO _____

7. Are you 18 or over? YES _____ NO _____

Patient Name (print): _____
If under 18 have parent or guardian print

Patient Signature: _____
If under 18 have parent or guardian sign

PATIENT CONSENT FORM

In order for us to provide treatment for your condition(s) it is necessary for you to give your informed consent. This signed consent applies only to treatments administered by **Lisa Maharajh, A.P., D.O.M.** (licensed in Florida as an Acupuncture Physician. Lic.) or any other licensed healthcare provider working for **Maharajh Acupuncture & Wellness**.

Under Florida State Law, Chapter 457, such treatments may include, but are not limited to, the following modalities (Note: In your individual case, it may not be appropriate to receive all the following, or any of the following, and any treatments will be discussed in advance.):

A. Acupuncture, which involves the insertion of very small in diameter, sterile, single use, stainless steel needles as approved for use by the FDA into classical acupuncture points, trigger points (areas of "congested muscle or muscle spasms") or other painful areas. These treatment sites will be determined by physical exam, including classical Traditional Chinese Medicine tongue and pulse diagnosis, palpation in which the physician touches areas of the patients concern to determine what may be occurring in the area, signs, and the patient's subjective symptoms.

B. Electrical Stimulations or "e-stim," which includes the use of the various electric devices such as TENS (Transcutaneous Electrical Nerve Stimulation), MENS (Microcurrent Electrical Nerve Stimulation), either attached directly to acupuncture needles, or used separately using electrical pads or wet towels.

C. Cupping which involves the use of suction cups around painful areas for the purpose of improving blood circulation in the area.

D. Dietary and Lifestyle Counseling: You may be asked, as part of a general treatment program, to make changes in your diet and/or to make alterations to your lifestyle, including methods such as meditation for stress relief, physical exercise, and looking for ways to change stressful factors in your life.

E. Tui-na, which is physical therapy and manipulation in Traditional Chinese Medicine and may include techniques to adjust the spine and skeleton and massage-like techniques to relieve painful areas.

F. Heat Therapy, which usually involves, but is not limited to, the use of infrared heat lamps.

G. Herbal Medicine: Traditional Chinese Medicine extensively uses single herbs and/or complex formulas consisting of many herbs which treat internal medical conditions. Dr. Lisa has also studied herbal medicine from a Western herbal medicine tradition (including Native American, European, traditional, and other western medical systems), and utilizes herbs from North America, South America, Europe, and Asia.

H. Nutritional Supplements: These include well-known vitamins and minerals as well as nutrients not as commonly known.

I. Homeopathic Medicine: Homeopathy is a German medical system used extensively by doctors of all medical backgrounds throughout the world. Homeopathic medicines are FDA-regulated, and have met the standards of the U.S. Homeopathic Pharmacopeia.

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MaharajhAcupuncture.com

J. **Acupoint Injection Therapy**: The State of Florida Board of Acupuncture has approved the right of Acupuncture Physicians who meet the Board's training criteria to inject homeopathic substances, nutrients (such as B-12), and herbal medicines, where appropriate. In order to treat a wide variety of conditions from pain to internal medicine problems, Dr. Lisa has met and exceeded the Board's requirements for Acupoint Injection Therapy. Dr. Lisa also has additional certification in prolotherapy which involves the injection of diluted sterile dextrose and vitamin B-12 into weak ligaments and tendons with the therapeutic goal of strengthening them. These solutions are non-toxic.

K. **Cosmetic Acupuncture** is the use of tiny acupuncture needles in the face for the purpose of reducing fine lines and wrinkles, and to encourage the production of collagen and elastin. This technique may leave minor bruising. Results vary per condition and from person to person.

L. **Microcurrent**: Microcurrent therapy reduces fine lines and wrinkles by stimulating the muscles of the face. This is similar to the way regular exercise strengthens muscles in the body and improves shape. Microcurrent can also be used to address various types of pain. This technique differs from electrical stimulation by working on soft tissue instead the nervous system. It is a painless procedure with little to no risk.

M. **Nutritional Blood Cell Analysis** utilizes a drop of blood from your finger or ear which is evaluated under a microscope to identify health risks and concerns. This technique DOES NOT replace regular blood testing done by your western physician.

During an office visit, the doctor may find it necessary to perform a physical exam. This exam may include the Traditional Chinese Medicine techniques of pulse and tongue diagnosis, visual examination and observation, and palpation (examining and exploring an area by touching). With the patient's permission, a female assistant will be present when examining a female patient if observation or palpation of the breasts or genital areas is deemed necessary.

All patient medical information is private. No copies of records, details, or other information regarding any patient will be provided to anyone without the patient's signed consent for the release of such records or information.

My signature below indicates that I understand all of the above information. Any areas of confusion or questions have been answered by Dr. Lisa, or one of her employees, to my satisfaction. I understand that I cannot receive treatment until I have signed this consent form.

_____

Patient's Name (printed)

_____ _____

Patient's Signature Date

(Parent's Signature required if patient is under age 18.)

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MaharajhAcupuncture.com

MEDICATION & SUPPLEMENT LOG

PATIENT _____ DOB _____ MEDICAL/ALLERGY ALERTS:

DATE	MEDICATION/SUPPLEMENT	DOSAGE	CHANGES	STOP DATE

NOTES:

_____

_____

_____

_____

Insurance

Please Provide the information for insurance verification.

First Name:

Last Name:

Your Email:

Your Phone #:

Address:

City:

State:

Zip Code:

Referred By:

Insurance Name:

Insurance Telephone #:

Group Number:

Insured ID#:

Insured DOB:

Insurance Type: HMO | PPO | EPO | POS | Auto Insurance | Workers Comp

Please call our office or fax this information prior to your visit.

Phone: (727) 848-8777

Fax: (727) 848-8778

Financial Agreement: Health Insurance

We would like to take a moment to welcome you to our office and assure that you will receive the very best of care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductibles and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.

Payment Arrangements

We require that you pay your co pay each visit. Your full portion of the balance expected to be paid when payment is received from your insurance carrier.

Assignment of Benefits

By signing this form you are authorizing that payment of medical benefits will be made directly to this office. If your insurance company sends the check directly to you, you will have to deposit the check into your account and write us a check for the total amount and deliver it to our office with the EOB (Explanation of Benefits).

Release of Information

By signing this form you are also authorizing this office upon request from your insurance carrier, the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party assignment, namely this office.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office and will be glad to answer any further questions that you might have.

I have read and agree to the above.

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Patient Signature **Date**