deYoe

WELLNESS

BETTER HEALTH STARTS HERE

- Acupuncture
- Acupuncture Laser Therapy
- Chinese Herbs
- Massage Therapy
- Ayurvedic Medicine
- Nutritional Counseling
- Tui Na
- Cupping
- Moxibustion

NEW PATIENT REGISTRATION INFORMATION

Dear DeYoe Wellness Patient,

Welcome to DeYoe Wellness! Thank you for allowing us the opportunity to assist with your health care needs. We value all of our patients and are committed to providing you with high-quality, health care services.

This packet includes all of the new patient forms that will need to be completed in order for us to assist with your care.

1. HIPAA Consent Agreement
2. Notice of Privacy Practices (HIPAA Notice)
3. Consent for Procedure
4. Consent for Treatment
5. Notice of Privacy Practices for Protected Health Information
6. Patient Questionnaire

Please take a few moments prior to your appointment to review and complete the registration forms within this packet. We ask that you bring the completed forms to your appointment along with a photo ID. Please note the payments methods below.

OPTIONS TO COMPLETE FORMS

1. Print out this document and complete the forms by hand
2. Use an online form-filler website such as http://www.pdffiller.com. You'll need to upload this PDF to pdffiller.com, complete and sign it, then download your completed form packet. Email your completed form packet PDF to: office@deyoewellness.com.

Please arrive 15 minutes early for your appointment. Directions to our practice locations can be found on our website at www.deyoewellness.com.

PAYMENT METHODS

We accept VISA, MasterCard and Cash, however we do not accept checks, American Express or Discover cards.

The staff of DeYoe Wellness is looking forward to assisting you with your health care needs. If you have any questions, please call the practice at (678) 982-7714 and we will be happy to help you.

Sincerely,

DeYoe Wellness

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HIPAA CONSENT AGREEMENT

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, DeYoe Wellness originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A a means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that DeYoe Wellness is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that DeYoe Wellness has already take action in reliance thereon.

I request **the following restrictions** to the use or disclosure of my health information:

_____

_____

Date Notice Effective Date or Version ____Accepted ____ Denied

_____

PRINT NAME DATE

_____

SIGNATURE DATE

_____

DEYOE WELLNESS, LLC DATE

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NOTICE OF PRIVACY PRACTICES
(HIPAA Notice)

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

Your Health Information Rights
Although your health record is the physical property of the healthcare organization that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information obtain a paper copy of the notice of information practices upon request inspect and obtain a copy of your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
This organization is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment purposes. For example: Information obtained by an, acupuncturist, massage therapist, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. The acupuncturist will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the acupuncturist will know how you are responding to treatment.

We will use your health information for payment purposes. For example: A bill may be sent to you or a third-party payer such as an insurance company, the Medicare program or any other organization, person or program that may be responsible for paying for services. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Health care providers within the organization, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others. This Information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contracts with business associates. An example is insurance billing done through a separate billing company who is an independent contractor. There may be additional independent contractors. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Workers' Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you or otherwise provide information about additional services or health care products you may find useful.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance to enable product recalls, repairs, or replacement.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Legal Matters: In the event of' a claim, litigation or other legal proceeding or contemplated legal matter, we may disclose health information to our attorneys and individuals or organizations working for them.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the HIPAA Privacy Official and Practice Manager, Lorraine Fordham, DeYoe Wellness at 37 Fawn Ridge Trail, Rabun Gap, GA 30568 or call us at **(678) 982-7714.**

If you believe your privacy rights have been violated, you can file a complaint with the HIPAA Privacy Official for DeYoe Wellness or with the secretary of Health and Human Services.

There will be no retaliation for filing a complaint.

Other Uses of Protected Health Information
Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PRINT NAME (PATIENT OR GUARDIAN) AGE (PATIENT OR GUARDIAN)

SIGNATURE DATE

RELATIONSHIP TO PATIENT (IF SIGNED BY A GUARDIAN ONLY)

DEYOE WELLNESS, LLC DATE

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of use of your information for health care operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your health information rights:
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office; Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office; File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;

Our Responsibilities

- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

- Communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.
- If you want to exercise any of the above rights, please contact our office at (678) 982-7714 during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you.
- We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice.
- You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our

"Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office at (678) 982-7714. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency. Food and Drug Administration (FDA) We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Public Health As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

PRINT NAME (PATIENT OR GUARDIAN) AGE (PATIENT OR GUARDIAN)

