***PATIENT HISTORY FORM***

Holistic Medicine

Acupuncture, Oriental Medicine, Hypnotherapy, Reiki, Yoga Therapy, Life Coaching

Lara Michelle Aitken, DOM/AP, CHT.

Name: ­­(Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_

Ht:\_\_\_\_\_\_\_ WT:\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address (optional for newsletter):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact’s name and phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician’s name and phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you find us (circle): Webpage\_\_\_\_\_\_\_ Physician Referral\_\_\_\_\_\_\_\_ Friend \_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Policy:**  Full payment is due at time of service.  We will verify coverage prior to treatment.  If for any reason we are not able to verify coverage prior to your treatment, you will be charged $100.00 for the first treatment and $75.00 for each additional treatment plus any additional therapies used(ie: injections) until verification is obtained.  Our fees are determined by the complexity of the particular case and different services used during treatment.  Any balance due on your treatment is your responsibility whether your insurance company pays or not.  By signing this paper, you authorize the release of any treatment information to any insurance company, adjuster or attorney that will assist in payment of a claim. You are also responsible to notify us immediately of any change in your insurance information.

**See last page for Pre Payment Plan**

**Cancellation Policy:**  It is imperative to keep all the scheduled appointments in order to ensure maximum therapeutic results.  Should you need to cancel an appointment, however you must call at least 24 hours in advance.  Otherwise a 50% charge will apply to your account.

**Informed consent:**  I hereby authorize Lara Aitken, DOM/AP. to perform, diagnose and treat according to professional standards of Oriental Medicine such as acupuncture, moxibustion, herbal therapies, cupping, Tui Na, electrical stimulation, magnet therapy, dermal friction, acupressure, dietary counseling, breathing techniques and exercises based on Oriental medical principles and Hypnosis.

I have been informed that possible side effects of Oriental medical treatment are rare however may include but are not limited to, transient bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensation of heat, cold, tingling or numbness, brief lightheadedness or fainting, broken needles, temporary worsening of some symptoms and risks of infection and pneumothorax.  Herbal remedies may have side effects including but not limited to, gastrointestinal disturbance.  Moxibustion can cause burns.

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me the information so that I might make educated decisions regarding duration and appropriateness of continued care with Lara Aitken,DOM/AP.  All my questions have been answered to my satisfaction.

Signature Patient/Parent/Guardian   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT GOALS:**

What is the main condition you would like to address?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this affect sleep, work, other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What diagnosis, if any, have you been given?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What treatments have you tried (list physician, date, results)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH HISTORY:**

Current medications (list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking blood thinners?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you/might you be currently pregnant?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any implants/pacemaker?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY:(**check all that apply)

 \_\_\_\_\_Allergies \_\_\_\_\_Hepatitis \_\_\_\_\_Seizures \_\_\_\_\_Cancer \_\_\_\_\_Diabetes \_\_\_\_\_Heart Disease \_\_\_\_\_Surgery

\_\_\_\_\_HIV Rev 02/2015 \_\_\_\_\_Stroke \_\_\_\_\_High Blood Pressure \_\_\_\_\_Epilepsy \_\_\_\_\_Thyroid Disease

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery History**:

List previous accidents/injuries/major illnesses

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE:** (circle yes or no)

Do you exercise regularly? Y / N\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Y / N If yes, how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? Y / N If yes, how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How much coffee/tea/soda do you drink per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any drugs? Y/N If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you eat the following:

Vegetables\_\_\_\_\_ Candy\_\_\_\_\_ Dairy\_\_\_\_\_ Red meat\_\_\_\_\_ Chips\_\_\_\_\_\_\_

Fruit\_\_\_\_\_ Fast food\_\_\_\_\_ Refined carbs (bread, pastries..)\_\_\_\_\_

Supplements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Check all that apply):**

**Energy level:**

 \_\_\_\_\_low energy \_\_\_\_\_low energy after exercise \_\_\_\_\_lethargic \_\_\_\_\_shortness of breath

\_\_\_\_\_sleepy during the day \_\_\_\_\_fatigue \_\_\_\_\_reluctant to talk \_\_\_\_\_catch cold easily **Circulation/blood:**

\_\_\_\_\_dizziness \_\_\_\_\_bleeding\_\_\_\_\_nose bleeds \_\_\_\_\_floater/spots \_\_\_\_\_numbness/tingling in extremities

**Lung & Associated TCM functions**

\_\_\_\_\_cough \_\_\_\_\_dry \_\_\_\_\_sputum \_\_\_\_\_nose bleeds \_\_\_\_\_dry mouth \_\_\_\_\_dry skin \_\_\_\_\_dry throat

\_\_\_\_\_fever & chills \_\_\_\_\_Sinus congestion \_\_\_\_\_dry nose \_\_\_\_\_sneezing \_\_\_\_\_overall achy body

\_\_\_\_\_sore throat \_\_\_\_\_difficulty breathing \_\_\_\_\_feeling sad \_\_\_\_\_allergies \_\_\_\_\_smoke cigarettes

\_\_\_\_\_melancholy \_\_\_\_\_headaches: How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spleen & Associated TCM functions**

 \_\_\_\_\_low appetite \_\_\_\_\_abdominal gas \_\_\_\_\_hemmorhoids \_\_\_\_\_crave sweets \_\_\_\_\_gurgling stomach

\_\_\_\_\_bruise easily \_\_\_\_\_abdominal bloating \_\_\_\_\_feel tired after eating \_\_\_\_\_nose bleed \_\_\_\_\_nose bleeds

\_\_\_\_\_worry \_\_\_\_\_over thinking \_\_\_\_\_pensive \_\_\_\_\_loose stools \_\_\_\_\_urgent BMs \_\_\_\_\_diarrhea \_

