Integrated Wellness Center

Dr. Lee W. Funk, DC, CCEP, AP, DOM
1511 US Hwy 1, Suite 203
Sebastian, FL 32958
772-581-3773
FAX 772-581-3746

PATIENT HEALTH HISTORY

Name:____Date:__________
Address:____
City, State, Zip Code:____
Home Phone:___________________________Cell Phone:___________________
Date of Birth:______________________________Age:_____________________
Email :____
Work Phone:____
Place of Employment:____
Occupation:____
Emergency Contact:__________________________Phone:_________________
Primary Physician:____
Referred By:____
Are you taking blood thinners (Coumadin, aspirin?)________________________
Current Medications:____
____
____
____
Are you/might you be currently pregnant?______________________________
Do you have any implants/pacemaker?_________________________________
Are you allergic to sulfur?____

TREATMENT GOALS:

What is the main condition you would like to address?_______________________
____
____
How does this affect your daily activities (sleeping, working, etc?)_____________
____
When did this condition begin?______________________________________
What diagnosis, if any, have you been given:_________________________________
What treatments have you tried?____________________________________
Other conditions you would like to address:__________________________________
____
____

If you are experiencing pain, please complete the following:
Quality of Pain:

____sharp ____stabbing ____throbbing ____dull
____burning ____cramping ____other
____continuous ____comes and goes
____numbness ____wakes you up at night

Do any of the following lessen the pain? ____heat ____cold
____holding the area (pressure) ____rest ____stretching
____gentle movement ____vigorous exercise ____massage

Do any of the following worsen the pain? ____heat ____cold
____pressure ____rest (Worse during sleep)
____movement ____weather (if so, explain)________________________

PAST MEDICAL HISTORY
Check all that apply and indicate date where applicable.

____Allergies ____Hepatitis ____Seizures
____Cancer ____HIV ____Stroke
____Diabetes ____Heart Disease ____Surgery
____Epilepsy ____High Blood Pressure ____Thyroid Disease

Other significant medical condition:____
Trauma/Accidents:____

LIFESTYLE
Do you exercise regularly?____
Do you smoke?__________________If so, how much?_________________________
Do you drink alcohol?____________If so, how much?__________________________
How much coffee/tea/soda do you drink per day?_____________________________
How much water do you drink per day?______________________________________
How often do you eat the following:
Vegetables_____________ Candy____________ Dairy_____________
Fruit__________________ Chips_____________
Red Meat______________ Fast Food_____________________________________
Refined carbs (bread, pastries, cookies, etc)____________________________________
What supplements do you currently take:______________________________________
____
____
Are you a vegetarian?____

CURRENT HEALTH INDICATORS

Height____________________________ Weight_________________________
Recent change in weight?____

Body Temperature

____Cold fingers _____Feel hot all over ____Thirsty
____Cold hands _____Feel hot in afternoon ____Thirsty at night
____Cold arms _____Night sweats ____Hot flashes
____Cold toes _____Feel hot in hands ____Sweat easily
____Cold feet _____Feel hot in feet ____Lack of sweat
____Cold legs _____Feel hot in face ____Take water to bed
____Feel cold all over _____Feel feverish

Energy Level

____Low energy _____Low energy after exercise
____Low energy at specific time of day. If so, when?___________________________
____Shortness of breath _____Sleepy during day ____Lethargic
____Reluctance to talk _____Catch colds easily ____Fatigue

Circulation/Blood

____Dizziness _____Bleeding ____Nose Bleeds
____See floaters/spots _____Numbness/tingling in extremities
____Bruising

Heart and Associated TCM Functions

____Palpitations ____Irregular heartbeat ____Pacemaker
____Insomnia ____Poor sleep ____Chest pain
____Mental Confusion ____Sores on tip of tongue ____Anxiety
____Chest pain traveling to arm or shoulder ____Restlessness

Lung and Associated TCM Functions

____Nasal Discharge: Color_________________________ Thick or thin__________
____Cough ____Dry Mouth ____Dry Skin
____Nose Bleeds ____Dry Throat ____Fever & chills
____Sinus congestion ____Dry nose ____Sneezing
____Overall achy body ____Stiff Neck ____Stiff Shoulders
____Sore throat ____Difficulty breathing ____Feel sad
____Allergies ____Smoke Cigarettes ____Melancholy
____Headaches. If so, where & how often_____________________________________
____