SIGNATURE DATE

RELATIONSHIP TO PATIENT (IF SIGNED BY A GUARDIAN ONLY)

DEYOE WELLNESS, LLC DATE

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CONSENT FOR PROCEDURE

PRINT NAME (PATIENT OR GUARDIAN) AGE (PATIENT OR GUARDIAN)

PATIENT DATE OF BIRTH (##-##-####) PATIENT EMAIL ADDRESS

PATIENT MAILING ADDRESS / CITY / STATE / ZIP

PATIENT HOME PHONE (###-###-####) PATIENT MOBILE PHONE (###-###-####)

I (or my authorized representative, i.e., parent guardian), _____, consent to
PRINT PATIENT NAME
the medical/surgical procedures outlined below to be performed by James DeYoe, LAc. Diplomate, LMT of DeYoe Wellness, LLC. and his/her staff, associates, or assistants to whom the physician(s) performing the procedure may assign designated responsibilities. The proposed procedure is _____
NAME OF PROCEDURE
for the diagnosis/treatment of _____. The procedure has been explained to me in
PATIENT SYMPTOM
terms that I understand. The explanation included:

- The nature and extent of the procedure to be performed.
- The most frequently occurring risks of the procedure involved, and those risks which are unlikely to occur but which may involve serious consequences, include but are not necessarily limited to the following: _____

  _____
- General risks which may include pain, scarring, bleeding and infection.
- The benefits of the procedure.
- The estimated period of incapacity or convalescence, if any.
- The risks and benefits of any reasonable alternatives to this procedure including having no treatment at all.

I was given the opportunity to ask any questions I have regarding the procedure and I have had those questions answered to my satisfaction. I understand that I may consult or could have consulted with another medical practitioner about this procedure. I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance. I authorize my physician to perform such additional procedures which in his/her judgment are incidentally necessary or appropriate to carry out my diagnosis/treatment.

If any unforeseen condition arises during this procedure which requires transportation to a hospital, additional procedures, operation or medication including anesthesia and blood transfusions, I further request and authorize my physician to do whatever he/she deems advisable on my behalf.

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns regarding the procedure, its attendant risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize my physician to perform the above discussed procedure.

PRINT NAME DATE

SIGNATURE DATE

RELATIONSHIP TO PATIENT (IF SIGNED BY A GUARDIAN ONLY)

DEYOE WELLNESS, LLC DATE

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CONSENT FOR TREATMENT

By signing below, I do hereby voluntarily consent to be treated with Acupuncture, Massage, Traditional Chinese Medicine, Homeopathy and Hypnosis by the Registered Acupuncturist, Licensed Massotherapist and Certified Hypnotherapist, of DeYoe Wellness.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time. _____

Cupping: I understand that if I receive cupping as part of therapy, there is a likelihood of bruising and/or discoloration on the body-area on which cupping is preformed. There may also be a slight probability of mild discomfort from this procedure. I understand that I may refuse this therapy. _____

Homeopathy: I understand that substances from the Homeopathic Materia Medica may be recommended to me to heal bodily symptoms or dysfunctions, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to : changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to use of Homeopathy. Should I experience any problems, which I associate with these substances, I should suspend taking them and call DeYoe Wellness immediately. _____

Acupressure/ Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable. _____

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment. _____

I acknowledge that the proposed procedure, the potential risks and benefits, and the possible complications of such procedure have been explained to me as well as the possible risks and benefits of not undergoing this procedure. I further acknowledge that alternative methods of available treatment were discussed with me, and that I was given adequate opportunity to ask questions pertaining to this procedure and the alternative methods. No guarantee or assurance has been given by anyone as to the results that may be obtained from this procedure.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

PRINT NAME (PATIENT OR GUARDIAN) AGE (PATIENT OR GUARDIAN)

SIGNATURE DATE

RELATIONSHIP TO PATIENT (IF SIGNED BY A GUARDIAN ONLY)

DEYOE WELLNESS, LLC DATE

SIGN BELOW ONLY IF YOU REQUESTED AND HAVE RECEIVED MORE DETAILED INFORMATION

I requested and received in substantial detail further explanation of the procedure or other alternative procedures or methods of treatment and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

X PATIENT OR GUARDIAN SIGNATURE DATE

DEYOE WELLNESS, LLC DATE

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PATIENT QUESTIONNAIRE

To our new patients: Welcome to the DeYoe Wellness! Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in your evaluation and treatment. ***All information is strictly confidential!***

