Akasha Center

FOR INTEGRATIVE MEDICINE, LLC.

Initial Health and Wellness History

Welcome to the Akasha Center. At The Akasha Center, we emphasize the team approach to wellness, prevention and treatment of disease. This teamwork is achieved through regular patient-centered meetings among the practitioners at Akasha, and through our partnership with you. Our purpose is to help you to achieve your health-related goals. In order to do that, we need to work together with you. ***That means that you will be invited to participate as actively as possible in the work we do together.***

The first step in that process requires you to commit time and energy to providing us with the information we require in order to best be of service to you. This health and wellness history may be more extensive than others you have completed. While we will certainly ask more questions of you in person in order to understand your health concerns and goals, it is helpful for the process for you to complete this form as thoroughly as possible. By completing this form in advance of your visit, you will allow us to make the best use of our time together, focusing on the issues most important to your overall health. **However, you may choose to answer only the questions with which you feel comfortable.**

The form goes into detail about your physical, mental, emotional and spiritual health. Please answer all questions as comprehensively as possible. ***We ask you to set aside some time to complete this, in a place where you can focus your attention on yourself.***

Please bring any appropriate medical records, x-ray reports, and pathology or lab reports with you to your first visit.

We provide many services which are considered complementary to the western medical approaches most commonly reimbursed by typical insurance companies. Insurers vary in their rules regarding reimbursement for psychotherapy, acupuncture, massage therapy and other modalities. ***Because of the changing nature of this system, private payment is necessary for our services at the time of your visit.*** We will provide all necessary documentation to you in order for you to submit a claim for reimbursement to your insurer.

Once again, welcome to our Center. We look forward to becoming health partners with you.

Patient Information

Last Name:	First Name:

☐ Parent/Guardian of patient? Name and Relationship to Patient:_____

Today's Date: _____/_____/_____ ☐ Male ☐ Female S.S.#_____

Date of Birth: _____/_____/_____ Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Other _____

Physical Address: _____ **Apt.** _____ **Billing Address:** _____ **Apt.** _____

City: _____ **State:** _____ **Zip:** _____ **City:** _____ **State:** _____ **Zip:** _____

Primary Number ( ) _____-_____ Home: ( ) _____-_____ Cell/Alternate.: ( ) _____-_____

Fax: ( ) _____-_____ Work: ( ) _____-_____ E-mail: _____

Employer: _____ Occupation: _____

Employer Address: _____ Telephone: ( ) _____-_____

INSURANCE INFORMATION

Company Name:_____Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Relationship: ☐Self ☐Spouse ☐Parent

Policy Number: _____ Group Number: _____

PHARMACY

Name/Loc: _____ Phone: ( ) _____-_____ Fax: ( ) _____-_____

EMERGENCY CONTACT

Name: _____Relationship to you _____

Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: ( ) _____-_____ Evening: ( ) _____-_____ Cell/Alt: ( ) _____-_____

REFERRED BY (specify)

☐ NAME _____ ☐ WALK-IN

☐ INTERNET: Search Engine / Browser (ex Google, Citysearch, Chamber…) ☐ RCVD EMAIL, Re:_____

_____ ☐ WORKSHOP, Title: _____

☐ FLYER, From: _____ ☐ OTHER:_____

CONFIDENTIALITY AND PAYMENT AGREEMENT

Last Name: _____ **First Name:** _____

DOB: _____/_____/_____ **Today's Date:** _____/_____/_____

A: The Akasha Center follows HIPPA guidelines. If you have not received a copy of the **Notice of Privacy Practices** explaining these guidelines and how we implement them, you may request one from our office or download one from our website www.akashacenter.com

Initial here _____ to acknowledge that you have read our HIPAA guidelines and agree with our approach.

B: In addition to the HIPAA guidelines, we are passionate about strictly protecting the confidentiality of all our patients. We also strongly emphasize an integrative team approach to wellness, prevention, diagnosis and treatment of disease. Therefore, it is of significant importance that our practitioners regularly come together, as a team, to discuss the various treatment modalities that we may be employing to treat you.

[ ] I authorize* the Akasha Center practitioners to discuss my diagnosis & treatment options with:

____ **Akasha Practitioners**
____ **External Practitioner(s)**_____
(Outside the de Mello Medical Corp and the Akasha Center for Integrative Medicine, LLC)

**This authorization does not include the release of medical records. Patients must be asked to sign a release form in order to for the Center to release medical records*

C: [ ] I authorize the Akasha Center to release information to my insurance company, pertaining to my care, in order for them to process a claim which is being submitted for reimbursement.

D: Please read thoroughly and acknowledge that you will adhere to the following Akasha payment policies:

1) I am responsible for paying fees at the time of service. Accepted forms of payment are personal checks, Visa, MasterCard & American Express. I will be responsible for a $25.00 service charge for non-sufficient funds.