Spleen and Associated TCM Functions

____Low appetite ____Abdominal gas ____Hemorrhoids
____Crave Sweets ____Gurgling stomach ____Bruise easily
____Abdominal bloating ____Feel tired after eating ____Nose bleeds
____Worry ____Over thinking ____Pensive
____Loose stools ____Urgent BMs ____Diarrhea
____Discomfort after BM ____Undigested food in stool ____Weight gain
____Blood in stool ____Mucous in stool ____Weight loss
____Constipation
Number of bowel movements per day (or per week)__________________________
____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 and Associated TCM Functions

____Heartburn ____Mouth Sores (canker sores)
____Pain after eating ____Bleeding, painful or swollen gums
____Large appetite ____Facial Swelling/Pain ____Vomiting
____Bad breath ____Acne ____Acid regurgitation
____Belching ____Hiccups ____Stomach pain

Liver/Gallbladder and Associated TCM Functions

____Alternating diarrhea and constipation ____High stress level
____Bitter taste in mouth ____Bad temper ____Headaches
____Anger easily ____Irritable ____Heat in head/face
____Frustration ____Lump in throat ____Muscle tension
____Depression ____Feel tense ____Muscle twitches
____Gall stones ____High pitched ringing in ears
____Discomfort/tightness/tension around ribcage ____Itchy skin/rashes
____Sexually transmitted disease (Which?_______________________________)

Eyes

____Itchy ____Bloodshot ____Dry
____Watery ____Blurred vision ____Poor vision
____Poor vision at night ____Eyes feel hot

Kidney and Associated TCM Functions

____Low back pain/weakness
____Cold sensation in low back
____Wake at night to urinate
____Bladder/Kidney/urinary infection
____Lack of bladder control
____Excessive hair loss/balding
____Frequent broken bones
____Weak or sore knees
____Cold sensation in knees
____Kidney stones
____Memory problems
____Feel fearful
____Easily startled
____Frequent cavities
____Libido: ____Normal ____High ____Low

Urination

____Normal color ____Reddish ____With Blood
____Dark yellow. If yes, do you take vitamins?____________________________
____Clear ____Cloudy ____Scanty
____Profuse ____Frequent ____Strong odor
____Painful ____Dribbling ____Urgent
____Difficult Other_____________________________________

For Women Only

Are you currently pregnant?____
Age at first period___________________ Age at menopause_________________
Number of pregnancies________________ Number of Live Births______________
Are you having or have you 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?_______________________________________
Other:____
Do you experience any of the following symptoms before or during your period?

____Abdominal cramps
____Breast tenderness/swelling
____Depression
____Dull pain
____Food cravings
____Headaches/Migraines
____Moodiness
____Sharp pain

For Men Only

Do you experience any of the following?

____Swollen testes
____Coldness or numbness in genitalia
____Testicular pain
____Impotence

Any other comments:

____
____
____
____
____
____
____
____

____ ________________________

Patient Signature Date

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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

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization ahs the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME
(print):____

PARENT SIGNATURE (for minor):____

SIGNATURE:____

DATE:____________________________

Office Use Only

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW.

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SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Date of Last Revision: **May 2007.**
Effective Date: **Immediately**

This information is made available on request by a patient.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For Medical Treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices that follows this summary.

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To: Patients Paying at the Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. We are able to do this because paying at time of service frees this office from time-consuming paper work and tracking of filed insurance claims.

At your initial visit, you will be responsible for the New Patient office visit. The bill will show the office visit and my fee. However, there are several procedures that may occur during your visit, which will be modified, any of these procedures used during your treatment will be reduced to $0.00, and you will be responsible for the office visit fee only.

97810-52	Acupuncture 1st 15 min	97813-52	Acupuncture w/Elec.stim1st 15 min
97811-52	Acupuncture 2nd 15 min	97814-52	Acupuncture w/Elec Stim 2nd 15 min
97010-52	Heat therapy	97140-52	Manual Therapy
97014-52	Elec. Stim (Unattended)	97530-52	Kinetic Activities
97032-52	Elec. Stim. (Attended)	97110-52	Therapeutic Exercises
99070-52	Needles		

The fee for the New Patient office visit (code 99203) is $ 150.00
The fee for each office visit after the initial visit (code 99213) is $ 90.00

I have read and understand the information contained therein.

_______________________________________Date__________
Patient's Signature

Yours in Health,

Dr. Lee Funk, AP
Acupuncture Physician