
HISTORIAL MÉDICO DEL PACIENTE

Complete este documento tanto como le sea posible. Algunas de las preguntas pueden parecer no estar relacionadas con su condición, pero la respuesta juega un papel importante en el diagnóstico y tratamiento de su condición. Toda la información es estrictamente confidencial.

INFORMACIÓN PERSONAL

Nombre _____

Sexo M ___ F ___ Fecha de Nacimiento: _____ Edad _____

Dirección _____ Ciudad _____ Estado _____

Zip code _____

Teléfono _____ Fijo _____ Celular _____ Trabajo _____

Email _____

¿Te gustaría estar en nuestra lista de e-mail? Si ___ No ___

Estado civil _____ #de hijos _____ edades _____

Ocupación _____

Contacto de emergencia:

Nombre _____ Teléfono _____ Relación _____

Nombre del médico primario _____ Teléfono _____

Menor de 18 años – Nombre del Representante:

Nombre _____ Relación con el paciente _____

¿Previa experiencia con la acupuntura? Si ___ No ___

HISTORIAL MÉDICO

Indique sus problemas de salud en orden de importancia:

Por favor, marque si usted tiene o ha tenido algunas de estas condiciones:

- | | | |
|---|--|---|
| <input type="radio"/> Abuso de sustancias | <input type="radio"/> Enf. de transmisión sexual | <input type="radio"/> Presión Arterial Alta/Baja |
| <input type="radio"/> Accidente cerebrovascular | <input type="radio"/> Enf. de Hígado o Vesícula | <input type="radio"/> Problemas venosos |
| <input type="radio"/> Alcoholismo | <input type="radio"/> Enfermedades del Riñón | <input type="radio"/> Reemplazo de articulaciones |
| <input type="radio"/> Alergias | <input type="radio"/> Enfermedades Cardiacas | <input type="radio"/> Sinusitis |
| <input type="radio"/> Anemia | <input type="radio"/> Enfermedad de la Tiroides | <input type="radio"/> Tendencia a sangrar |
| <input type="radio"/> Artritis | <input type="radio"/> Enfermedad Pulmonar | <input type="radio"/> Tosferina |
| <input type="radio"/> Artritis reumática | <input type="radio"/> Esclerosis Múltiple | <input type="radio"/> Gastritis |
| <input type="radio"/> Asma | <input type="radio"/> Desmayos | <input type="radio"/> Trasplante de Órganos |
| <input type="radio"/> Auto Inmune | <input type="radio"/> Fatiga Crónica | <input type="radio"/> Trastornos alimenticios |
| <input type="radio"/> Bronquitis | <input type="radio"/> Fibromialgia | <input type="radio"/> Trauma al nacer |
| <input type="radio"/> Cálculos biliares | <input type="radio"/> Fiebre Reumática | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Cáncer o tumor | <input type="radio"/> Glaucoma | <input type="radio"/> VIH/SIDA |
| <input type="radio"/> Cándida (Hongos) | <input type="radio"/> Gota | <input type="radio"/> Otros |
| <input type="radio"/> Colesterol Alto | <input type="radio"/> Hepatitis | |
| <input type="radio"/> Colitis | <input type="radio"/> Hernia | |
| <input type="radio"/> Convulsiones/Epilepsia | <input type="radio"/> Herpes | |
| <input type="radio"/> Degeneración Macular | <input type="radio"/> Ictericia | |
| <input type="radio"/> Desfibrilador | <input type="radio"/> Impotencia | |
| <input type="radio"/> Desorden de salud mental | <input type="radio"/> Intento de suicidio | |
| <input type="radio"/> Diabetes | <input type="radio"/> Intolerancias / Alergias alimentos | |
| <input type="radio"/> Discos herniados | <input type="radio"/> Marcapasos | |
| <input type="radio"/> Diverticulitis/Síndr. intestino irritable | <input type="radio"/> Migraña | |
| <input type="radio"/> Dolor Crónico | <input type="radio"/> Mono | |
| <input type="radio"/> Dolor de cabeza | <input type="radio"/> Neumonía | |
| <input type="radio"/> Enfermedades de la piel | <input type="radio"/> Osteoporosis | |
| <input type="radio"/> Enfermedad de Lyme | <input type="radio"/> Parkinson | |