2) I have provided credit card information and understand that I will be held responsible for a ***cancellation fee for the full cost of the missed visit if I do not cancel within at least a 48-hour period or are a no-show.*** If I cancel within the 48-hour period and **reschedule the appointment within 2 weeks**, the cancellation fee will be waived for ***one time only.***

3) If I opt to submit insurance claims, I will be provided a Superbill and Insurance Form to submit to my insurance company. The Akasha Center has signed an opt out agreement with Medicare, I understand that I cannot bill Medicare for any services rendered at the Akasha Center.

4) I understand that supplements and herbs **are not** included on Superbills and unopened supplements **are returnable** within 30 days of purchase and opened supplements **are not** returnable.

Prescription Refill Requests
There may be a charge for prescription refills authorized or written at any and all times, other than a scheduled office visit. This includes any special orders into pharmacies.

I have read and agree to the above terms and conditions

Print Name: _____

Signature: _____ **Date:** _____/_____/_____

NAME: _____

I. Goals: What would you most like to achieve through your work at the Akasha Center?

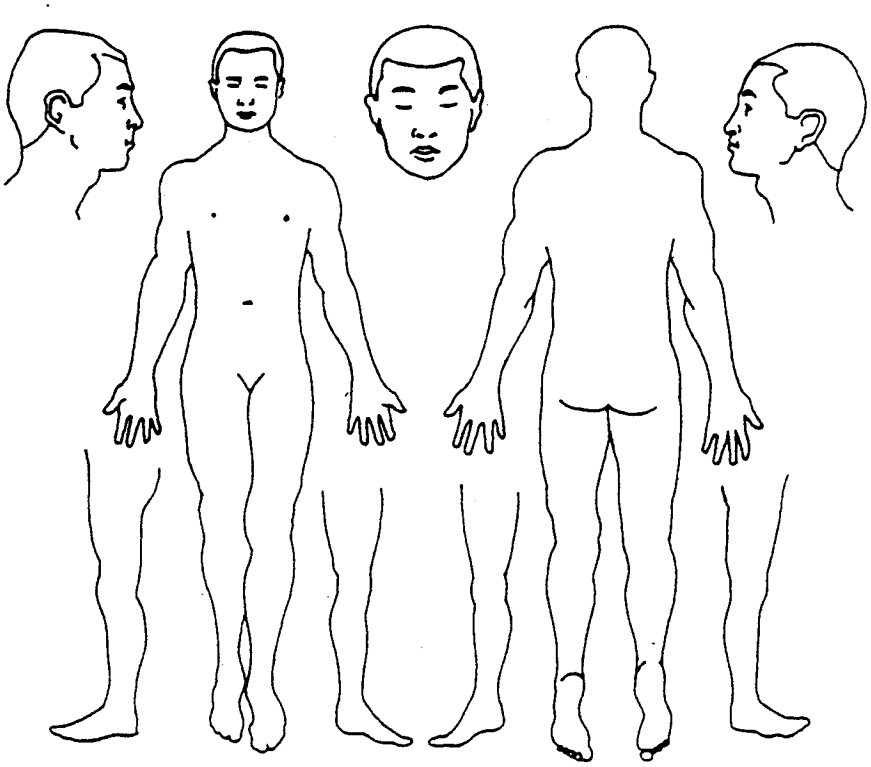
1. _____
2. _____
3. _____
4. _____
5. _____

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you. (most concerning to least, along with the duration of the symptom)

1. _____
2. _____
3. _____
4. _____

Use the following illustration to indicate painful or distressed areas:

X = mild
XX = moderate
XXX = strong



III. Symptoms *Please check all of the following symptoms that you are currently experiencing:*

General:

- ☐Poor Sleeping
- ☐Fatigue
- ☐Fevers
- ☐Chills
- ☐Tremors
- ☐Sweat Easily
- ☐Night Sweats
- ☐Poor Appetite
- ☐Cravings
- ☐Weight Gain
- ☐Weight Loss
- ☐Change in appetite
- ☐Localized Weakness
- ☐Poor Balance
- ☐Bleed or Bruise easily
- ☐Hot Flashes
- ☐Catch colds easily
- ☐Peculiar tastes/smells
- ☐Strong thirst (cold or hot drinks)
- ☐Fainting
- ☐Allergies
- ☐Sudden energy drop at what time of day? _____
- ☐General feeling of heaviness in body
- ☐Mental heaviness, sluggishness or fogginess
- ☐Seizures

Skin and Hair:

