South Denver Acupuncture and Herbal Medicine Clinic

Patient Information and Disclosure

Name_____Phone (H) _____ (W) _____

Age_____Height_____Weight_____

Address_____

City_____State_____Zip Code_____

Date of Birth_____Sex_____Occupation_____

Employer's Name & Address_____

Marital Status_____Number of Children_____

Personal Physician_____

Date of Last Completed Physical Exam_____

In Case of Emergency Contact_____Phone_____

- Acupuncture, Acupressure, Tui Na, Massage, Reflexology, health or corrective exercises and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medical care. Therapies and advice offered shall not be construed by the patient to be a Western Medical diagnosis or treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any condition and get at least two medical opinions. It is your right and responsibility for your own health.
- The Colorado Acupuncture Practice Act states, "Practice of acupuncture means the insertion and removal of acupuncture needles, the application of heat therapies to specific areas of the human body, and traditional oriental adjunctive therapies. Traditional oriental adjunctive therapies within the scope of acupuncture may include manual, mechanical, thermal, electrical, and electromagnetic treatment, the recommendation of oriental therapeutic exercise, and subject to federal law, the recommendation of herbs and dietary guidelines." The "Practice of Acupuncture" shall be defined by traditional oriental medical concepts and shall not include the utilization of western medical diagnostic tests and procedures such as magnetic resonance imaging, radiographs, computerized tomography scans, and ultrasound. "Practice of Acupuncture" does not mean: Osteopathic medicine and manipulative treatments; Chiropractic medicine or chiropractic adjustments; or Physical Therapy.
- Acupuncture has been explained to me as a treatment consisting of the insertion of acupuncture needles through the skin at certain points on the body, as well as other oriental modalities as described by the Colorado Acupuncture Practice Act. The purpose being to alleviate or treat symptoms or disorders.
- I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of numbness, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms.

Patient further understands and agrees to hold harmless, to indemnify and protect against court action the individual practitioners, employees, and the South Denver Acupuncture and Herbal Medicine Clinic LLC, in the event of an accidental injury on the premises.

Do you have an allergy to latex exam gloves? _____Yes_____No

How did you hear about us? (Please Check One)

- ☐ Google/Internet Search
- ☐ Groupon/ Amazon Local (Circle One)
- ☐ Facebook
- ☐ LinkedIn
- ☐ Friend/Family/Co-worker Referral Who?_____
- ☐ Physician Referral Who?_____
- ☐ Lecture or Workshop Which?_____

Signed_____Date_____

phone (720) 260.1892 | southdenvertcm@gmail.com | www.southdenvertcm.com
2950 S. Jamaica Ct. Suite 303 | Aurora, CO 80014

COLORADO MANDATORY DISCLOSURE STATEMENT

SOUTH DENVER ACUPUNCTURE AND HERBAL MEDICINE CLINIC

Christopher Shiflett, L.Ac Phone: 720.260.1892

2950 S. Jamaica Ct., Suite 303

Aurora, CO 80014

Education and Experience

Christopher Shiflett earned his Master of Science in Traditional Chinese Medicine from the Colorado School of Traditional Chinese Medicine in December 2013. This three year program consists of 3,500 hours of education including 1,000 hours of clinical practice. He was certified as a Diplomate in Oriental Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in March 2014. This includes certification in Clean Needle Technique, Acupuncture, Asian Bodywork and Chinese Herbology. Christopher has also earned a Bachelor of Science in Integrated Therapeutic Practices from Metropolitan State University. Christopher is a Colorado native and has practiced in the South Denver Metro area since April 2014.

Christopher's training includes adjunctive therapies such as moxibustion, tui na, acupressure, cupping, auriculotherapy, and dietary and lifestyle recommendations.

Christopher is a member of the Acupuncture Association of Colorado. He is a registered acupuncturist in Colorado. This license has never been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health and Environment, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable factory-sterilized needles are utilized.

Christopher is trained and experienced in the recommendation and application of adjunctive therapies and herbs as defined by traditional oriental medical concepts.