Indique enfermedades, cirugías u hospitalizaciones que haya tenido y el año en que ocurrieron:

_____ Fecha _____

_____ Fecha _____

_____ Fecha _____

_____ Fecha _____

HISTORIAL FAMILIAR

Indique enfermedades de la familia, tanto físicas como mentales y edades de muerte:

Madre _____

Padre _____

Hermanos _____

Medicamentos, Hierbas y Suplementos (Indique cuáles está tomando en este momento)

Alergias ¿Ha tenido alguna reacción alérgica por algún medicamento, comida, químicos y medioambientales (ronchas, irritación de la piel, problemas para respirar? Sí _____ No _____

Si marcó Sí, por favor haga una lista: Describa la reacción alérgica _____

¿ Usted fuma ? Sí _____ No _____ ¿Cuánto? _____

¿ Usted toma café/te ? Sí _____ No _____ ¿Cuánto? _____

¿ Usted toma bebidas alcoholicas ? Sí _____ No _____ ¿Cuánto? _____

¿ Hace ejercicio ? Sí _____ No _____ ¿ Con qué frecuencia ? _____

¿Qué tipo de ejercicios? (caminar, correr, nadar) _____

SINTOMAS MÉDICOS DEL PACIENTE

Por favor, marque si usted tiene alguno de los siguientes síntomas:

LIV/GB(WOOD)

- | | | |
|---|--|--|
| <input type="radio"/> Irritabilidad/Enojo | <input type="radio"/> Calambres/contracciones musculares | <input type="radio"/> Temblores |
| <input type="radio"/> Depresión/Estrés | <input type="radio"/> Tensión | <input type="radio"/> Dolor |
| <input type="radio"/> Dolor de Cabeza/Migraña | <input type="radio"/> Dolor | <input type="radio"/> abdominal/distensión |
| <input type="radio"/> Problemas Visuales/visión borrosa | <input type="radio"/> Articulaciones/Cuello/Hombro | <input type="radio"/> Dificultad para digerir las grasas |
| <input type="radio"/> Ojos rojos/secos/picor | <input type="radio"/> Mala Circulación | <input type="radio"/> Indecisión |
| <input type="radio"/> Cálculos en la vesícula | <input type="radio"/> Uñas blandas/quebradizas | <input type="radio"/> Tensión Hombros/ Cuello |
| <input type="radio"/> Mareos | <input type="radio"/> Zumbido en los oídos | <input type="radio"/> Insomnio 11 pm-3 am |
| <input type="radio"/> Sensación de nudo en la garganta | <input type="radio"/> Herpes simple | |
| <input type="radio"/> Apretar los dientes por la noche | | |
-

- | | | |
|---|---|--|
| <input type="radio"/> Ht/SI (Fire) | <input type="radio"/> Cuero cabelludo seco | <input type="radio"/> Epistaxis (sangrado nasal) |
| <input type="radio"/> Palpitaciones | <input type="radio"/> Erupción cutánea | <input type="radio"/> Enrojecimiento facial |
| <input type="radio"/> Dolor de Pecho | <input type="radio"/> Quiste/tumor | <input type="radio"/> Picazón/ ardor en la piel |
| <input type="radio"/> Insomnio/problemas de sueño | <input type="radio"/> Infección de oído | <input type="radio"/> Sed |
| <input type="radio"/> Asustarse fácilmente | <input type="radio"/> Dolor de garganta | <input type="radio"/> Sudoración nocturna |
| <input type="radio"/> Inquietud/agitación | <input type="radio"/> Ganglios inflamados | <input type="radio"/> Exceso de alegría |
| <input type="radio"/> Sueños vívidos | <input type="radio"/> Sabor amargo en la boca | <input type="radio"/> Ruidos en el estomago |
| <input type="radio"/> Falta de alegría en la vida | <input type="radio"/> Problemas de encías | |
-

