BETTER HEALTH & WELLNESS CENTER

Jonathan Clark AP, DOM-Dana McGrady AP, DOM-Carolyn J. Shashaguay AP, DOM
1803 N. Wickham Rd., Suite 6, Melbourne, FL 32935
www.bhawc.com
Clinic: 321-259-8250 Fax: 321-254-6505

A. **TREATMENT**-Any and all health care and treatment, which may include acupuncture, herbal formulas, Tui Na, therapeutic exercises and/or nutritional counseling. I understand that needling and cupping therapy may cause bruising in some cases.

B. **FNANCIAL INFORMATION**-All professional fees are due at the time services are rendered. I hereby acknowledge and accept full responsibility for any and all yearly deductibles, co-insurance, co-payments and any other services or procedures rendered by Jonathan Clark AP, DOM, Dana McGrady AP, DOM, or Carolyn J. Shashaguay AP, DOM, which may not be covered under my current health insurance and/or plan. I further agree that I will pay for these obligations in full upon receipt of the statement, unless prior financial arrangements have been made.

C. **INSURANCE RELEASE OF INFORMATION**-Jonathan Clark AP, DOM, Dana McGrady AP, DOM, or Carolyn J. Shashaguay AP, DOM is authorized to release ant information to my insurance company, for the purpose of assessing claims. The information includes records of examination, diagnosis, treatment and billing information, during the duration of care. This may include, but is not limited, to faxing of medical information.

D. **AUTHORIZATION OF COMPENSATION**-Payment is made directly to Jonathan Clark AP, DOM, Dana McGrady AP, DOM, or Carolyn J. Shashaguay AP, DOM for the amount due after services have been rendered. Payment can be made by major credit cards, cash or approved checks. Full Payment is due at time of service.

E. **MISSED APPOINTMENTS**-Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatment will be more effective if you follow treatment guidelines and stick to your treatment schedule. Please help me to serve you better by keeping scheduled appointments.

Name:		**Ht. Wt.**	
Street:		**Birth date:**	**Sex: F/M**
City:		**Occupation:**	
State:	**Zip:**	**Age:**	**Married: Y/N**
E-mail:		**Phone: Home/Cell**	
Referred by:		**Phone: Work**	

Patient Signature **Authorized Provider Representative**

Personal Representative Printed **Personal Representative Signature**

Date: ____________________

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PATIENT CONSENT FORM

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 WITH THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.**
- **OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.**
- **CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.**

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above 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 you are not required to agree to my requested restrictions, but you do agree that you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ____________________ **Date:** __________

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APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your licensed acupuncturist and members of the staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders. Information about treatment alternatives, or other health related information at any time.

This notice is effective as of date signed. This authorization will expire seven years after date on which you last received services from us.

I authorize you to use or disclose my health information in the manner describe above; I am also acknowledging that I have received a copy of this authorization.

Patient Name Printed **Date**

Patient Signature **Authorized Provider Representative**

Personal Representative Printed **Personal Representative Signature**

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INFORMED CONSENT TO ACUPUNCTURE TREATMENT

ACUPUNCTURE HAS BEEN USED AS A MEDICAL THERAPY FOR OVER TWO THOUSAND YEARS IN THE ORIENT. HERE IN THE WEST WE HAVE ONLY BEGUN TO RESEARCH ITS EFFICACY AND MODE OF ACTION. ACUPUNCTURE, NEVERTHELESS, HAS GAINED RECOGNITION AS A STANDARD METHOD OF TREATMENT BY THE AMERICAN MEDICAL COMMUNITY AT LARGE. WE HAVE OBSERVED GOOD RESULTS FROM ITS USE AND KNOW OF VERY FEW PROBLEMS OR COMPLICATIONS.

I AUTHORIZE THE ACUPUNCTURISTS TO ADMINISTER ACUPUNCTURE, WHICH PRIMARILY INVOLVES THE INSERTION OF NEEDLES AT ONE OR MORE POINTS ON THE BODY, TWIRLING OF THE NEEDLES AND/OR APPLYING HEAT TO THE NEEDLES OR SKIN.

DERMAL FRICTION (GWA SHA): THIS INVOLVES SCRAPING THE SURFACE OF THE SKIN USING A LUBRICANT TO DECREASE FRICTION. THIS PRODUCES A DEEP REDNESS OF THE SKIN WHICH LAST 3-4 DAYS BEFORE DISAPPEARING.