Fee Schedule

Intake and Consultation	$80 + Cost of Herbs
Follow Up Treatment	$60 + Cost of Herbs
Herbal Consultation only	$40

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Director of Professions and Occupations, Acupuncture Licensure, 1560 Broadway, Suite 1350, Denver, Colorado, 80202. Telephone (303) 894-7800

I have read and understand this document

Patient or Guardian's Signature: _____ Date: _____

South Denver Acupuncture and Herbal Medicine Clinic

Acupuncture Informed Consent to Treatment Form

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, Moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), heat lamp therapy, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of Moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Acupuncturist:

Christopher Shiflett L.Ac Dipl. OM NCCAOM

X_____ _____

Signature of Patient or Representative (indicate relationship if signing for patient) Date

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SOUTH DENVER ACUPUNCTURE & HERBAL MEDICINE CLINIC
COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand that COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.
I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.
To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided below) Initials

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- Person contact, in which COVID-19 can be transmitted. **Initials** _____

- I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand There are alternatives to receiving this care, which could include receiving care from another type of provider, or Postponing care altogether at this time. However, while I understand the potential risks associated with receiving Treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. **Initials** _____

- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics Of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. **Initials** _____

- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell **Initials** _____

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in The past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; Or 2) Domestically within the United States by commercial airline, bus, or train. **Initials** _____

- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected With COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected With COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to Proceed with providing care. **Initials** _____

- I have been offered a copy of this consent form. **Initials** _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.
I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OF FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

PATIENT/GUARDIAN NAME:_____SIGNATURE_____DATE_____

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South Denver Acupuncture & Herbal Medicine Clinic

Office Policies

Cancellations & Missed Appointments

Please provide 24-hour notice of cancellation prior to your scheduled appointment. After the first missed appointment without 24hr notification a $30 fee will be assessed. After the second missed appointment without 24hr prior notification a $60 fee will be assessed for this and all future missed or late cancelled appointments.

Reasons for being dismissed/denied treatment:

Patients who show inappropriate conduct, non-or-late payment of fees, or safety concerns may be denied treatment.

Financial Policy

Your payment is due in full at the time of service. For your convenience, we accept cash, check, or credit cards (Visa or MasterCard only). For checks returned to us as unpaid by your bank, you will be charged a $25 fee.

Insurance Policy

We do not accept or bill insurance. We will gladly give you a receipt for all of your treatments so you can submit them to your insurance company for reimbursement.

The undersigned hereby understands and agrees to comply with the above policies. I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company.

Please indicate your understanding and acceptance of these policies by signing below.

_____	_____	_____
Patient's Signature	***Patient's Name***	***Date***

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South Denver Acupuncture and Herbal Medicine Clinic

Permission to Call

Occasionally situations arise in which we may need to call you. For instance, there is a cancellation at a time you previously requested and we would like to call and offer that time slot to you. To protect the privacy of you, the patient, SDAHMC would like to know that if a situation such as the one described abover or one similar to that should occur, can we contact you by phone and if so please let us know at which number(s) you would like to be contacted.

Please check the appropriate line

___Contact me at any of my numbers listed on the Patient Information and Disclosure Form.

___Contact me only at my work number. That number is_____

___Contact me only at my home number. That number is_____

___Contact me only at my cell number. That number is_____

___Do not contact me at any of my phone numbers.

Signed_____Date_____

Printed Name_____

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South Denver Acupuncture and Herbal Medicine Clinic

Notice of Privacy Practices

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.

The South Denver Acupuncture and Herbal Medicine Clinic (SDAHMC) is require, by law, to maintain the privacy and confidentiality of you protected health information and how to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with the SDAHMC."

"It is our policy to provide a substitute healthcare provider, authorized by SDAHMC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

Payment

We expect payment at the time the services are rendered but in the event you file an insurance claim, we may disclose your health information to your insurance provider for the purpose of payment or health care operations via phone, fax, email, or US Mail.