- | | | |
|--|--|--|
| <input type="radio"/> Sp/ST (Earth) | <input type="radio"/> Órganos prolapsados | <input type="radio"/> Gases/eructos |
| <input type="radio"/> Sensación pesadez en el cuerpo | <input type="radio"/> Moretones y sangrado fácil | <input type="radio"/> Distensión Abdominal |
| <input type="radio"/> Fatiga después de comer | <input type="radio"/> Mal aliento | <input type="radio"/> Hemorroides |
| <input type="radio"/> Difícil levantarse por la mañana | <input type="radio"/> Apetito disminuido/aumentado | <input type="radio"/> Constipación |
| <input type="radio"/> Edema (inflamación) | <input type="radio"/> Ansiedad de dulces | <input type="radio"/> Diarrea |
| <input type="radio"/> Músculos cansados a menudo | <input type="radio"/> Hipoglicemia | <input type="radio"/> Dolor Abdominal |
| <input type="radio"/> Extremidades frías | <input type="radio"/> Náusea/vómito | <input type="radio"/> Indigestión/acidez |
-

- Pensar demasiado
- Tendencia a ganar peso
- Mente nublada
- Alergias a comida
- Preocupación excesiva

Lu/LI (Metal)

- | | | |
|--|---|--|
| <input type="radio"/> Tos seca | <input type="radio"/> Sed | <input type="radio"/> Dificultad para respirar |
| <input type="radio"/> Tos con flema | <input type="radio"/> Dolor de garganta | <input type="radio"/> Asma/alergias |
| <input type="radio"/> Congestión nasal | <input type="radio"/> Erupciones en la piel/urticaria/
piel seca | <input type="radio"/> Catarros frecuentes |
| <input type="radio"/> Goteo postnasal | <input type="radio"/> Ronquido | <input type="radio"/> Fiebre leve que va y viene |
| <input type="radio"/> Sinusitis | <input type="radio"/> Pena/tristeza | |
| <input type="radio"/> Boca/garganta/nariz seca | | |