ELECTROACUPUNCTURE: UTILIZES A SMALL BATTERY POWERED STIMULATOR WHICH PROVIDES A PULSATING SENSATION SET TO YOUR COMFORT LEVEL WHEN APPLIED TO INSERTED NEEDLES OR DIRECTLY ON A BODY POINT.

INDIRECT MOXABUSTION: THIS IS A HEAT TREATMENT WITH THE HEAT SUPPLIED BY BURNING OF THE HERB ARTEMISIA VULGARIS EITHER UPON AN INSERTEC NEEDLE OR THROUGH AN INSULATING MATERIAL SO AS TO WARM THE SKIN.

CUPPING: IS A DERMAL SUCTION TREATMENT IN WHICH A VACUUM IS CREATED IN A WOODEN, GLASS OR PLASTIC CUP PLACED ON THE SKIN SO AS TO IMPROVE CIRCULATION IN THE AREA.

MAGNETIC/IONIC TREATMENT: THIS INVOLVES THE PLACING OF SMALL SPECIALIZED MAGNETS OR PELLETS OF VARIOUS METALS ON THE BODY. VERY RARELY THER MAY BE A MILD SKIN REACTION WHICH SHOULD VANISH IN DAYS.

I UNDERSTAND THAT ALL QUESTIONS POSED BY ME REGARDING THE PROCEDURES TO BE USED WILL BE ANSWERED PRIOR TO RECEIVING MY INITIAL TREATMENT AND IN NO MANNER HAVE I BEEN GUARANTEED A BENEFICAL RESULT FROM TREATMENT. I UNDERSTAND THAT IN CONSIDERATION OF THE TIME RESERVED FOR ME THAT I WILL BE CHARGED FOR A FULL OFFICE VISIT FOR ANY CANCELLATIONS NOT MADE 24 HOURS IN ADVANCE. I FURTHER UNDERSTAND THAT IN THE EVENT OF THIRD PARTY REIMBURSMENTS, I SHALL BE PERSONALLY RESPONSIBLE FOR ANY UNPAID BALANCE TO THIS OFFICE.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND I CONSENT TO THE USE OF ACUPUNCTURE AND/OR ALLIED TECHNIQUES.

Patients Signature: ______________________________ **Date:** ____________

Parent's Signature (if patient is a minor): ______________________________

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INFORMED CONSENT OVERVIEW

Electro-acupuncture point measurement devices combine the fundamentals of Chinese acupuncture with modern electronics for diagnosis. During the past thirty years, doctors have identified the interrelationship between acupuncture points and individual organ and tissue systems. Doctors have also succeeded in measuring the electrical conductivity of these points with Electro-acupuncture point measurement devices and in explaining the diagnostic meaning of the measured values. The literature claims that early disturbed organ functions can be discovered long before clinical symptoms appear.

The objective of this research investigation is to correlate the data obtained from Electro-acupuncture with the modern electronics diagnoses obtained from patient health history questionnaires, finding on physical examination, laboratory and radiologic evaluations, and for the purpose of learning more about the possible benefits of humanity.

PROCEDURES- these procedures are totally non-invasive (the skin is not pierced). Skin conductance measurements are obtained by holding the point measurement device on certain established points located primarily on your hands and feet.

DEVICE- the Electro-acupuncture point measurement device that will be used is classified as a non-significant risk experimental device. It measures the skin conductance with a very small electric current exposed to certain established acupuncture points. The purpose of this study is to document the validity and reliability of these devices. It is expected that this study will last for a minimum of five years.

RISKS/DISCOMFORT- because of the nature of this device as explained above, the risk has been determined to be non-significant. It is possible that you might feel some discomfort as the pressure requirement for accurate Electro-acupuncture measurement varies. Your doctor has received information about the particular measurement method, and will answer any questions you may have regarding the level of discomfort.

RESULTS/BENEFITS- if the Electro-acupuncture point measurement procedures fail the doctor will not posses additional information concerning your symptoms and will rely on traditional subjective and objective information in his diagnosis of your condition. The benefits you could reasonably expect after the investigation confirms the validity of Electro-acupuncture point measurement process would be access to non-invasive diagnostic procedures that could be helpful to your doctor in early diagnostic of your symptoms.

ALTERNATIVE PROCEDURES- alternative traditional laboratory and radiologic procedures are available. Your doctor will explain and recommend the appropriate alternative procedures to you. **IT IS YOUR RESPONSIBILITY TO ARRANGE FOR ALTERNATE TRADIONAL PROCEDURES AND BY SIGNING THE INFORMED CONSENT YOU AGREE TO ACCEPT THIS DUTY.**

SCOPE OF INVESTIGATION- more than one thousand patients of all ages and sexes are expected to participate in this study.

