Dr. Debbie Vaughn, DAOM

Traditional Chinese Medicine Health Profile

Welcome, new patient! The information you provide here is confidential. Please fill out this form as completely as possible so that your health concerns may be best addressed.

Name		Date
Date of birth		Age
Email	Occupation	
Main phone #	Other Phone #	
Address		
Emergency Contact & Phone #		
Relationship Status	# of Children	
Male ☐ Female ☐	Height	Weight
How did you hear about the clinic?		

Main Concerns

_____

_____

_____

Have you been evaluated for this condition? Yes ☐ No ☐ Diagnosis_____
How long ago did this begin?_____ How does it affect your daily activities?

_____

What treatments have you tried?

_____

What makes it better? _____ What makes it worse? _____

Lab Results: (Include copies)

_____

_____

Current Medications and Supplements

Medicine/Supplement	Dose	Reason	How long?	Prescribed by

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Medical History

	Self	Family		Self	Family		Self	Family
Cancer			Heart disease			High blood pressure		
Breathing Problems			Seizures			High Cholesterol		
Diabetes			Arthritis			Digestive disorders		
Hepatitis			Addiction			Eating Disorders		
Thyroid problems			Mental Illness			Other		

Allergies: (drugs, chemicals, foods, environment) _____

Food cravings: _____

Surgeries, hospitalizations & significant injuries: (include dates)
_____
_____

Birth history (prolonged labor, forceps/c-section delivery)_____
How was your health as a child?_____

Lifestyle
How do you feel about these areas of you life?

	Great	Good	Ok	Poor	Bad	Comments
Self	☐	☐	☐	☐	☐	_____
Partner	☐	☐	☐	☐	☐	_____
Family	☐	☐	☐	☐	☐	_____
Work	☐	☐	☐	☐	☐	_____
Sex	☐	☐	☐	☐	☐	_____
Diet	☐	☐	☐	☐	☐	_____
Fitness	☐	☐	☐	☐	☐	_____
Spirituality	☐	☐	☐	☐	☐	_____

How often do you exercise? _____ What kind? _____
What time do you typically go to sleep and wake up? _____
How do you deal with stress? _____
Do you have enough time for these things?_____

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Diet

Are you on a special diet? _____

What are some of the things you commonly eat for:

Breakfast: _____

Lunch: _____

Snack: _____

Dinner: _____

Indicate the use and frequency of the following:

	Yes	No	How much?		Yes	No	How Much?
Coffee				Water			
Tobacco				Soda			
Alcohol				Recreational Drugs			

Please check if you have recently had these conditions:

General

- ☐ Night sweats
- ☐ Poor balance
- ☐ Sudden energy drop
- ☐ Poor appetite
- ☐ Sweat easily
- ☐ Bruises
- ☐ Poor sleep
- ☐ Tremors
- ☐ Fatigue
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight change
- ☐ Body runs hot
- ☐ Body runs cold
- ☐ Frequent colds
- ☐ Allergies

Skin & Hair

- ☐ Acne
- ☐ Rashes
- ☐ Recent moles
- ☐ Itching
- ☐ Eczema
- ☐ Dandruff
- ☐ Dry skin
- ☐ Oily skin
- ☐ Hair changes
- ☐ Skin changes
- ☐ Loss of hair
- ☐ Other

Head, Eyes, Ears, Nose & Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Jaw clicks
- ☐ Dental problems
- ☐ Oral sores
- ☐ Vertigo
- ☐ Facial pain
- ☐ Blurry vision
- ☐ Eye pain
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Spots in vision
- ☐ Nose bleeds
- ☐ Other

Musculoskeletal

- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Numbness
- ☐ Radiating pain
- ☐ Reduced mobility
- ☐ Stiffness
- ☐ Other

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Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling of feet
- ☐ Fainting
- ☐ Hand swelling

Respiratory

- ☐ Painful breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Chest Pain
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Phlegm

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Chronic laxative use
- ☐ Belching
- ☐ Parasites
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Other