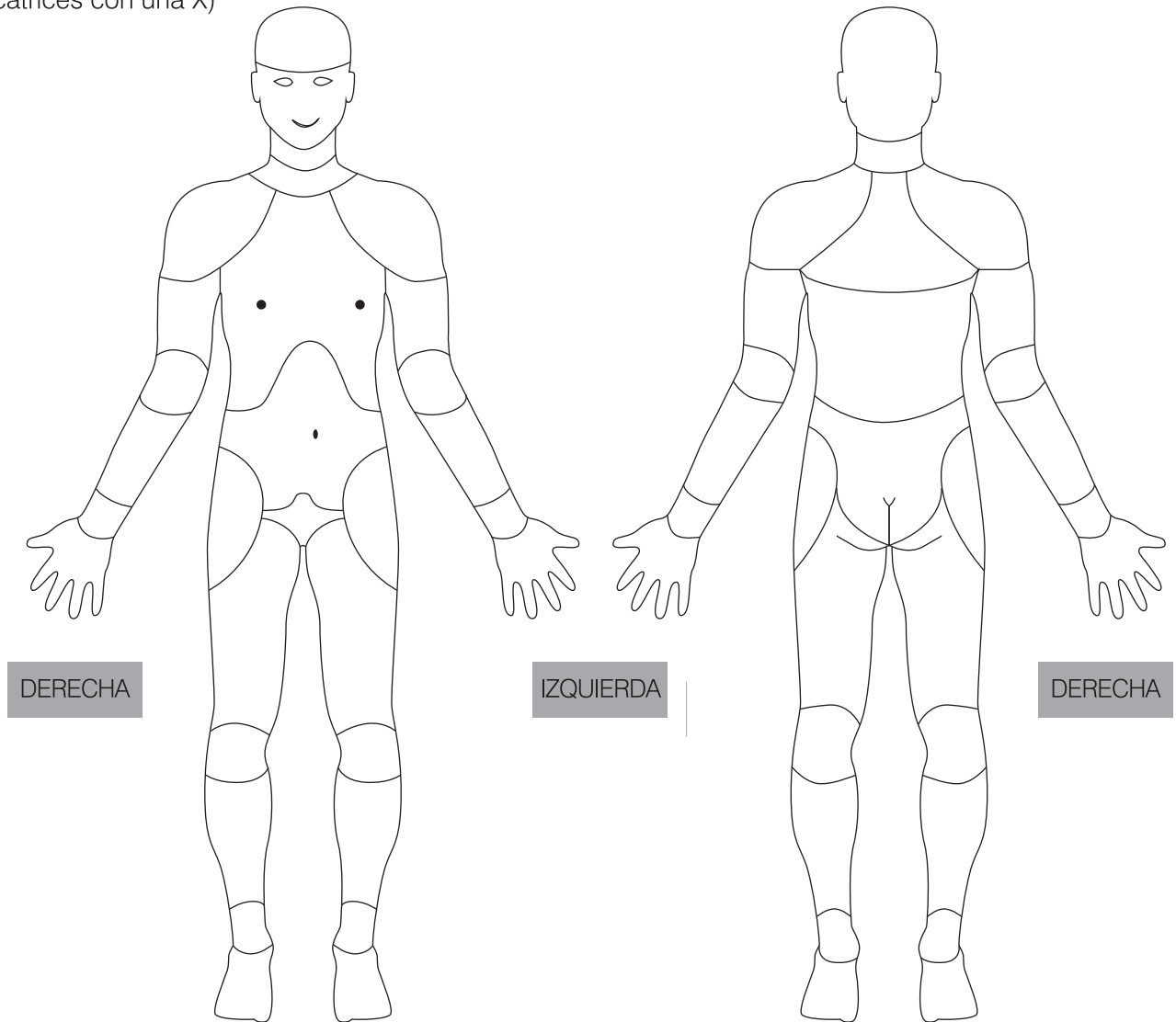
Kid/UB (water)

- | | | |
|--|--|---|
| <input type="radio"/> Problemas para orinar | <input type="radio"/> Exceso de la libido | <input type="radio"/> Miedo |
| <input type="radio"/> Problemas de Vejiga | <input type="radio"/> Mala memoria | <input type="radio"/> Calores/sudor nocturno |
| <input type="radio"/> Falta de control de vejiga | <input type="radio"/> Pérdida de cabello | <input type="radio"/> Piernas /rodillas débiles |
| <input type="radio"/> Debilidad/Dolor espalda baja | <input type="radio"/> Problema de oído | <input type="radio"/> Cambio repentino de peso |
| <input type="radio"/> Disminución densidad ósea | <input type="radio"/> Caries/pérdida de dientes | <input type="radio"/> Inestabilidad emocional |
| <input type="radio"/> Sentirse frío fácilmente | <input type="radio"/> Antojo/Evita alimentos salados | |
| <input type="radio"/> Disminución de la libido | | |

OTROS

- Ciática
- Dolor neural
- Túnel Carpiano
- Entumecimiento
- Bursitis/tendinitis

Favor de marcar claramente las zonas de dolor y cualquier cicatriz (indicar áreas de dolor con un círculo y cicatrices con una X)



Esta gráfica ha sido diseñada usando imágenes de Freepik.com

El dolor es:

- Agudo
- Quemante
- Punzante
- Calambre
- Pesado
- Se mueve
- Fijo
- Otro

Lo que hace que el dolor mejore:

- Presión
- Frío
- Calor
- Ejercicio
- Otro

Lo que hace que el dolor empeore:

- Presión
- Frío
- Calor
- Ejercicio
- Otro

Libido:

- Normal
- Aumentado
- Disminuido

Solo para mujer

1. ¿Esta usted embarazada? Si _____ No _____
 2. Número de embarazos _____
 3. Edad del primer período _____
 4. Edad de la menopausia, si es aplicable _____
 5. ¿Es tu ciclo de menstruación regular? Si _____ No _____
 - a. Número promedio de días de flujo _____
 - b. El flujo es _____normal _____abundante _____escaso
- ¿Experimenta síndrome premenstrual? Si _____ No _____
- ¿Se presentan coágulos con su periodo? Si _____ No _____

Certifico que la información proporcionada en este formulario es veraz y refleja mi condición física, mental y emocional actual. Actualizaré mi Información cuando sea necesario en cuanto ocurran cambios significativos pertinentes.

Firma del paciente: _____ Fecha: _____

Revisado con el paciente _____ Dra. Isabel C Silva, AP, DOM Fecha: _____

CONSENT FORM

I hereby request and consent to the performance of acupuncture treatments and other procedures with the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated 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, Tui-Na (Chinese massage), Chinese herbal medicine, Acupoint Injection Therapy, and nutritional counseling. 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 sites that may last a few days, and dizziness or fainting. Burns and/or scarring are the potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 safe environment.

I understand that vitamins and/or homeopathic remedies in the form of sterile supplements are injected into acupuncture points by means of hypodermic needles, may be recommended to me to treat bodily dysfunctions or disease. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: pain, mild bleeding, bruising, redness, swelling or numbness around injection site, muscle stiffness, soreness at site of injection, fatigue, diarrhea, mild to severe allergic reactions, and possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the Acupoint Injection Therapy (AIT)

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 taste or smell. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. The herbs and nutritional supplements (which are from plant, animal and mineral substances) 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 pregnant or become pregnant.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, and 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.

Patient Signature: X _____ Date: _____

(Or Patient Representative)

Acupuncturist Signature: _____ Dr. Isabel C Silva AP, DOM

NOTICE OF PRIVACY POLICIES

The following is the privacy policy of Oriental Medical Center as described in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires Oriental Medical Center by law to maintain the privacy of your personal information and to provide you with notice of Oriental Medical Center's legal duties and privacy policies with respect to your Personal Health Information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information. This office may send birthday cards, newsletters and appointment reminders (telephone, text, email, letters, etc.)

Use or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. The following are the circumstances under which we are permitted by law to use or disclose your Personal Health Information:

As Required By Law. We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Your rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your Personal Health Information. It is your right to request the following regarding your Personal Health Information:

- Right to request restrictions of use or disclosure of your Protected Health Information.
- Right to receive confidential communications.
- Right to inspect and copy your Personal Health Information.
- Right to request amendment of your Personal Health Information.
- Right to receive and Accounting of Disclosures of your Personal Health Information.

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Complaints files with the Secretary of DHHS must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred.

*U.S. Department of Health and Human Services
DHHS (Office of Civil Rights)
200 Independence Ave. SW Room 509 Building F
Washington, DC 20201*

If you have questions or want more information regarding HIPAA, please contact:
Isabel Cristina Silva AP, DOM at telephone: (407) 223-7419.

Patient Signature: X _____ Date: _____
(Or Patient Representative)

**AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION
BY ALTERNATE MEANS**

Patient Name: _____ DOB: _____

From time to time it may be necessary for a representative of Satori Vitae Health and Wellness to contact patients for various notification purposes that could include Personal Health Information such as:

- Appointment reminders/confirmation/rescheduling

I authorize Satori Vitae Health and Wellness and/or staff to leave detailed, personal health information by the following means.

Check and complete all that apply:

METHOD	NUMBER WITH AREA CODE
<input type="radio"/> Cell Phone/Voice Message	_____
<input type="radio"/> Text Message	_____
<input type="radio"/> Email	_____

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Satori Vitae Health and Wellness in writing should I wish to change any of information noted above and to notify Satori Vitae Health and Wellness if my contact information changes.

Patient or Legally Authorized Representative's Signature

Date