QUESTIONS- your doctor will answer any questions about this study you may have. Please do not hesitate to ask any question concerning any area of this study, your diagnosis or treatment.

Regarding any possible medical applications, the device at this point is still considered experimental in the United States and is not intended to be used to establish or confirm any diagnosis of clinical disease. Since performance standards for this device have not yet been established, its appropriate use is solely as a Class IIIA investigational device under the guidelines of the F.D.A. This means that all the information gathered must be confirmed with conventional means of diagnosis. Though literature states the Bio-energetic testing may be used as a medical diagnostic procedure in other parts of the world, it is considered as an unsubstantiated procedure in the U.S.A.

FREE TO DECLINE- YOU ARE FREE TO DECLINE PARTICIPATION IN THE STUDY, OR TO WITHDRAW CONSENT AND TO DISCONTINUE PARTICIPATION AT ANY TIME WITHOUT PREJUDICE TO YOURSELF.

I HAVE FULLY READ AND UNDERSTAND THE ABOVE INFORMATION ABOUT THE STUDY, THE ELEMENTS OF INFORMED CONSENT, MY RESPONSIBILITIES, AND HEREBY CONSENT TO THE USE OF THE ELECTRO-ACUPUNCTURE POINT MEASUREMENT DEVICE. FOR THE PURPOSE OF ADVANCING MEDICAL KNOWLEDGE, I CONSENT TO THE USE OF CLINICAL REPORTS AND RESULTS OF MY CASE FOR STUDY, RESEARCH AND SCIENTIFIC PURPOSES.

Name: ______________________________ **Date:** ______________

Last First Middle

SIGNATURE: ______________________________

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HEALTH QUESTIONAIRE

Mark "X" where appropriate	YES	NO	COMMENTS:
1. Did/do you have dental work?			
2. Did/do you have pets?			
3. Did/do you work around chemicals?			
4. Did/do you work with asbestos?			
5. Did/do you live in an older home?			
6. Did/do you work with formaldehyde?			
7. Did/do you crave sweets?			
8. Did/do you have afternoon fatigue?			
9. Did/do you have post nasal drips?			
10. Have you ever had yeast infections?			
11. Do you have frequent bladder infections?			
12. Do you have difficulty urinating?			
13. Do you have skin problems?			
14. Do you have headaches?			
15. Do you have sinus problems?			
16. Do you have menstrual problems?			
17. Do you have heartburn or gas?			
18. Do you have a sour stomach?			
19. Do you have nausea often?			
20. Do you have peeling fingernails?			
21. Do you have white spots on nails?			
22. Do you have discharge from eyes?			
23. Do you joints ache?			
24. Do you easily catch colds or flu?			
25. Were you a sickly child?			
26. Do your hands and/or feet swell?			
27. Have you gained or lost weight?			
28. Do you smoke? Did you?			
29. Do you have constipation?			
30. Do you have leg cramps?			
31. Have you ever had fever blisters?			
32. Are you pregnant?			
33. Do you have allergies?			
34. Did/do you get allergies shots?			
35. Have you had tonsillectomy?			
36. Have you had a hysterectomy?			
37. Do you have gallbladder problems?			
38. Do you over-react to medicines?			
39. Do you have chronic fatigue?			
40. Are you on thyroid medication?			
41. Are taking Premarin?			
42. How many cups of coffee per week do you drink?			
43. How many cups of soda per week do you drink?			
44. Do you exercise?			
45. Are you depressed, sad, irritable?			
46. Do you live in a new house?			
47. Do you sleep well at night?			
48. Does weather affect your ailments?			

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DEVELOPING A TIMELINE

CIRCLE ANY THAT APPLY, ADD OTHERS OR EXPALIN WHERE NEEDED.

PHYSICAL: Pre-birth: any drugs, alcohol, smoking or severe illness in the mother (particularly of a viral nature): also consider any emotional shocks to mother during pregnancy or on mother/father at time of conception (see section on emotional traumas below); ultrasound or other invasive/testing.