- ☐Rashes
- ☐Ulcerations
- ☐Hives
- ☐Skin rashes
- ☐Itching
- ☐Eczema
- ☐Pimples
- ☐Recent Moles
- ☐Dry skin
- ☐Skin discoloration
- ☐Heat sensations in hands, feet, chest
- ☐Loss of Hair
- ☐Dandruff
- ☐Change in hair or skin texture
- ☐Any other hair or skin problem?_____

Head, Eyes, Ears, Nose and Throat:

- ☐Dizziness
- ☐Concussion
- ☐Headaches
- ☐Frequent Headaches
- ☐Migraines
- ☐Glasses
- ☐Poor Vision
- ☐Eye Strain
- ☐Eye Pain
- ☐Night Blindness
- ☐Color Blindness
- ☐Cataracts
- ☐Blurry Vision
- ☐Earaches
- ☐Ringing in Ears
- ☐Poor Hearing
- ☐Nose Bleeds
- ☐Spots in front of eyes
- ☐See floating black spots
- ☐Sinus problems
- ☐Recurrent sore throats
- ☐Frequent ear infections
- ☐Bleeding, swollen painful gums
- ☐Dry mouth, throat, nose
- ☐Blood shot eyes/ dry eyes
- ☐Facial Pain
- ☐Sores on lips or tongue
- ☐Grinding teeth
- ☐Teeth Problems
- ☐Jaw clicks

Behavioral:

- ☐Anxiety
- ☐Panic attacks
- ☐Poor Memory
- ☐Depression
- ☐Inability to concentrate
- ☐Anger
- ☐Attention Deficit Hyperactive Disorder / ADD
- ☐Obsessive Compulsive Disorder
- ☐ Insomnia

Muscular-Skeletal:

- ☐Stiff neck/ shoulders
- ☐Back Pain
- ☐Low Back Pain
- ☐Neck Pain
- ☐Muscle spasm, twitching, cramping
- ☐Sore, cold or weak knees
- ☐Joint Pain, where? _____

Symptoms, continued *Please check all of the following symptoms that you are currently experiencing:*

Cardiovascular:

- ☐High blood pressure
- ☐Chest pain
- ☐Irregular heartbeat
- ☐Palpitations
- ☐Dizziness
- ☐Fainting
- ☐Cold hands or feet
- ☐Swelling of hands
- ☐Swelling of feet
- ☐Myocardial Infarction
- ☐Blood clots
- ☐Phlebitis
- ☐Difficulty in breathing
- ☐Chest pain radiating to shoulder
- ☐Tight feeling in chest
- ☐Numbness of hands and feet
- ☐Any other heart or blood vessel problems?

Respiratory:

- ☐Cough, periodical
- ☐Cough, consistent
- ☐Coughing Blood
- ☐Asthma
- ☐Bronchitis
- ☐Pneumonia
- ☐Pain with a deep breath
- ☐Sinus Congestion
- ☐Shortness of Breath

If so, with ☐Rest or ☐Exercise?

- ☐Difficulty in breathing when lying down

Gastrointestinal:

- ☐Nausea
- ☐Vomiting
- ☐Diarrhea alternating with constipation
- ☐Diarrhea
- ☐Loose stools
- ☐Constipation
- ☐Chronic laxative use
- ☐Burning sensation after eating
- ☐Heartburn/ indigestion
- ☐Indigestion
- ☐Stomach pain
- ☐Abnormal pain or cramps
- ☐Gas
- ☐Belching
- ☐ Abdominal bloating and/or gas after eating
- ☐Feeling tired after eating
- ☐Bad breath
- ☐Bitter taste in mouth
- ☐Rectal pain
- ☐Hemorrhoids
- ☐Black stools
- ☐Bloody stools
- ☐Prolapsed organs (Previously diagnosed)
- ☐Any other problems with your stomach or intestines?

_____

Genito-Urinary :

- ☐Impotency

Urination is:

- ☐Normal color
- ☐Clear/Pale
- ☐Dark yellow
- ☐Reddish
- ☐Vaginal/Penile discharge
- ☐Sexually Transmitted Disease
- ☐Cloudy
- ☐Scanty
- ☐Odorous
- ☐Burning
- ☐Kidney stones

Do you wake up to urinate?
☐yes ☐no

- ☐Painful
- ☐Blood y
- ☐Urgent
- ☐Incontinent

How often? _____

Any other problems with your genital urinary system?
_____

- ☐Decreasing in flow
- ☐Infrequent
- ☐Frequent

Symptoms, continued

FOR WOMEN:

1. Are you pregnant now? ☐Yes ☐No ☐Unsure
2. Indicate number of occurrences:

   Live Births _____ Pregnancies_____ Miscarriages _____ Abortions _____
3. Age: First period _____ Menopause (if applicable) _____
4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / _____
5. Any History of an Abnormal Pap Smear? ☐Yes ☐No If so, what / when? _____
6. Is your menses cycle regular? ☐Yes ☐No

   a) Average number of days of flow _____
   b) The flow is: ☐ Normal ☐ Heavy ☐ Light
   c) The color is: ☐ Normal ☐ Dark ☐ Purple ☐ Light Brown ☐ Brown
7. Do you have the following menstruation related signs/symptoms?