"Since you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Worker's Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease and infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a , fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or translating organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:

"As a courtesy to our patients, we may call your home, usually the day prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we will leave a reminder message on your answering machine or with, the person answering the form. No personal health information will be disclosed during this recording or message other than the/date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable event to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal information about your condition for the purposes of SDAHMC sponsored fund-raising events."

Change of Ownership

In the event that SDAHMC is sold or merged with another organization, your health information record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised however, that SDAHMC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information. We will charge you reasonable cost-based fee expenses such as copies and staff time. The fee is set as base fee of $25.00 for 10 pages or less; additional fee of $1.00 per page for pages 11-60, $0.50 per page for pages 61-400. The base fee must be paid at the time of the request and the balance paid at the time of pick up.
- You have the right to request that SDAHMC amend your protected health information. Please be advised, however, that SDAHMC is not required to agree to amend our protected health information. If you request to amend your health information has been denied, you will be provided with and explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right an accounting of disclosures of your protected health information made by SDAHMC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

SDAHMC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, SDAHMC is required by law to comply with this notice.

SDAHMC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact SDAHMC office by calling:(720)-260-1892. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or how SDAHMC had handled your health information should be directed to the SDAHMC office by calling :(720)-260-1892. If they are not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complain, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 independence Avenue, SW
Room 509F HHHF
Washington, VA 20201

This notice is effective as of February 1, 2014. I have read the Notices of Privacy Practices and understand my rights contained in the notice

By way of my signature on the acknowledgement of Receipt of Notice of Privacy Practices, I have provided SDAHMC my authorization and consent to use and disclose my personal health care information for the purposes of treatment, payment of health care operations as described in the Notice of Privacy Practices.

South Denver Acupuncture and Herbal Medicine Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures of South Denver Acupuncture and Herbal Medicine Clinic. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

_____ _____

Patient Signature Date

_____ _____

Clinic Administrative Signature Date

Health History Form

Please place a check mark for symptoms/ diseases you have had in the past. Circle the name of any symptoms/ diseases you are currently experiencing and write the frequency, intensity, and duration.

General Symptoms

- ___ Tremors
- ___ Headache
- ___ Migraines
- ___ Fever
- ___ Chills
- ___ Cold hands/feet
- ___ Sweating
- ___ Fainting/dizziness/vertigo
- ___ Motion sickness
- ___ Convulsions
- ___ Loss of Sleep/ Insomnia
- ___ Fatigue
- ___ Nervousness
- ___ Depression
- ___ Loss of Weight
- ___ Forgetfulness
- ___ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, feet (circle which apply)
- ___ Confusion
- ___ Other

Eyes, Ears, Nose & Throat

- ___ Failing vision
- ___ Eye pain or sensitivity
- ___ Eye strain
- ___ Blurry vision
- ___ Cross eyed
- ___ Eye inflammation
- ___ Glaucoma
- ___ Cataracts
- ___ Color blindness
- ___ Spots/ lines in vision
- ___ Deafness
- ___ Earache
- ___ Loss of hearing
- ___ Ear discharge
- ___ Ear noises, ringing
- ___ Nose bleeds, nasal obstruction
- ___ Nasal drainage
- ___ Loss of smell
- ___ Sinus infection
- ___ Hay fever
- ___ Allergies
- ___ Sore throat
- ___ Hoarseness
- ___ Difficult speech
- ___ Difficult swallowing
- ___ Loss of taste or change in tastes
- ___ Dental decay
- ___ Gum problems
- ___ Tonsillitis
- ___ Asthma/ Bronchitis/ Pneumonia
- ___ Frequent colds/ flu
- ___ Thyroid problems
- ___ Enlarged/swelling of glands
- ___ Other

Skin, Hair, Nails

- ___ Skin eruptions
- ___ Eczema/ Psoriasis
- ___ Itching
- ___ Clammy skin
- ___ Dryness
- ___ Bruise easily
- ___ Cuts heal slowly
- ___ Boils
- ___ Rashes
- ___ Mole/ Warts
- ___ Sensitive Skin
- ___ Hives or Allergy
- ___ Hair Problems
- ___ Finger/ Toenail problems