BIRTH: Mother had difficult labor; forceps used; use of anesthetics on mother, late breathing or oxygen deprivation.____________________

VACCINATIONS: Dates of first vaccination of each kind received (can ignore booster shots.)____________________

ALLERGIES: ____________________

ACCIDENTS: Car accidents, falls, blows to the head, concussions, broken bones, dog bites. ____________________

MEDICATION TAKEN WITHIN THE LAST TWO MONTHS: (including vitamins, over the counter drugs, herbs, homeopathic etc.____________________

SURGICAL INTERVENTIONS: E.G. tonsils, adenoids, dental, abdominal, (including cesarean section); circumcision, vasectomy, hysterectomy, etc. ____________________

SIGNIFICANT ILLNESS: Cancer, diabetes, high blood pressure, heart disease, hepatitis, rheumatic fever, thyroid disease, seizures, etc.____________________

HABITS/DRUG USE: Antibiotics, anti-depressants, recreational drugs, cigarettes, coffee, tea, cola, alcohol, sugar, salt, etc. ____________________

FAMILY MEDICAL HISTORY: Diabetes, cancer, high blood pressure, heart disease, stroke, seizure, asthma, allergies, alcoholism, other.______________________________

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HORMONES: Birth control pills, hormone replacement therapy, IVF, etc. ______________________________

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SEVERE INFECTION: E.G. Lyme disease, mononucleosis, Epstein-bar, measles, chicken pox, mumps, TB, pneumonia, etc. ______________________________

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OCCUPATIONAL STRESSES: Chemical, physical, psychological, etc. ______________________________

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ELECTRICAL SHOCKS: Including medical treatments. ______________________________

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MENTAL/EMOTIONAL: Traumas involving loss, abandonment, grief, betrayal, (e.g. death, loss of trust, relationship breakups, loss of independence, job loss.) ______________________________

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TRAUMAS INVOLVING GREAT FEAR/ANXIETY, STRESS: ______________________________

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TRAUMAS: Involving anger and indignation/humiliation (particularly where the emotion was suppressed "swallowed"), guilt (mostly that someone tried to put on you.)______________________________

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Trauma of feeling of envy or jealousy, or guilt that you put on yourself, self-blame, shame: ______________________________

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Trauma involving abuse, whether mental/emotional or sexual: ______________________________

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EXERCISE: ______________________________

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CLINICAL APPRAISAL INDICATOR

Instructions:

Indicate the symptoms that apply to you **(LEAVE BLANK, THE BOXES THAT DO NOT APPLY TO YOU!):**

1. = ***MILD*** Symptoms (Occurs 1-2 times/year)
2. = ***MODERATE*** Symptoms (Occurs several times/month)
3. = ***SEVERE*** Symptoms (Aware of it constantly)

Group One	Group Two
1. _ Nervous Stomach	12. _Perspire Easily
2. _ Dry Mouth/Eyes/Nose	13. _Muscle-Leg-Toe Cramps at Night
3. _ Pulse Speeds After Meal	14. _Eyelids Swollen, Puffy
4. _ Keyed Up, Fail to Calm	15. _Indigestion Soon After Meals
5. _ Mentally Alert, Quick	16. _Digestion Rapid
6. _ Extremities Cold, Clammy	17. _Vomiting Frequent
7. _ Heart Pounds After Retiring	18. _Difficulty Swallowing
8. _ Acid Foods Upset	19. _Constipation, Diarrhea Alternating
9. _ Cold Sweats Often	20. _Joint Stiffness After Rising
10. _ Fever Easily Raised	21. _Circulation Poor, Sensitive to Cold
11. _ Neuralgia-Like Symptoms	22. _Subject to Colds, Asthma, Bronchitis
Are Your Symptoms Made Worse By Emotional Stress?	***Are Your Symptoms Made Worse by Physical Stress?***

Group Three	Group Four
23. _Afternoon Headaches	31. _Bruise Easily, "Black and Blue" Spots
24. _Get "Shaky" if Hungry	32. _Sigh Frequently, "Air Hunger"
25. _Faintness if Meals Delayed	33. _Aware of "Breathing Heavily"
26. _Heart Palpitates if Meals Missed or Delayed	34. _Open Windows in Closed Rooms
27. _Eat When Nervous	35. _Susceptible to Colds and Fevers
28. _Awaken After a Few Hours of Sleep Hard to Get Back to Sleep	36. _Swollen Ankles, Worse at Night
29. _Crave Candy or Coffee in Afternoons	37. _Muscle Cramps, Worse During Exercise
30. _Abnormal Craving for Sweets or Snacks	38. _Dull Pain in Chest or Radiating into Left Arm, Worse on Exertion
	39. _Hands and Feet Go to Sleep Easily, Numbness
	40. _Tendency to Anemia
	41. _Tension Under the Breastbone/Feeling of Tightness, Worse on Exertion