Neuro-psychological

- ☐ Depression
- ☐ Loss of coordination
- ☐ Anxiety
- ☐ Bad temper
- ☐ Stress
- ☐ Suicidal thoughts
- ☐ Bi-polar
- ☐ Other

Genital-urinary

- ☐ Kidney stones
- ☐ Painful urination
- ☐ Incontinence
- ☐ Dribbling
- ☐ STD
- ☐ Decrease in flow
- ☐ Genital pain
- ☐ Other

Female

- ☐ Painful periods
- ☐ Irregular periods

Days of period _____

# of Pregnancies _____

- ☐ Hot flashes
- ☐ Fibroids
- ☐ Clots

# of Births_____

- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Birth control _____

# of Miscarriages _____

- ☐ Infertility
- ☐ PMS
- ☐ C-section

Male

- ☐ Prostate problems
- ☐ Testicular problems
- ☐ Discharge
- ☐ Ejaculation problems
- ☐ Erectile dysfunction
- ☐ Frequent seminal emission
- ☐ Infertility
- ☐ Other

Additional information:

Dr. Debbie Vaughn, DAOM

Fee Schedule

New Patient Visit (90 min)	$150
Follow-up Treatments (60 min)	$90
Nutrition/Lifestyle Consultation	$90/hour
Package Discount	$400 for 5 treatments ($50 savings)

Financial Agreement

I understand that payment is due in full at the time of service in the form of cash, check or credit card. If I wish to file with my insurance, I must still pay Dr. Debbie Vaughn, DAOM in full. A receipt with procedure and ICD-9 codes will be provided at my request. I understand that 24 hour notice is required for cancellations and that otherwise I can be charged full price for the visit

Referral Policy

I, Dr. Debbie Vaughn, DAOM, reserve the right to refuse treatment at any time if I feel that the treatment is inappropriate to either myself or the patient. If such a case occurs, I will refer you to the most appropriate place to continue seeking healthcare.

I am notifying the Acupuncturist, Dr. Debbie Vaughn, DAOM of the following:

___ Yes ___ No I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the Acupuncturist. _____ (initials)

___Yes ___No I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs, I understand that the Acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

Patient / Representative name (print) Relationship to Patient

Signature Date

Dr. Debbie Vaughn, DAOM

Informed Consent to Oriental Medical Health Care

I request and consent to the performance of the following on myself (or patient named below, for whom I am legally responsible) by Dr. Debbie Vaughn, DAOM.: acupuncture and other Oriental medical procedures including diagnostics such as questioning, pulse evaluation, palpation on a variety of areas of my body, range of motion, orthopedic testing; acupressure, heat therapy and electrical stimulation, cupping, moxibustion;, herbal and dietary supplement prescriptions; dietary, exercise and healthy lifestyle recommendations. I understand I have opportunities to discuss the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied. I understand and am informed that, as in conventional Western medicine, there are risks to treatment. I understand that although these risks are unlikely, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain where a needle is inserted or where cupping or herbal application is made to the skin or radiating from those locations; nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment, during the course of my treatment, as the practitioner feels at the time, based on the facts then known, to be in my best interest. I understand that acupuncture and Oriental medicine treatments may not have the desired therapeutic affect when combined with excessive medication, alcohol consumption or illegal drug use at the time of treatment. If there is reasonable cause to believe that treatment is not appropriate for a patient, then treatment may not be performed at that time. I have read, or have had read to me, this informed consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above procedures and conditions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient / Representative name (print) Relationship to Patient

Signature Date

HIPAA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to the “Notice of Privacy Practices.” I understand that I have the right to review this notice prior to signing this document. I understand that Dr. Debbie Vaughn, DAOM may need to contact me with appointment reminders or information related to my treatments. By signing this form, I understand that all information discussed will be held confidential except in the instance where my safety or the safety of others may be at risk.

I have read, understand and agree to the above conditions.

Patient / Representative name (print) Relationship to Patient

Signature Date