SUN CITY CENTER HEALTH AND WELLNESS LLC
3040 E COLLEGE AVE
RUSKIN, FL 33570
813-331-3940

Please complete the following information as accurately as possible. In order for us to verify your insurance benefits we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME_____DATE_____

ADDRESS_____

CITY/STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

EMAIL_____

BIRTHDATE_____AGE_____MARITAL STATUS_____CHILDREN_____

PLACE OF EMPLOYMENT_____SOCIAL SECURITY #_____
SUMMER ADDRESS_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____
NAME OF EMERGENCY CONTACT_____PHONE#_____

FAMILY MEDICAL DOCTOR_____
MEDICATIONS:_____
_____
SURGICAL HISTORY:_____
_____
MEDICAL HISTORY:_____
_____
_____
Have you been in an AUTO ACCIDENT?____DATE_____WORKERS COMP?_____DATE_____
HAVE YOU HAD ACUPUNCTURE IN THE LAST 12 MONTHS?_____
ARE YOU CURRENTLY RECEIVING HOME HEALTH FOR ANY CONDITION?_____

Is today's problem caused by
☐Injury ☐ Workman's Compensation ☐ Chronic Duration ☐ Acute Duration

Major medical complaint _____

Primary complaint _____

Secondary Complaint _____

Please list any medicine, herbs, vitamins or therapies utilized to treat this condition

_____

To allow for precautions do you have? ☐ HIV/Aids ☐ Hepatitis ☐ Other infectious illness

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? ☐ Yes ☐ No

Authorization and release I authorize payment of insurance benefits directly to the Sun City Center Health and Wellness LLC. I authorize the physician(s) of Sun City Center Center Health and Wellness LLC to release all information necessary to communicate with personal physicians and other healthcare providers and payons to secure the payment of benefits. I understand that I am responsible for all costs of acupuncture care, regardless of insurance coverage. I also understand that there is no guarantee of treatment results and I give permission to be administered acupuncture and adjunctive treatment.

The patient understands and agrees to allow Sun City Health and Wellness LLC to use their patient health information for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your patient health information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your patient health information we encourage you to read the HIPPA notice that is available to you at the front desk before signing this consent. The following person{s} have my permission to receive my personal health information

_____

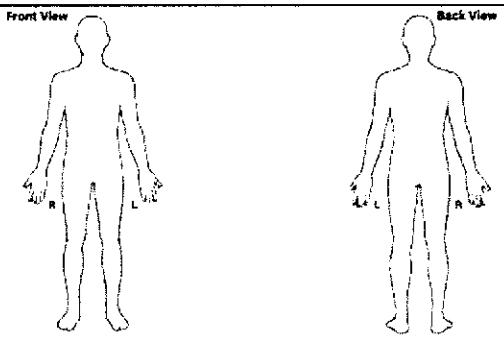
_____

Patient's signature _____

Print patient name_____ Date _____

Indicate on the drawings below where you have pain/symptoms

Patient Name: _____ **Date of Birth:** _____



Chief Complaint: _____

How often do you experience your symptoms?

☐ Constantly (76-100%) of the time ☐ Frequently (51-75%) of the time

☐ Occasionally(26-50%) of the time ☐ Intermittently (1-25%) of the time

How would you describe this typeof pain?

☐ Sharp ☐ Numb ☐ Achy ☐ Diffuse ☐ Sharp with motion

☐ Burning ☐ Shooting ☐ Stiff ☐ Dull ☐ Tingly

☐ Stabbing with motion ☐ Shooting with motion ☐ Electric-like with motion

☐ Other _____

How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0-10 (10 being the worst) How would you rate your problem? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

How much has your problem interfered with your lifestyle?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

Who else haveyou seen for your problem

☐ Chiropractor ☐ Neurologists ☐ Orthopedists ☐ Primary Care Physician

☐ MassageTherapists ☐ ER Physician ☐ Physical Therapist ☐ No one

☐ Other _____

How long have you had this problem? _____

How do you think the problembegan? _____

Do you consider this problemtobesevere? ☐ Yes ☐ Yes, at times ☐ No

What aggravates the problem? _____

What concerns you the most about your problem, what does it prevent?

_____