Group Five	Group Six
43. _Dry Skin	54. _Lower Bowel Gas Several Hours After Eating
44. _Skin Rashes Frequent	55. _Burning Stomach Sensation, Relieved by Eating
45. _Bitter Metallic Taste in Mouth in Mornings	56. _Coated tongue
46. _Bowel Movements Painful or Difficult	57. _Indigestion ½ to 1 Hour After Eating; May be up to 3-4 Hours
47. _Biliousness	58. _Gas Shortly After Eating
48. _Greasy Foods Upset	59. _Stomach "Bloating" After Eating
49. _Stools Light-Colored	
50. _Pain Between Shoulder Blades	
51. _Laxatives Used Often	
52. _History of Gall-Bladder Attacks or Gallstones	
53. _Sneezing Attacks	

Group Seven

Section "A"

60. _Pulse fast at Rest
61. _Nervousness
62. _Can't Gain Weight
63. _Intolerance to Heat
64. _Highly Emotional
65. _Flush Easily
66. _Night Sweats
67. _Inward Trembling
68. _Heart Palpitates
69. _Insomnia

Section "B"

70. _Impaired Hearing
71. _Decrease in Appetite
72. _Ringing in Ears
73. _Constipation
74. _Mental Sluggishness
75. _Headaches Upon Arising Wears Off During Day
76. _Slow Pulse, Below 65
77. _Increase in Weight

Section "C"

78. _Low Blood Pressure
79. _Failing Memory
80. _Increased Sex drive
81. _Headaches, "Splitting/Rending"
82. _Decreased Sugar Tolerance

Section "D"

83. _Bloating of Intestines
84. _Abnormal Thirst
85. _Weight Gain Around Hips/Waist
86. _Sex Desire Reduced/Lacking
87. _Tendency to Ulcers, Colitis
88. _Increased Sugar Tolerance
89. _Women: Menstrual Disorders
90. _Young Girls: Lack of Menstrual Function

Section "E"

91. _Hot Flashes
92. _Headaches
93. _Dizziness
94. _Increased Blood Pressure
95. _Sugar in Urine (Not Diabetes)
96. _Masculine Tendencies (Female)
97. _Low Blood Pressure
98. _Chronic Fatigue
99. _Weakness, Dizziness
100. _Tendency to Hives
101. _Arthritic Tendencies
102. _Perspiration Increases
103. _Crave Salt
104. _Brown Spots/Discoloring of Skin
105. _Allergies: Tendency to Asthma
106. _Exhaustion: Muscular and Nervousness
107. _Respiratory Disorders

Group	Eight
Female Only:	***Male Only:***
108. _Painful Menses	119. _Tire too Easily
109. _Premenstrual tension	120. _Urination Difficult
110. _Very Easily Fatigued	121. _Night Urination Frequent
111. _Depressed Feeling Before Menstruation	122. _Pain on Inside Legs or Heel
112. _Menstruation Excessive and Prolonged	123. _Feeling of Incomplete Bowel Evacuation
113. _Painful Breasts	124. _Prostate Trouble
114. _Menstruation to Frequently	125. _Leg Nervousness at Night
115. _Vaginal Discharge	126. _Diminished Sex Drive
116. _Menopause, Hot Flashes, Etc.	
117. _Menses Scanty	
118. _Acne, Worse at Menses	

Group Nine	Group Ten
127. _Chronic Cough	137. _Frequent Urination
128. _Pain Around Ribs	138. _Rose-Colored/Bloody Urine
129. _Shortness of Breath	139. _Dripping After Urination
130. _Chest Pain	140. _Difficulty Passing Urine
131. _Difficulty Breathing	141. _Cloudy Urine
132. _Coughing Up Phlegm	142. _Rarely Need to Urinate
133. _Coughing Up Blood	143. _Frequent Bladder Infections
134. _Bronchitis (Frequent)	144. _Painful/Burning When Passing Urine
135. _Infections Settle in Lungs	145. _Urination When you Cough/Sneeze
136. _Sensitive to Smog	146. _Strong-Smelling Urine

Group	Eleven
Section "A"	***Section "B"***
147. _Throat Infections	155. _Chronic Lung Congestion
148. _Poor Wound Healing	156. _Post-Nasal Drip
149. _Slow to Recover from Cold/Flu	157. _Breathe Through Mouth
150. _Get Boils/Cysts	158. _Swollen Tongue
151. _Swollen Lymph Nodes	159. _Hyperactivity
152. _Catch Colds/Flu to Easily	160. _Food Sensitivity/Allergy
153. _Bumpy Skin on Back of Arms	
154. _Inflamed/Bleeding Gums	

IMPORTANT: Please list below your four main health complaints, in order of importance:

1. ____________________

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2. ____________________

____

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3. ____________________

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4. ____________________

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