PERSONAL HISTORY Today's Date ____/_____/_____

Name _____ Date of Birth___/____/_____ Age _____

Address / City / State / Zip _____

Occupation _____ Birthplace_____

Home Phone (_____)_____ Work Phone (_____)_____

E-Mail Address _____ Referred by _____

Date of Last Examination ____/_____/_____ Name of Primary Physician _____

Have you ever had acupuncture? ❑ Yes ❑ No If yes, when?____/_____/_____

For what condition(s)? _____

_____

Allergies _____

MAIN PROBLEMS/REASONS FOR THIS APPOINTMENT
(if possible, rank in terms of importance to you) _____

_____

How long have you experienced symptoms? _____

Your condition is improved by? _____

Your condition is aggravated by? _____

Additional problems or concerns you would like addressed: _____

_____

*Note: we may not be able to address every problem during the course of one visit.

PATIENT NAME _____ Today's Date ____/_____/_____

CURRENT MEDICATIONS

	Dosage	Frequency

Current Herbs / Vitamins / Supplements

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

List prior illnesses, injuries, hospitalizations, surgery and/or trauma

Date	Issue	Treatment

PATIENT NAME _____ Today's Date ____/_____/_____

PERSONAL AND FAMILY MEDICAL HISTORY
Check all that apply

	SELF	MOTHER	FATHER	GRAND PARENTS	SIBLING	SPOUSE	CHILDREN
AIDS	❑	❑	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑	❑	❑
Alzheimer's	❑	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	❑	❑	❑
Birth Defects	❑	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑	❑
Breast Cancer	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑
Colon Cancer	❑	❑	❑	❑	❑	❑	❑
COPD	❑	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑
Heart Attack	❑	❑	❑	❑	❑	❑	❑
Heart Trouble	❑	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑
IBS	❑	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑	❑
Liver Disease	❑	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑	❑
Migraine Headaches	❑	❑	❑	❑	❑	❑	❑
Pneumonia	❑	❑	❑	❑	❑	❑	❑
Prostate Cancer	❑	❑	❑	❑	❑	❑	❑
Sickle Cell Anemia	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑
Suicide		❑	❑	❑	❑	❑	❑
Tuberculosis	❑	❑	❑	❑	❑	❑	❑
Ulcers	❑	❑	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑	❑	❑

PATIENT NAME _____ Today's Date ____/_____/_____

SOCIAL HISTORY
Check all that apply

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Highest Level of Education ❑ High School ❑ College ❑ Professional School ❑ Other _____
Memories of Your Childhood ❑ Mostly Happy ❑ Normal ❑ Mostly Painful ❑ Don't Recall
Rate Current Life ❑ Satisfactory ❑ Boring ❑ Too Demanding ❑ Generally Unsatisfactory
Current Living Arrangements ❑ Alone ❑ w/Family ❑ Roomate(s) ❑ Significant Other
List Any Children by Gender and Age _____
Major Stresses within Last 6 Months ❑ Money ❑ Job ❑ Marriage ❑ Home Life ❑ Children
List Any Other Stressors _____

PERTINENT TRAVEL HISTORY
Out of U.S., epidemic areas during last 12 months

Date	Location	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY
Check all that apply

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed
Highest Level of Education ❑ High School ❑ College ❑ Professional School ❑ Other _____
Memories of Your Childhood ❑ Mostly Happy ❑ Normal ❑ Mostly Painful ❑ Don't Recall
Rate Current Life ❑ Satisfactory ❑ Boring ❑ Too Demanding ❑ Generally Unsatisfactory
Current Living Arrangements ❑ Alone ❑ w/Family ❑ Roomate(s) ❑ Significant Other
List Any Children by Gender and Age _____
Major Stresses within Last 6 Months ❑ Money ❑ Job ❑ Marriage ❑ Home Life ❑ Children
List Any Other Stressors _____