☐Difficulty with Orgasm	☐Cramps	☐PMS	☐Heavy Vaginal Discharge between periods
☐Pain with Intercourse	☐Nausea	☐Bleeding between Periods	
☐Blood Clots	☐Breast Distention	☐Vaginal Discharge	

FOR MEN:

1. Do you have any bothersome urinary symptoms? ☐Yes ☐No

   Describe:_____
2. Check all that apply:

☐Erectile dysfunction	☐Difficulty with orgasm	☐Pain or swelling of testicles	☐Frequent need to urinate at night
☐ Impotence/erectile dysfunction	☐Premature ejaculation	☐Feeling of coldness or numbness in external genitalia	
	☐Pain/Subtly of testicles		

3. Do you get up at night to urinate? ☐Yes ☐No How often? _____
4. To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

   _____
5. Have you sought Medical intervention for these problems? If so, when? _____

   _____
6. What treatments have you tried for these problems and how successful have they been?

   _____

IV. Medical History

Please check all that apply	*Date Diagnosed*		*Date Diagnosed*
☐ Diabetes	___ / ___ / ___	☐ Heart Disease	___ / ___ / ___
☐ High Blood Pressure	___ / ___ / ___	☐ High Cholesterol	___ / ___ / ___
☐ Thyroid Disease	___ / ___ / ___	☐ Seizures	___ / ___ / ___
☐ Cancer	___ / ___ / ___	☐ Hepatitis	___ / ___ / ___
☐ HIV	___ / ___ / ___	☐ Others	___ / ___ / ___

V. Surgical History

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

VI. Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VII.Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies (to medications, chemicals or foods):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

VIII. Nutrition

1. Do you follow a special diet? ☐ Yes ☐ No If yes, how would you describe the diet? (ie Vegetarian, Vegan, Low Carb, etc.)

   _____

2. What do you eat on a "typical" day?
   a) Breakfast _____
   b) Lunch _____
   c) Dinner _____
   d) Snacks _____
   e) Foods you tend to crave: _____
   f) Foods you dislike: _____

IX. Social History

1. How much per day do you use of the following?
   a) Coffee, tea, soft drinks: _____
   b) Alcohol: _____
   c) Cigarettes, cigars, other tobacco: _____
   d) Other drugs: _____
2. Have you ever had a problem with *alcohol* or *alcoholism*? ☐ Yes ☐ No
3. Have you ever had a problem with *dependency* on other drugs? ☐ Yes ☐ No
4. If yes which and when?

   _____
5. Do you have a known history of any exposure to *toxic* substances? ☐ Yes ☐ No
6. If so, please list which and when you first noticed symptoms? _____

   _____
7. In the past year, how many days have been significantly affected by your health? _____
8. How many days did you feel generally poor? _____
9. How many times were you in the hospital? _____
10. Please describe your current exercise regimen:

    Hours per week: _____ Activities: _____ ☐No Exercise
11. How many hours of sleep do you usually get per night during the week? _____
12. Do you awake feeling rested? ☐ Yes ☐ No Do you feel you sleep well at night? ☐ Yes ☐ No
13. Who would you describe as your source of primary social support? (relationship to you)

X. Occupation

Status:

☐Employed Title/Description_____ Length of time at current job _____

☐Unemployed ☐Full-time Parent

Level of enjoyment with job: ☐Very high ☐High ☐Moderate ☐Low ☐Very low

Stress Level at job: ☐Very high ☐High ☐Moderate ☐Low ☐Very low

Spiritual Beliefs

1. How would you describe your spiritual beliefs? (i.e. religious affiliation, belief in God or some higher power)

2. If you belong to a religious or spiritual group, please describe._____
3. Do you think your relationship with a higher power has anything to do with your health? ☐ Yes ☐ No
4. What practices do you engage in relating to your spiritual beliefs? (i.e. prayer, meditation, communion)

5. What myths, superstitions or mottos (i.e. “Do unto others,…”) were common in your family growing up?

6. If you were to describe the life ethic or principle that guides you, what would it be?

7. Anything else you would like to add regarding your current health, past health, goals, etc.

XI. Other Information

Please list and briefly describe the most significant events in your life:
1. _____
2. _____
3. _____
4. _____

Have you been treated for emotional issues? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Do you have any other neurological or psychological problem? ☐ Yes ☐ No
Describe any previous psychotherapy _____
_____
_____

Previous Complementary Medicine Experiences:
Please describe diagnosis and approximate dates of any previous treatment. _____