Respiratory

- ___ Chronic cough
- ___ Spitting up phlegm
- ___ Spitting up blood
- ___ Chest pain
- ___ Difficulty breathing
- ___ Wheezing
- ___ Other

Cardio-Vascular

- ___ Rapid beating heart
- ___ Slow beating heart
- ___ Irregular beating heart
- ___ High blood pressure
- ___ Low blood pressure
- ___ Pain over heart
- ___ Previous stroke
- ___ Previous Heart Attack
- ___ Hardening of arteries
- ___ Swelling of ankles
- ___ Poor circulation
- ___ Paralytic stroke
- ___ Varicose veins
- ___ High Cholesterol
- ___ Low Cholesterol
- ___ Anemia
- ___ Other

Muscle & Joints

- ___ Stiff neck or neck pain
- ___ Pain between shoulders
- ___ Backache
- ___ Tailbone, Foot, toe, or heel problems
- ___ Hand, wrist or finger problems
- ___ Hernia
- ___ Spinal curvature
- ___ Faulty posture
- ___ Swollen joints
- ___ Stiff joints
- ___ Painful joints
- ___ Arthritis
- ___ Sore muscles
- ___ Weak muscles
- ___ Walking problems
- ___ Sciatica
- ___ Other

Genitourinary

- ___ Frequent urination
- ___ Scanty urine
- ___ Painful urination
- ___ Blood in urine
- ___ Pus in urine
- ___ Kidney infection or stones
- ___ Bed wetting
- ___ Inability to control urine
- ___ Bladder problems
- ___ Foul smelling urine
- ___ Discolored/ cloudy urine
- ___ Urinary tract infections
- ___ Other

Gastrointestinal

- ___ Eating disorder
- ___ Poor appetite
- ___ Excessive hunger
- ___ Difficulty chewing
- ___ Belching
- ___ Bad breath
- ___ Nausea
- ___ Gas
- ___ Indigestion
- ___ Heartburn
- ___ Vomiting
- ___ Vomiting of blood
- ___ Pain in abdominal area
- ___ Distention of abdomen/ bloating
- ___ Constipation
- ___ Diarrhea
- ___ Undigested food in stool
- ___ Black stool
- ___ Blood in stool
- ___ Mucous in stool
- ___ Colon problems
- ___ Anal problems
- ___ Hemorrhoids (Piles)
- ___ Intestinal Worms
- ___ Liver Problems
- ___ Gall bladder problems/ stones
- ___ Jaundice
- ___ Colitis
- ___ Weight Problems
- ___ Other

Female

- ___ PMS
- ___ Painful menstrual periods
- ___ Excessive flow
- ___ Hot flashes
- ___ Irregular cycle
- ___ Period cramps of backache
- ___ Previous miscarriage
- ___ Vaginal discharge
- ___ Vaginal pain
- ___ Breast pain
- ___ Lumps in breast
- ___ Menopausal symptoms
- ___ Abnormal bleeding
- ___ Reduced sex drive
- ___ Pregnancy
- ___ Pregnancy complications
- ___ Abnormal Pap Tests
- ___ Pain during intercourse
- ___ Other

Male

- ___ Prostate problems
- ___ Genital pain or problems
- ___ Reduced sex drive
- ___ Premature ejaculation
- ___ Seminal emission
- ___ Impotence
- ___ Discharges
- ___ Other

Other

- ___ Edema
- ___ Hepatitis
- ___ Herpes
- ___ Cancer
- ___ Diabetes
- ___ TB
- ___ Epilepsy
- ___ Alcoholism / Substance Abuse
- ___ Depression
- ___ Mental Emotional Disorder
- ___ HIV+/AIDS
- ___ Sexually Transmitted Disease
- ___ Other

Patient Medication Information

Please List All Medications that you are currently taking along with the dosage, frequency you take the medication, and the medical reason for its use.

Date	Drug Name	Dosage	Frequency	Reason

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