

The Healing Arts Institute of Juno Beach
13901 U.S. Hwy 1, Suite 10
Juno Beach, Fl. 33408

Patient Information

We welcome you to the Healing Arts Institute of Juno Beach. Working together we can develop and implement your personal "Comprehensive Care Program" and create new possibilities in the treatment and prevention of illness and dis-ease in Body, Mind and Spirit.

Please fill out the following:

Name: _____ Date: _____

Address: _____ Birth date: _____

City: _____ Zip: _____ Social Sec#: _____

Home Phone: _____ Occupation: _____

Work Phone: _____ Employer: _____

Married: _____ Single: _____ Partner: _____

If you have children: Ages _____ If child parent Name: _____

Referred by, how did you find out about the Institute? _____

Please describe the reason you have come here and the symptoms you are experiencing:

What other health care are you presently receiving?

A NOTE TO OUR PATIENTS: Alternative, complementary, or preventative healthcare is only possible when the physician has a complete picture of the patient Physically Mentally and Emotionally. Please complete this questionnaire as thoroughly as possible Thank you.

Please list the most important health concerns in their order of significance:

1.)
2.)
3.)
4.)
5.)

YOUR HEALTH HISTORY:

Health as a child Good Fair Poor

Hospitalizations: (Year and Reason)

1.)
2.)
3.)
4.)
5.)

Surgeries: (Year and Reason)

1.)
2.)
3.)
4.)
5.)

Serious Illnesses or Injury: (Year and Cause)

1.)
2.)
3.)
4.)
5.)

Vaccinations	Yes	No
Adverse Reactions	Yes	No
When?	_____	

MEDICATIONS

Supplements, prescriptions and non-prescription drugs. Please include everything (pills, tablets, liquids, ointments, suppositories, etc.) and include dosage:

1.)	2.)
3.)	4.)
5.)	6.)
7.)	8.)
9.)	10.)
11.)	12.)

ALLERGIES List any allergies you have

Drugs _____.
 Food _____.
 Other _____.
 What happens when you have an allergy attack? _____.
 _____.

Habits Please click any that apply:

Substance use Alcohol Yes No _____.
 Caffeine Yes No _____.
 Tobacco Yes No _____.
 Past Tobacco use Yes No _____.
 Recreational Drugs Yes No _____.
 Are you satisfied with your diet as it is now? Yes No _____.
 Do you crave: Starches Yes No _____.
 Sweets Yes No _____.
 Salt Yes No _____.
 Fats Yes No _____.
 Do you: Sleep Well? Yes No _____.
 Wake Rested? Yes No _____.
 Average hours of sleep _____.
 Enjoy your work? Yes No _____.
 Spend time outside? Yes No _____.
 How much? _____.
 Exercise regularly? Yes No _____.
 What type? Yes No _____.
 How long? _____.
 How often? _____.

Family History

	Father	Mother	Sibling	Other Relative
Cancer				
Diabetes				
Heart Disease				
High blood pressure				
Stroke				
Mental Illness				
Asthma, hay fever				
Dermatitis				
Tuberculosis				
If deceased :age and cause of death				

REVIEW OF SYSTEMS Check all that apply:

FEMALE REPRODUCTIVE

- Number of days menstrual flow _____
- Length of complete cycles _____
- Bleeding between periods _____
- Regular cycles _____
- Pain during sexual activity _____
- Cramps _____
- Abnormal vaginal discharge _____
- Excessive flow _____
- PMS _____
- Date of last PAP smear _____
- Number of pregnancies _____
- Number of births _____
- Number of miscarriages _____
- Birth control _____
- What type _____
- Menopausal symptoms _____
- Fertility problems _____

MALE REPRODUCTIVE

- Hernias _____
- Testicular pain or masses _____
- Sexual difficulties _____
- Any prostate problems _____
- Venereal disease _____
- Discharge or sores _____
- Difficulty starting or stopping urination _____

MUSCULOSKELETAL

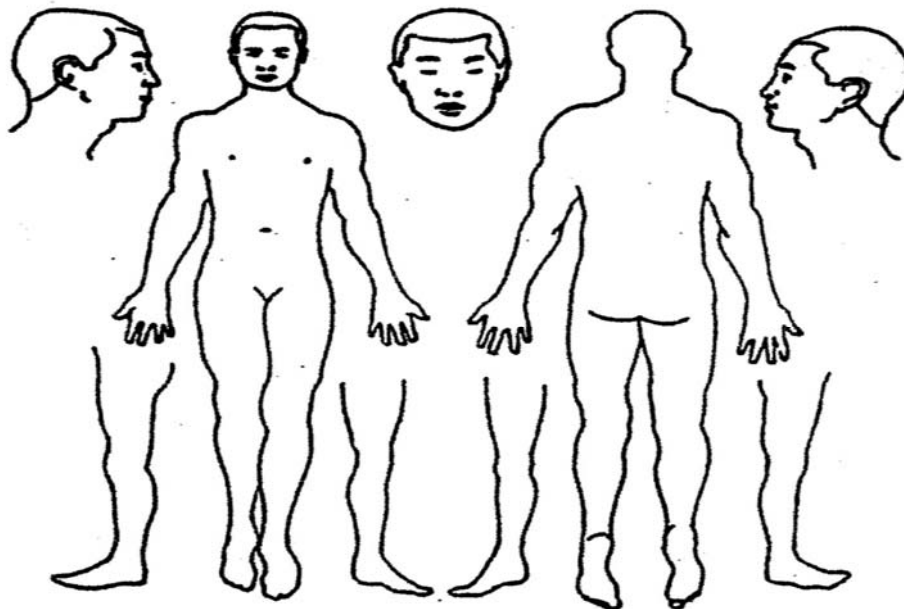
- Joint pain or stiffness _____
- Broken bones _____
- Muscle spasms or cramps _____
- Weakness _____

ENDOCRINE

- Thyroid problems _____
- Heat or cold intolerance _____
- Hypoglycemia _____

BREASTS

- Do you self exam regularly? _____
 - Lumps _____
 - Pain or tenderness? _____
 - Nipple discharge? _____
- Indicate on the diagram any problem areas:



GENERAL

Weight _____
Weight 1 year ago _____
Height _____
Night sweats _____
Fatigue _____
Date of last physical exam _____

SKIN

Rashes _____
Inflammation _____
Infection _____
Growths _____
Changes in hair/nails _____

HEAD

Headache _____
Head injury _____

EYES

Impaired vision _____
Eye Pain _____
Tearing or dryness _____
Double Vision _____

EARS

Impaired hearing _____
Ringing _____
Dizziness _____

NOSE and SINUSES

Frequent colds _____
Nose bleeds _____
Stiffness _____
Sinus problems _____
Post-nasal drip _____

MOUTH and THROAT

Frequent sore throat _____
Sore tongue _____
Sores on mouth or lips _____
Gum Problems _____
Horseness _____
Dental Problems _____

NECK

Swollen glands _____
Pain or stiffness _____

BLOOD

Anemia _____
Easy bleeding bruising _____

HEART

Heart disease _____
High-blood pressure _____
Rheumatic fever _____
Chest Pain _____
Swelling ankles _____
Palpitations/Fluttering _____

RESPIRATORY

Cough _____
Spitting up blood _____
Wheezing _____
Difficulty breathing _____
Pain on breathing _____
Shortness of breath _____
Positive TB test ever _____

DIGESTION

Trouble swallowing _____
Heartburn _____
Stomach pain _____
Change in thirst _____
Nausea _____
Vomiting _____
Bowels move(circle one) daily/more/less _____
Blood in stools _____
Belching or gas _____
Liver/Gall bladder disease _____
Hemorrhoids _____

URINARY

Pain on urination _____
Infrequency _____
Inability to hold urine _____
Bladder infections _____

CIRCULATION

Deep leg pain _____
Cold hands/feet _____
Varicose veins _____

NEUROLOGIC

Fainting _____
Seizures _____
Paralysis _____
Muscles weakness _____
Loss of memory _____

EMOTIONAL ISSUES

Apathy _____
Depression _____
Sadness _____
Mood swings _____
Anxiety or nervousness _____
Tension _____
Fears of phobias _____
Anger or Rage _____
Irritability _____
Other _____

INFORMED CONSENT

I the undersigned, hereby give consent to the administration of treatment by acupuncture and the methods of Traditional Oriental Medicine and/or German electro-acupuncture and/or homeopathy and/or other natural therapeutic methods, administered by Cecilia Erazo-Fritz, A.P.

1. I understand that the understanding of health and illness according to these medical traditions is different from that accepted by modern allopathic medicine; that acupuncture may be considered an experimental or investigative procedure in the United States; and that Oriental medicine, German electro-acupuncture, homeopathy, and other natural methods may have not yet been established as clinically valid practices in the United States.
2. I understand that there are no implied or stated guarantees of success or effectiveness of a specific treatment or series of treatments concerning acupuncture, Oriental medicine, German electro-acupuncture, homeopathy, and other natural methods; and that I volunteer to receive these treatments solely because of my own personally held belief that they may be effective in my particular case.
3. I understand that acupuncture is the insertion of special needles through the skin, with or without the addition of heat or electrical stimulation, at certain points on the body with the intent of improving function and/or relieving pain. I understand that certain side effects may result from acupuncture. These may include some pain or discomfort, localized bruising, minor bleeding, weakness, fainting, nausea, and possible temporary aggravation of symptoms that existed prior to treatment.
4. I understand that any herbal, homeopathic, or other substances given to me as remedies by Cecilia Erazo-Fritz, A.P. are composed of substances compounded for my use in a manner delineated in traditional Oriental, homeopathic, or other pharmacopeias and/or material medicas, not in a manner considered valid by modern scientific pharmacology. They are not prepared by modern pharmaceutical companies or agencies, and are not recognized as effective medical treatments by modern allopathic physicians or pharmacologists. I further understand that all of these substances may be biologically active in many ways, and that it is impossible to guarantee that any individual may not have an allergic reaction to them. I agree to ingest these substances with caution and in accordance with their accompanying prescription instructions. I have been made aware that certain side effects may result from these natural substances, and that these include but are not limited to the aggravation of symptoms existing prior to taking these substances.
5. I understand that I have not by any of the forgoing provisions agreed to cease or not pursue any conventional or non-conventional medical treatments or opinions, which I so choose. I further understand that I may stop treatment at any time.

I hereby certify by my signature that I have carefully and completely read this entire form, and that I understand all of its provisions as described above. I further certify that I have discussed any questions and received answers to my satisfaction, and that nothing has been communicated to me in any manner, which differs or is in conflict with the above.

Signature _____ SS# _____ Date of Birth _____

Signature of Parent /Guardian _____

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our office may sometimes need to disclose medical information or payment information protected by HIPAA to your family members or close friends involved in you health care. Under HIPAA, unless you specifically object, we are allowed to use our professional judgment in deciding whether to discuss your medical and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information.

Name _____

Address _____ Phone _____

- You may communicate with the following individuals relating to my medical or payment information:

- Please do not discuss my medical or payment information with the following individuals:

- Please do not discuss my medical or payment information with anyone.

Signature

Date