LIFESTYLE / SELF-CARE HISTORY
Current Smoker? ❑ Yes ❑ No If Yes, How Many Years _____ # Packs/Day _____
Former Smoker? ❑ Yes ❑ No If Yes, How Many Years _____ When Quit _____
Current Alcohol Use? ❑ Yes ❑ No If Yes, Drink Type _____ # Drinks/Day _____
Drink Caffeinated Beverages? ❑ Yes ❑ No If Yes, Drink Type _____ # Drinks/Day _____
Use Recreational Drugs? ❑ Yes ❑ No If Yes, What _____ #/Day _____
Manage Stress Well? ❑ Yes ❑ No ❑ Not Sure ❑ Need Help
Exercise Regularly? ❑ Yes ❑ No ❑ If No, Why? _____
Job Satisfaction? ❑ Yes ❑ No ❑ If No, Why? _____

PATIENT NAME _____ Today's Date ____/_____/_____

LIFESTYLE / SELF-CARE HISTORY continued

Allow Time to Unwind? ❑ Yes ❑ No ❑ If No, Why? _____

Sleep Well? ❑ Yes ❑ No ❑ If No, Why? _____

Satisfied with Sex Life? ❑ Yes ❑ No ❑ If No, Why? _____

Satisfied with Social Life? ❑ Yes ❑ No ❑ If No, Why? _____

Satisfied with Spiritual Life? ❑ Yes ❑ No ❑ If No, Why? _____

Diet Considered Healthy Enough? ❑ Yes ❑ No ❑ If No, Why? _____

Typical Breakfast _____

Typical Lunch _____

Typical Dinner _____

Typical Snacks _____

CURRENT HEALTH DEVICES

❑ Eyeglasses ❑ Contact Lenses ❑ Hearing Aid ❑ Dentures ❑ Neck or Back Brace ❑ Pacemaker
❑ IUD or Diaphragm ❑ Artificial Limbs

CURRENT SYMPTOMS

Check all symptoms that you are currently experiencing

GENERAL

❑ Poor appetite
❑ Heavy appetite
❑ Strongly prefer cold drinks
❑ Strongly prefer hot drinks
❑ Recent weight loss
❑ Recent weight gain
❑ Poor sleep
❑ Heavy sleep
❑ Dream-disturbed sleep
❑ Fatigue
❑ Lack of strength
❑ Bodily heaviness
❑ Cold hands or feet
❑ Poor circulation
❑ Shortness of breath
❑ Fever
❑ Chills
❑ Night sweats
❑ Sweats easily
❑ Muscle cramps
❑ Vertigo or dizziness
❑ Bleed/bruise easily
❑ Peculiar taste (desribe)
_____

RESPIRATORY SYSTEM

❑ Pneumonia
❑ Difficulty breathing when lying down
❑ Asthma/wheezing
❑ Shortness of breath
❑ Coughing up blood
❑ Cough
If yes, color of phlegm
_____
Wet or dry? _____
❑ Tight chest

HEAD, EYES, EARS, NOSE & THROAT

❑ Glasses
❑ Eye strain
❑ Eye pain
❑ Red eyes
❑ Itchy eyes
❑ Spots in eyes
❑ Poor vision
❑ Blurred vision
❑ Night blindness
❑ Glaucoma
❑ Cataracts
❑ Teeth problems
❑ Grind teeth
❑ TMJ
❑ Facial pain
❑ Gum problems
❑ Sores on lips or tongue
❑ Excessive saliva
❑ Sinus problems
❑ Excessive phlegm
❑ Color of phlegm
_____
❑ Recurrent sore throat
❑ Swollen glands
❑ Lumps in throat
❑ Enlarged thyroid
❑ Nose bleeds
❑ Ringing in ears
❑ Poor hearing
❑ Earaches
❑ Headaches
❑ Migraines
❑ Concussion(s)
❑ Other head/neck issues

PATIENT NAME _____ Today's Date ____/_____/_____

CURRENT SYMPTOMS continued
Check all symptoms that you are currently experiencing

CARDIOVASCULAR SYSTEM

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Blood clots
- ❑ Fainting
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Tachycardia
- ❑ Heart palpitations
- ❑ Phlebitis
- ❑ Irregular heartbeat

GASTROINTESTINAL SYSTEM

- ❑ Nausea
- ❑ Vomiting
- ❑ Acid regurgitation
- ❑ Gas
- ❑ Hiccups
- ❑ Bloating
- ❑ Bad breath
- ❑ Diarrhea
- ❑ Constipation
- ❑ Laxative use
- ❑ Black stools
- ❑ Mucous stools
- ❑ Intestinal pain or cramping
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Anal fissures

Bowel movements:
- ❑ Frequency _____
- ❑ Color _____
- ❑ Odor _____
- ❑ Texture/form _____
- ❑ Other _____

