ZEN BODYWORKS
TRADITIONAL CHINESE MEDICINE

Dr. Lenore Maio AP

INITIAL PATIENT HISTORY / INTAKE

Legal Name

Date of Birth Email

Street Address City, State & Zip Code

Alternative Address

Home Phone Mobile Phone Work Phone

Social Security No. Drivers License

Emergency Contact Name, Relationship and Phone(s)

Who may we thank for referring you?

What is the chief concern that brought you here today for consultation and treatment?

What outcome do you reasonably expect to achieve from your treatment(s) today and in the future?

Have you received any of the following treatments for your current/past conditions?

Please check treatments used.

- Acupuncture
- Cupping
- Moxibustion
- Electrical Stimulation
- Medical Massage
- Relaxation Massage
- Herbal Therapy
- Supplement Therapy
- Medical Qigong
- Reiki
- Energy Therapies
- Movement Therapies
- Exercise Therapies
- Nutritional & Lifestyle Counseling
- Meditation
- Tai Chi
- Yoga
- Passive or Active Stretch Technique
- Prolotherapy
- Homeopathic Injection
- Other Injection Therapy
- Chiropractic
- Physical Therapy
- NAET
- Surgery
- Laser
- Aquatic
- Conventional Medical Prescription
- Color
- Sound
- Heat
- Eye
- Ear
- Aroma therapies

If any other therapies have been received that are not listed above, please describe.

Are you under the current care of a physician? If you answer 'yes' please provide the physician's name, phone number and practice location.

Yes No Physician

Do you currently take any prescription medication? Yes No

If you answered 'yes', please list the medication names, their dosages and frequency.

Are you currently taking non prescription medications? Please check all that apply.

- Laxatives
- Aspirin
- Sedatives
- Vitamins
- Other supplements/herbs
- Topical remedies

Over the counter non prescription medications (describe)

MEDICATIONS/ALLERGIES

Please list the current prescription medications;herbs and herbal formulas;prescription or nonprescription supplements; topical prescription or nonprescription remedies; medications as well as any special dietary or allergy restrictions you have or are taking and all known allergies.

Please list and briefly describe past traumatic injuries and surgeries and give exact or approximate dates of occurrence. ADDITIONALLY, please indicate if this injury is part of a current legal case. Please note that all patient documentation copies are provided at $1.50 per page and testimony or services for court cases including consultations, depositions and other like meetings are charged at $350-500 per hour.

Do you commonly suffer from any of the following symptoms? Please check all that apply.

- Asthma
- Headaches
- Psychological Disorders
- Fatigue
- Nervousness
- Depression
- Fainting
- Bleeding Disorders
- Sleep Disorders
- Uncontrolled Anger or Outbursts of Violence
- Frequent Sadness or Crying
- Kidney or Bladder Problems
- Irritability/Muscle Spasms/ Muscle Tightness or
- Structural Rigidity
- Painful Joints / Arthritis
- Constipation
- Swollen Joints
- Pinched Nerve
- Sinus Problems
- Thyroid Problems
- Ulcers
- Diabetes
- High or Low Blood Pressure
- Seizures
- Respiratory Disorders
- Contagious Diseases
- Cancer
- Contagious Diseases
- Limited Range of Motion
- Breathlessness
- Irregular Gait
- Bleeding Disorders

Other, please describe.

Do you have a family history (immediate family) of any of the above symptoms? Please indicate below.

Mother Father

Sibling Grandparent

How many hours do you sleep?

When you awake, do you feel rested?

Do you dream? Are you able to remember your dreams?

What color is your urine?

Do you experience urinary urgency or frequency?

Do you have a daily bowel movement? More than one?

Please describe the consistency of your bowel movement(s)

If you are female, when was your last menstrual cycle?

Are your cycles normal?

Please describe your cycle's frequency, quality, and pain levels if any:

How much water do you drink daily? What type of water?

How much do you weigh currently?

What comprises your typical daily meals?

Breakfast

Lunch

Dinner

Snacks

Are you allergic to or opposed to consuming any foods? Please name them and whether it is an allergy or a dislike.

How much alcohol do you drink? Daily? Weekly? Monthly?

Do you have an exercise program? Please describe it briefly.

Please provide any further information on injury, pain, illness or disease you are currently or previously experiencing that will assist us in providing you with proper care.

VOLUNTARY INFORMED CONSENT TO TREATMENT

I voluntarily consent to participate in treatment/therapy performed by Lenore Maio AP. I understand that the scope of treatment may include acupuncture, electrical stimulation with acupuncture, muscle stimulation, cupping, moxa, Tui'na (medical soft tissue therapy), Guasha (the use of a handheld device to treat the skin surface and underlying structures with micro and minor damage in accelerating area healing), magnets, herbal and homeopathic prescriptive medicine remedies, Medical Injection Therapy, soft tissue manipulation, nutritional and lifestyle counseling, assessment for mental illness as it applies to referral for care, assessment for medical conditions and illness outside of Lenore Maio AP's scope of practice as it applies to referral for other medical care, assessment for indications of domestic, physical or child abuse as it would apply to notification of a law enforcement agency or referral to outside medical care and services, Qigong (medical energy work) and where indicated, referral to another qualified medical practitioner. I the undersigned state the information that I have given is true and correct to the best of my knowledge. I agree to treatment by a health services practitioner at Zen Bodyworks and will not hold the practitioner responsible for information important to my care I failed to provide. I understand that acupuncture or certain herbal and homeopathic remedies may be contraindicated during the following conditions: pregnancy, a prevailing condition of stress, when fatigued, or in a weakened state and under treatment or care for illness and disease or any type as well as genetic conditions you may not be currently aware of. I understand that under certain conditions nausea, dizziness, or fainting may occur. I also understand that bruising, hematoma, bleeding, and/or temporary soreness may occur. No guarantees or assurances have been made concerning the results of this treatment or procedure. I have not withheld any information regarding my medical history and unless stated otherwise I assert that I (or whom I am assuming responsibility for granting care access) am/are in good health.I also state I am responsible for the payment of all services rendered at the time of treatment by check or cash. No insurance assignment is accepted.

Name _____ Signature of Patient _____ Date _____

Name _____ Signature of Patient/Guardian _____ Date _____

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include: Limited access to facilities where information is stored. Policies and procedures for handling information. Requirements for third parties to contractually comply with privacy laws.

All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use: In administering your health care, we gather and maintain information that may include non-public personal information.

About your financial transactions with us (billing transactions): From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other healthcare practitioners. From healthcare providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you (information that can identify you - e.g. your name, address, Social Security Number, etc.).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 561-248-8499. For further information on our business and to contact us by email go to www.zenbodyworks.net.