



11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever   Diphtheria   Rheumatic Fever   Mumps   Measles   German Measles   Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio   Tetanus   Rubella/Mumps/Rubella   Pertussis   Diphtheria   Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In this section, please CIRCLE current conditions and UNDERLINE past conditions:

15. **Emotional:**   Mood Swings   Nervousness   Mental Tension   Sadness   Depression   Anger   Anxiety

16. **Energy and Immunity :**   Fatigue   Slow Wound Healing   Chronic Infections   Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat :**

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

18. **Respiratory:**   Pneumonia   Frequent Common Colds   Difficulty Breathing   Emphysema

Persistent Cough   Pleurisy   Asthma   Tuberculosis   Shortness of Breath

Other Respiratory Problems: \_\_\_\_\_

19. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever
			Varicose Veins

20. **Gastrointestinal:**

Ulcers            Changes in Appetite    Nausea/Vomiting    Epigastric Pain    Passing Gas    Heartburn  
Belching        Gall Bladder Disease    Liver Disease        Hepatitis B or C    Hemorrhoids    Abdominal Pain

21. **Genito-Urinary Tract :**

Kidney Disease        Painful Urination    Frequent UTI                      Frequent Urination    Heavy Flow  
Kidney Stones        Impaired Urination    Blood in Urine                      Frequent Urination at Night

22. **Female Reproductive/Breasts:**

Irregular Cycles        Breast Lumps/Tenderness    Nipple Discharge                      Heavy Flow  
Vaginal Discharge        Premenstrual Problems    Clotting                                      Bleeding Between Cycles  
Menopausal Symptoms    Difficulty Conceiving                      Painful Periods

23. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_                      4. Birth Control Type: \_\_\_\_\_                      7. # of Abortions: \_\_\_\_\_  
2. # of Days of Menses: \_\_\_\_\_                      5. # of Pregnancies: \_\_\_\_\_                      8. # of Live Births: \_\_\_\_\_  
3. Length of Cycle: \_\_\_\_\_                      6. # of Miscarriages: \_\_\_\_\_

24. **Male Reproductive:**

Sexual Difficulties        Prostrate Problems                      Testicular Pain/Swelling                      Penile Discharge

25. **Musculoskeletal:**

Neck/Shoulder Pain        Muscle Spasms/Cramps                      Arm Pain                      Upper Back Pain                      Mid Back Pain  
Low Back Pain                      Leg Pain                      Joint Pain (if so, where?): \_\_\_\_\_

26. **Neurologic:**

Vertigo/Dizziness        Paralysis                      Numbness/Tingling                      Loss of Balance                      Seizures/Epilepsy

27. **Endocrine:**

Hypothyroid                      Hypoglycemia                      Hyperthyroid                      Diabetes Mellitus                      Night Sweats                      Feeling Hot or Cold

28. **Other:**

Anemia                      Cancer                      Rashes                      Eczema/Hives                      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

29. **Lifestyle:**

- a. Do you typically eat at least three meals per day? Y N If no, how many? \_\_\_\_\_
- b. Exercise routine: \_\_\_\_\_
- c. Spiritual practice: \_\_\_\_\_
- d. How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? Y N
- e. Level of education completed: High School Bachelors Masters Doctorate Other
- f. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_  
Do you enjoy work? Y/N Why/Why not? \_\_\_\_\_
- g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_
- h. Have you experienced any major traumas? Y N Explain: \_\_\_\_\_  
\_\_\_\_\_
- i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_
- j. Television habits: \_\_\_\_\_ Reading habits: \_\_\_\_\_
- k. Interests and hobbies:

How did you hear about us? _____
Would you like to receive our email newsletter? _____

The Borden Wellness Center  
Adrienne Borden, AP  
3131 S. Tamiami Tr. Suite 102  
Sarasota, FL 34239  
941.316.9355

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised notice by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- Acupuncture Associates reserves the right to leave confidential messages (ie: appt reminders) on your answering machine or voicemail. Please print the number where you would like to receive messages if other than your home number: \_\_\_\_\_
- Correspondence from Acupuncture Associates from may be in a sealed envelope marked "Confidential".
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this consent.
- *Please note:* If you choose to have Community Room treatments, please understand this is a public room and there will be other patients present. Every effort will be made to protect your privacy; however, in the event you may overhear any information, please keep it confidential as you will want others to do the same for you. If this is an issue for you, please opt for private treatments.

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This consent was signed by: \_\_\_\_\_ (print name)

Patient/Guardian signature: \_\_\_\_\_ (sign name)

Relationship (if other than patient) \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_ (print name-practice rep.)

Date: \_\_\_\_\_