

**Harmony Primary Care Center**  
 339 Cypress Pkwy, Ste 250, Kissimmee, FL 34759  
 Julian Zhu, L.Ac., O.M.

**Health History Questionnaire**

<b>Name:</b>		<b>Date of First Visit:</b>	
Address:		e-Mail:	
City:	State:	Phone (Mobile):	
Zip:	Birth Date:		
Age:	Sex:	Ht:	Wt:
Marital Status:		Occupation:	
Family Physician/Phone#:			
Specialist/phone#:			
Emergency Contact:		Contact Phone:	
Referred By:			
How/Where did you find us:		Internet:	
Have you been treated by acupuncture or Oriental medicine before?			

**Responsible Party Signature:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Main Problem(s)** you would like us to help you with: \_\_\_\_\_  
 \_\_\_\_\_

**How long** ago did this problem begin (be specific)? \_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, sex)? \_\_\_\_\_  
 \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_  
 \_\_\_\_\_

**What kinds of treatment have you tried?** \_\_\_\_\_

**Past Medical History** (please include dates): \_\_\_\_\_

**Significant Illnesses:** Cancer    Diabetes    Hepatitis    High Blood Pressure    Seizures  
 Heart Disease    Rheumatic Fever    Thyroid Disease    Venereal Diseases    Othe

**Surgeries:** \_\_\_\_\_

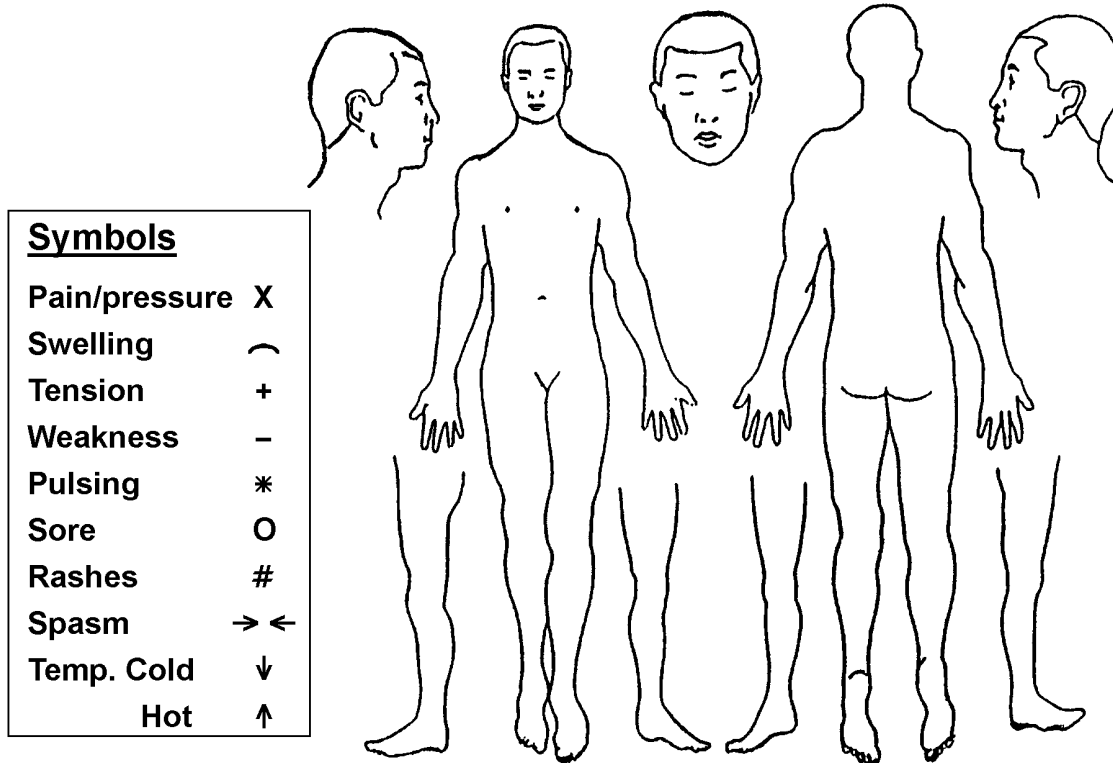
**Significant Trauma** (auto accidents, falls, etc.): \_\_\_\_\_

**Allergies** (drugs, chemicals, foods): \_\_\_\_\_

**Family Medical History:** \_\_\_\_\_

**Medicines** taken within the last two months (vitamins, drugs, herbs, etc.): \_\_\_\_\_  
 \_\_\_\_\_

Indicate painful or distressed areas:



Occupation: \_\_\_\_\_ Occupational stress (chemical, physical, psychological, etc.): \_\_\_\_\_

Do you have a regular exercise program? \_\_\_\_\_ Please describe: \_\_\_\_\_  
 Have you ever been on a restricted diet? \_\_\_\_\_ What kind? \_\_\_\_\_  
 Do you smoke? \_\_\_\_\_ How many packs of cigarettes do you smoke a day? \_\_\_\_\_  
 How much coffee, tea, or cola do you drink per week? \_\_\_\_\_  
 How much alcohol do you drink per week? \_\_\_\_\_  
 Please describe any use of drugs for non-medical purposes \_\_\_\_\_

Please check if you have had (in the **last three months, skip if not apply**):

**General**

- Poor Appetite     Poor Sleeping     Fatigue     Poor Balance     Change in Appetite
- Chills     Night Sweats     Localized Weakness
- Sweat Easily     Tremors     Cravings     Weight Loss
- Weight Gain     Strong Thirst     Bleed or Bruise Easily

**Skin and Hair**

- Rashes     Ulcerations     Hives     Hair/skin texture change
  - Itching     Eczema     Pimples     Dandruff     Loss of Hair     Recent moles
- Any hair or skin problems? \_\_\_\_\_

**Head, Eyes, Ears, Nose, and Throat**

- Dizziness     Concussions     Migraines     Jaw click
- Grinding Teeth     Ringing in Ears     Poor Hearing     Spots in Front of Eyes
- Sinus Problems     Nose Bleeds     Recurrent Sore Throats

Headaches (Where and when?)  
Any other head or neck problems?