\_\_\_\_\_discomfort after BM \_\_\_\_\_undigested food in stool \_\_\_\_\_weight gain \_\_\_\_\_blood in stool

 \_\_\_\_\_mucus in stool \_\_\_\_\_constipated Number of bowel movements per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prolapsed organ. If so, which organ and when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dampness:

\_\_\_\_\_general feeling of heaviness in body \_\_\_\_\_mental fogginess \_\_\_\_\_mental sluggishness

\_\_\_\_\_nausea \_\_\_\_\_chest congestion \_\_\_\_\_vaginal discharge \_\_\_\_\_overweight \_\_\_\_\_swelling. If so, where:

**Stomach & Associated TCM Functions:**

\_\_\_\_\_heart burn \_\_\_\_\_mouth sores \_\_\_\_\_pain after eating \_\_\_\_\_large appetite \_\_\_\_\_

bleeding, painful or swollen gums \_\_\_\_\_facial swelling/pain \_\_\_\_\_vomiting \_\_\_\_\_bad breath

\_\_\_\_\_acne \_\_\_\_\_acid regurgitation \_\_\_\_\_belching \_\_\_\_\_hiccups \_\_\_\_\_stomach pain

**Liver/Gallbladder & Associated TCM Functions:**

\_\_\_\_\_Alternating diarrhea and constipation \_\_\_\_\_High stress level \_\_\_\_\_Bitter taste in mouth

\_\_\_\_\_bad temper \_\_\_\_\_headaches \_\_\_\_\_Anger easily \_\_\_\_\_Irritable \_\_\_\_\_heat in head/face

 \_\_\_\_\_muscle tension \_\_\_\_\_Frustration \_\_\_\_\_Lump in Throat \_\_\_\_\_muscle twitches \_\_\_\_\_Depression

\_\_\_\_\_Feel tense \_\_\_\_\_gall stones \_\_\_\_\_itchy skin/rashes \_\_\_\_\_high pitch ringing in ears

\_\_\_\_\_Itch/pain in genitals \_\_\_\_\_seizure/convulsions \_\_\_\_\_discomfort/tightness/tension around ribcage

\_\_\_\_\_sexually transmitted disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyes:

 \_\_\_\_\_itchy \_\_\_\_\_blood shot \_\_\_\_\_dry \_\_\_\_\_watery \_\_\_\_\_blurred vision \_\_\_\_\_poor vision \_\_\_\_\_poor vision

\_\_\_\_\_eyes feel hot at night

**Heart and Associated TCM Functions:**

 \_\_\_\_\_palpitations \_\_\_\_\_irregular heart beat \_\_\_\_pacemaker \_\_\_\_\_insomnia \_\_\_\_\_poor sleep

 \_\_\_\_\_chest pain \_\_\_\_mental confusion \_\_\_\_\_sore on tip on tongue \_\_\_\_\_anxiety

\_\_\_\_\_chest pain arm to shoulder \_\_\_\_\_restlessness

**Kidney and Associated TCM Functions:**

 \_\_\_\_\_low back pain/weakness \_\_\_\_\_weak/sore knees \_\_\_\_\_cold sensation in low back

 \_\_\_\_\_cold sensation in knees \_\_\_\_\_wake at night to urinate \_\_\_\_\_kidney stones

\_\_\_\_\_bladder/kidney/urinary infection \_\_\_\_\_memory problems \_\_\_\_\_lack of bladder control

\_\_\_\_\_feel fearful \_\_\_\_\_excessive hair loss/balding \_\_\_\_\_easily startled \_\_\_\_\_frequent broken bones

\_\_\_\_\_frequent cavities \_\_\_\_\_libido \_\_\_\_\_normal \_\_\_\_\_high \_\_\_\_\_low

Urination:

\_\_\_\_\_normal color \_\_\_\_\_reddish \_\_\_\_\_with blood \_\_\_\_\_dark yellow \_\_\_\_\_clear \_\_\_\_\_cloudy \_\_\_\_\_scanty

\_\_\_\_\_scanty \_\_\_\_\_profuse \_\_\_\_\_painful \_\_\_\_\_dribbling \_\_\_\_\_urgent \_\_\_\_\_difficult

\_\_\_\_\_other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Women ONLY:**

Are you pregnant: Age of first period:

Number of pregnancies: Number of live births:

Are you having or have had difficulty conceiving?

Are your menses regular or irregular? Is your flow heavy or light?

How many days does your period last? How many days between periods?

Do you experience any of the following symptoms before or during your period? \_\_\_\_\_abdominal cramps

\_\_\_\_\_food cravings \_\_\_\_\_breast tenderness/swelling \_\_\_\_\_headaches/migraines \_\_\_\_\_depression

\_\_\_\_\_moodiness \_\_\_\_\_dull pain \_\_\_\_\_sharp pain

 **For Men ONLY:**

Do you experience any of the following?

\_\_\_\_\_swollen testes \_\_\_\_\_testicular pain \_\_\_\_\_impotence \_\_\_\_\_coldness or numbness in genitalia

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).



 Patient’s Signature Date

Lara Michelle Aitken, Acupuncture Physician

(407)654-8700

Prepayment Plan Terms and Conditions

* Purchase of 12 sessions for a total amount of $850.00

Patient has 90 days from date of signing to utilize this pre-paid plan at which time it expires.

Payment of the prepayment plan will be taken in full on the day this contract is initially signed.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to the above terms and conditions and allow

Lara Aitken to take payment for:

\_\_\_\_\_ 12 sessions for a total of $850.00

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature Date

(407)654-8700

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