MUSCULOSKELETAL SYSTEM

- ❑ Neck/shoulder pain
- ❑ Muscle pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Joint pain
- ❑ Rib pain
- ❑ Limited range of motion
- ❑ Limited use
- ❑ Other _____ _____ _____

SKIN & HAIR

- ❑ Rashes
- ❑ Hives
- ❑ Ulceration
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Dandruff
- ❑ Itching
- ❑ Hair loss
- ❑ Change in hair/skin texture
- ❑ Fungal infection
- ❑ Other _____ _____ _____

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Numbness
- ❑ Tics
- ❑ Poor memory
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily stressed
- ❑ Abuse survivor
- ❑ Considered/ attempted suicide
- ❑ Seeing therapist
- ❑ Other _____ _____ _____ _____

GENITOURINARY SYMPTOMS

- ❑ Pain upon urination
- ❑ Frequent urination
- ❑ Urgent urination
- ❑ Blood in urine
- ❑ Incontinent
- ❑ Incomplete urination
- ❑ Venereal disease
- ❑ Bedwetting
- ❑ Wake to urinate
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Kidney stones
- ❑ Impotence
- ❑ Premature ejaculation
- ❑ Nocturnal emission
- ❑ Other _____

PATIENT NAME _____ Today's Date ____/_____/_____

CURRENT SYMPTOMS continued
Check all symptoms that you are currently experiencing

GYNECOLOGICAL SYSTEM

❑ Age menses began _____
❑ Cycle length ____ days total
❑ Vaginal odor
❑ Date of last cycle ___/___/___
❑ Irregular periods
❑ Clots
❑ Vaginal sores
❑ Vaginal discharge
❑ Discharge color
_____
❑ Date of last PAP
___/___/___
❑ Painful periods
❑ PMS
❑ Breast lumps
❑ Pregnancies # ____
❑ Live births # ____
❑ Premature births # ____
❑ Age at menopause ____

EMOTIONAL STRESS SCALE

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

NO STRESS **MODERATELY STRESSED** **EXTREMELY STRESSED**

Rate your stress level for:

❑ Work ____
❑ Health ____
❑ Money ____
❑ Love ____
❑ Family ____
❑ Future ____
❑ General ____

If not noted, it is either negative, non-contributory, and/or non-pertinent

Additional comments _____

_____

_____

_____

_____

HEALTH SCREENING HISTORY
List the date of your most recent test or exam for the following

GYNECOLOGICAL
Mammogram ___/___/___
PAP smear ___/___/___
Self breast exam ___/___/___
Dr. breast exam ___/___/___

BLOOD WORK
Cholesterol ___/___/___
Blood sugar ___/___/___
Other ___/___/___

IMMUNIZATIONS
Polio ___/___/___
Tetanus ___/___/___
Hepatitis ___/___/___
Pneumonia ___/___/___
Flu shot ___/___/___

GENITOURINARY
Stool blood ___/___/___
Rectal exam ___/___/___
Prostate ___/___/___
Scope lower bowel
___/___/___
Self testicle exam
___/___/___
Dr. testicle exam
___/___/___

PATIENT NAME _____ Today's Date ____/_____/_____

HEALTH SCREENING HISTORY continued
List the date of your most recent test or exam for the following

ANATOMY/ PROCEDURE	X-RAY	MRI	CT SCAN	ULTRASOUND	BONE SCAN	PET SCAN	EMG
BACK							
BRAIN							
CHEST							
COLON							
EXTREMITIES (ARM/LEG)							
GALLBLADDER							
KIDNEY							
NECK							
PELVIS							
STOMACH							
OTHER							

PRIMARY CARE PHYSICIAN

Doctor's Name _____

Address / City / State / Zip _____

Office Phone (_____)_____ Office Fax (_____)_____

May we contact your Primary Care Physician or reffering doctor? ❑ Yes ❑ No

This History Record has been designed to facilitate our patient's continuity of care at DeYoe Wellness. This is a confidential record and will be kept in our facility. Information contained and collected in this record will not be released to anyone without your authorization to do so.

_____
PRINT NAME (PATIENT OR GUARDIAN) AGE (PATIENT OR GUARDIAN)

_____
SIGNATURE DATE

_____
RELATIONSHIP TO PATIENT (IF SIGNED BY A GUARDIAN ONLY)

_____
DEYOE WELLNESS, LLC DATE