### **Cardiovascular**

High Blood Pressure       Low Blood Pressure       Chest Pain       Blood Clots  
 Irregular Heartbeat       Dizziness       Fainting       Phlebitis  
 Cold Hands or Feet       Swelling of Hands       Swelling of Feet       Difficulty in Breathing  
Any other heart or blood vessel problems?

### **Respiratory**

Cough       Coughing Blood       Asthma       Difficulty in Breathing When Lying Down  
 Bronchitis       Pneumonia       Pain with a Deep Breath       Phlegm (What color?)  
Any other lung problems?

### **Gastrointestinal**

Nausea       Vomiting       Diarrhea       Abdominal Pain or Cramps  
 Constipation       Gas       Belching       Chronic Laxative Use       Bad Breath  
 Black Stools       Blood in Stools       Indigestion       Hemorrhoids       Rectal Pain  
Any other problems with your stomach or intestines?

### **Genito-Urinary**

Pain When Urinating       Frequent Urination       Blood in Urine       Decrease in Flow  
 Urgency to Urinate       Unable to Hold Urine       Kidney Stones       Impotency  
Do you wake up to urinate?      How often?  
Any particular color of your urine?  
Any other problems with your genital or urinary system?

### **Pregnancy and Gynecology**

\_\_\_ Number of Pregnancies      \_\_\_ Number of Births      \_\_\_ Premature Births  
\_\_\_ Miscarriages      \_\_\_ Abortions      \_\_\_ Age at First Menses  
\_\_\_ Period between Menses      \_\_\_ Duration      \_\_\_ First Date of Last Menses  
 Unusual Character (Heavy or Light)       Irregular periods  
 Painful Periods       Clots       Last PAP  
 Vaginal Discharge       Vaginal Sores       Breast Lumps  
 Changes in Body/Psyche Prior to Menstruation  
Do you use birth control?      What type and for how long?

### **Musculoskeletal**

Neck Pain       Muscle Pains       Knee Pain       Hip Pain       Hand/Wrist Pains  
 Back Pain       Muscle Weakness       Foot/Ankle Pains       Shoulder Pain  
Any other joint or bone problems?

### **Neuropsychological**

Seizures       Dizziness       Loss of Balance  
 Areas of Numbness       Lack of Coordination       Poor Memory       Bad Temper  
 Concussion       Depression       Anxiety       Easily Susceptible to Stress  
Have you ever been treated for emotional problems?  
Have you ever considered or attempted suicide?  
Any other neurological or psychological problems?

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**Informed Consent for Treatment**

I, \_\_\_\_\_, hereby authorize the private practitioners of life essentials TCM center to perform the following specific procedures **as necessary** to facilitate my diagnosis and treatment:

**Acupuncture:** insertion of special disposable needles through the skin into underlying tissues at specific points on the surface of the body.

**Cupping:** a technique used to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

**Heating Lamp or Pad:** produces heat on the acupoints and meridians.

**Electrical Acupuncture:** use of electrical device to produce electrical stimulation on the acupuncture needles.

**Herbs:** may be given in the form of powders, pastes, or plasters. Herbal formulas may include shell, mineral, and animal materials.

**Moxa:** indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

**Dietary Advice:** based on traditional Chinese Medicine Theory.

I recognize the potential risks and benefits of these procedures as described below:

**Potential Risks:** discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of the symptoms prior to the acupuncture treatment.

**Potential Benefits:** natural drugless relief of present symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the present problem and the strengthening of the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by life essentials TCM center or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understood the life essentials TCM center's HIPAA Privacy Policies or which a copy can be requested in person at our office.

\_\_\_\_\_  
Signature of Patient, Patient Representative, or Guardian

\_\_\_\_\_  
Date

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**Notice of Privacy Policies**

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Dr. Jing Shen.

**Legal Responsibilities of Dr. Jing Shen:** As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

**Protected Health Information Use and Disclosure:** Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

**Treatment:** Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

**Payment:** Your protected health information may be used and disclosed to obtain payment for services we provided to you.

**Healthcare Processes:** We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

**Person Involved In Care:** In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

**Marketing Health-Related Services:** The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

**Required By Law:** Your protected health information may be used or disclosed if required by law.

**Abuse or Neglect:** As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a



## Initial Diagnosis and Treatment

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaints:

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Secondary Complaints:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

History of Disease/Condition:

Energy Level: _____	BM: _____
Sleep Situation: _____	Urination: _____
Diet and Digestion: _____	Sweating: _____
Head or Cold: _____	Menses: _____

Emotion:

Stress:

Tongue Diagnosis:

Pulse Diagnosis:

JiYi Diagnosis:

Patter Diagnosis:

Treatment Recommendations: