



Health in Harmony
ACUPUNCTURE & WELLNESS

Confidential Health History Questionnaire

Please help us learn more about you so that we may provide you with the most effective care. Each answer provides important information that allows us to optimize your health care results. Thank you for your thorough responses.

Dr. Dawn Potter-Balusik, AP, DOM Date: _____

Last Name		First Name		Middle Initial	Social Security # (last 4 digits)	
Street Address			City		State	Zip
Home Phone	Cell Phone		Permission to text your appointment reminders? Yes No	Age	Sex	Date of Birth
Marital Status	Employer & Occupation		Emergency Contact: Name & Phone			
Height	Weight	Blood Pressure		Date of BP Reading	Blood Type	
E-mail Address (for newsletters & appointment reminders)			How did you hear about us?			
Are you currently under Doctor's care?		MD's Name		MD's Phone		
List your reasons for today's visit, in order of importance.						
What treatments have you tried or are you currently doing for these conditions?						
Check if you have a <u>FAMILY HISTORY</u> of any of these:						
<input type="checkbox"/> Allergies <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Cancer		<input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure		<input type="checkbox"/> Kidney disease <input type="checkbox"/> Mental illness <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Other inheritable disease		

**Please identify current symptoms by marking the box under the “Now” column.
Mark the “Past” column only if a past condition was particularly severe or significant.**

<p>Past Now</p> <input type="checkbox"/> <input type="checkbox"/> Abdominal / stomach pain <input type="checkbox"/> <input type="checkbox"/> Abnormal appetite <input type="checkbox"/> <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> <input type="checkbox"/> Belching <input type="checkbox"/> <input type="checkbox"/> Heartburn / reflux <input type="checkbox"/> <input type="checkbox"/> Gas <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Black stool <input type="checkbox"/> <input type="checkbox"/> Blood in stool <input type="checkbox"/> <input type="checkbox"/> Mucous in stool <input type="checkbox"/> <input type="checkbox"/> Undigested food in stool <input type="checkbox"/> <input type="checkbox"/> Rectal pain / hemorrhoids <input type="checkbox"/> <input type="checkbox"/> Regular laxative use <input type="checkbox"/> <input type="checkbox"/> Unusually thirsty <input type="checkbox"/> <input type="checkbox"/> Overweight <input type="checkbox"/> <input type="checkbox"/> Weight changes	<p>Past Now</p> <input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Excessive sweating <input type="checkbox"/> <input type="checkbox"/> Lack of perspiration <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> Night sweats <input type="checkbox"/> <input type="checkbox"/> Cold Hands/Feet/Nose <input type="checkbox"/> <input type="checkbox"/> Tendency to be too hot <input type="checkbox"/> <input type="checkbox"/> Tendency to be too cold	<p>Past Now</p> <input type="checkbox"/> <input type="checkbox"/> Anger <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Fear <input type="checkbox"/> <input type="checkbox"/> Frustration <input type="checkbox"/> <input type="checkbox"/> Grief or sadness <input type="checkbox"/> <input type="checkbox"/> Irritability <input type="checkbox"/> <input type="checkbox"/> Mood swings <input type="checkbox"/> <input type="checkbox"/> Obsession <input type="checkbox"/> <input type="checkbox"/> Panic Attacks <input type="checkbox"/> <input type="checkbox"/> Stress <input type="checkbox"/> <input type="checkbox"/> Worry
<input type="checkbox"/> <input type="checkbox"/> Bleeding / bruising easily <input type="checkbox"/> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> <input type="checkbox"/> Poor circulation <input type="checkbox"/> <input type="checkbox"/> Dizzy spells or fainting <input type="checkbox"/> <input type="checkbox"/> Chest pain / pressure <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> <input type="checkbox"/> Palpitations / chest fluttering <input type="checkbox"/> <input type="checkbox"/> Pounding heart beat <input type="checkbox"/> <input type="checkbox"/> Racing heart beat	<input type="checkbox"/> <input type="checkbox"/> Dry eyes <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> Itchy eyes <input type="checkbox"/> <input type="checkbox"/> Tearing eyes <input type="checkbox"/> <input type="checkbox"/> Poor vision <input type="checkbox"/> <input type="checkbox"/> Night or color blindness <input type="checkbox"/> <input type="checkbox"/> Earaches <input type="checkbox"/> <input type="checkbox"/> Ringing or sounds in ears <input type="checkbox"/> <input type="checkbox"/> Hearing problems <input type="checkbox"/> <input type="checkbox"/> Sinus problems <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> Snoring <input type="checkbox"/> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> <input type="checkbox"/> Dry mouth or throat <input type="checkbox"/> <input type="checkbox"/> Sore throat <input type="checkbox"/> <input type="checkbox"/> Swollen glands <input type="checkbox"/> <input type="checkbox"/> Frequent hoarseness <input type="checkbox"/> <input type="checkbox"/> Mouth or lip sores <input type="checkbox"/> <input type="checkbox"/> Many cavities or root canals <input type="checkbox"/> <input type="checkbox"/> Unusual taste in mouth <input type="checkbox"/> <input type="checkbox"/> Teeth grinding or clenching <input type="checkbox"/> <input type="checkbox"/> Jaw Problems or TMJ <input type="checkbox"/> <input type="checkbox"/> Facial pain <input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Victim of Child Abuse <input type="checkbox"/> <input type="checkbox"/> Victim of Domestic Abuse <input type="checkbox"/> <input type="checkbox"/> Victim of Sexual Abuse <input type="checkbox"/> <input type="checkbox"/> War Veteran
<input type="checkbox"/> <input type="checkbox"/> Chronic cough <input type="checkbox"/> <input type="checkbox"/> Coughing blood <input type="checkbox"/> <input type="checkbox"/> Frequent chest colds <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/> Tightness of chest <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Coughing up Phlegm Color of Phlegm _____	<input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> Burning or painful urination <input type="checkbox"/> <input type="checkbox"/> Difficult urination / retention <input type="checkbox"/> <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> <input type="checkbox"/> Loss of bladder control	<input type="checkbox"/> <input type="checkbox"/> Acne pimples <input type="checkbox"/> <input type="checkbox"/> Dry skin / Oily Skin <input type="checkbox"/> <input type="checkbox"/> Itching or burning skin <input type="checkbox"/> <input type="checkbox"/> Skin rash or sores <input type="checkbox"/> <input type="checkbox"/> Tendency to get hives <input type="checkbox"/> <input type="checkbox"/> Scalp itching or flaking <input type="checkbox"/> <input type="checkbox"/> Early graying of hair <input type="checkbox"/> <input type="checkbox"/> Loss of hair <input type="checkbox"/> <input type="checkbox"/> Nail fungus <input type="checkbox"/> <input type="checkbox"/> Weak / brittle nails
<input type="checkbox"/> <input type="checkbox"/> Chronic or recurrent infection <input type="checkbox"/> <input type="checkbox"/> Fatigue or tiredness <input type="checkbox"/> <input type="checkbox"/> Sudden energy drop at _____ <input type="checkbox"/> <input type="checkbox"/> Frequent antibiotic use		<input type="checkbox"/> <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> <input type="checkbox"/> Poor concentration <input type="checkbox"/> <input type="checkbox"/> Poor memory <input type="checkbox"/> <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> <input type="checkbox"/> Shaking or trembling <input type="checkbox"/> <input type="checkbox"/> Stuttering or stammering
<input type="checkbox"/> <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> <input type="checkbox"/> Waking up frequently <input type="checkbox"/> <input type="checkbox"/> Wake up still tired <input type="checkbox"/> <input type="checkbox"/> Many dreams <input type="checkbox"/> <input type="checkbox"/> Nightmares		
LIFESTYLE & DIET		
<input type="checkbox"/> Tobacco <input type="checkbox"/> E-Cigarettes <input type="checkbox"/> Marijuana	<input type="checkbox"/> Recreational Drugs <input type="checkbox"/> High Stress <input type="checkbox"/> Occupational Hazards	Exercise: (describe)
<input type="checkbox"/> Coffee (amt): _____ <input type="checkbox"/> Tea (amt): _____ <input type="checkbox"/> Soft Drinks (amt): _____ <input type="checkbox"/> Energy Drinks (amt) _____ <input type="checkbox"/> Alcohol (amt): _____ <input type="checkbox"/> Water (amt): _____	<input type="checkbox"/> Artificial Sweeteners <input type="checkbox"/> Fast Food <input type="checkbox"/> Vegetarian/ Vegan <input type="checkbox"/> High Protein <input type="checkbox"/> Gluten-free <input type="checkbox"/> Low Fat <input type="checkbox"/> Crave Sugar <input type="checkbox"/> Crave Salt	Herbs/Vitamins/Supplements: (list)

FOR MEN

Past Now

- Genital pain, swelling or itching
- Abnormal sex drive [] high [] low
- Erectile dysfunction

Past Now

- Low sperm count / motility / morphology
- Penile discharge
- Prostate problem (PSA reading:_____)

FOR WOMEN

Past Now

- Abnormal PAP smear
- Abnormal sex drive
- Abortion history
- Bleeding between periods
- Breast lumps / tenderness
- Clots in menstrual blood
- Difficulty conceiving

Past Now

- Endometriosis
- Fibroids
- Genital pain, swelling or itching
- Heavy bleeding with periods
- Hysterectomy
- Menopausal symptoms
- Miscarriage

Past Now

- Ovaries removed
- Pain with intercourse
- Painful periods
- Pelvic inflammatory disease
- Polycystic ovary disease
- Premenstrual tension / PMS
- Vaginal discharge or dryness

Are you currently pregnant or trying to become pregnant?

Duration of periods:

Number of pregnancies you've had:

Interval between periods (onset to onset):

Number of births you've had:

Dates of last period:

Ages of your children:

Past birth control methods:

Current birth control method:

Check if you have or had any of these:

Past Now

- Addiction (to _____)
- AIDS / HIV
- Allergies (to _____)
- Anemia
- Arthritis
- Asthma
- Bleeding disorder
- Blood clots
- Bronchitis
- Cancer / tumor
- Cataracts
- Chicken pox
- Chronic fatigue syndrome
- Colon / bowel disease
- Diabetes
- Emotional / mental illness
- Emphysema

Past Now

- Epilepsy / Seizure disorder
- Gall bladder disease / stones
- Glaucoma
- Gout
- Gum disease
- Heart disease
- Hepatitis or jaundice
- Herpes
- High / Low blood pressure
- High cholesterol
- Kidney stones
- Kidney or bladder infection
- Liver disease
- Lupus
- Malaria
- Measles, Mumps or Rubella
- Mononucleosis

Past Now

- Multiple sclerosis
- Osteoporosis / osteopenia
- Pacemaker
- Parkinson's
- Pneumonia
- Polio
- Rheumatic or Scarlet fever
- Shingles
- Spinal meningitis
- Stroke
- Tuberculosis
- Thyroid trouble or goiter
- Ulcer
- Varicose veins
- Venereal disease

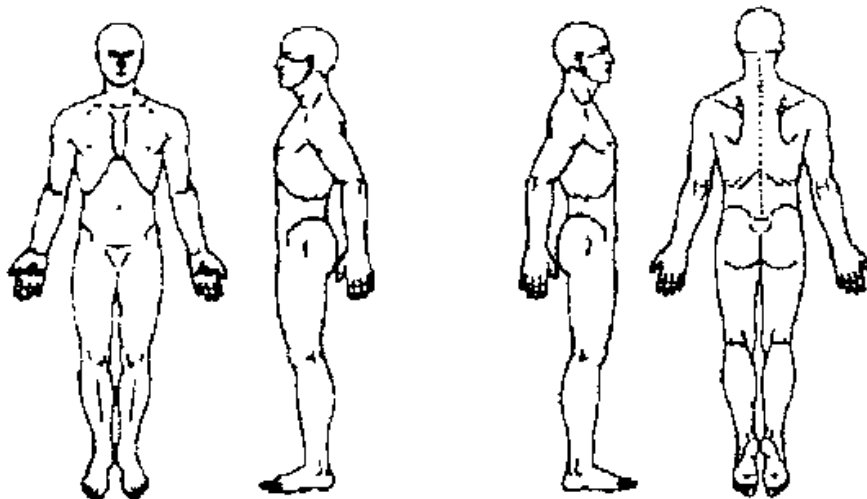
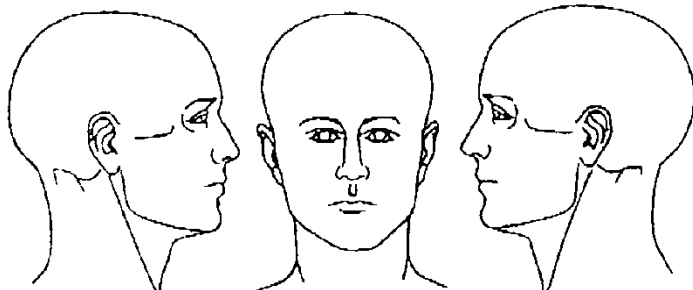
Other:

Surgeries, hospitalizations & dates:

Accidents, injuries & dates:

Medications, reasons & dosages:

Please Indicate Areas of Pain or Discomfort:



- Back pain or trouble ----- Severity 1 2 3 4 5
- Muscle pain, spasm, cramping - 1 2 3 4 5
- Muscle weakness ----- 1 2 3 4 5
- Restless or nervous legs ----- 1 2 3 4 5

- Spinal disc problems ----- Severity 1 2 3 4 5
- Stiff or painful neck ----- 1 2 3 4 5
- Swelling ----- 1 2 3 4 5
- Tendonitis (where: _____)

Please describe your pain/discomfort:

By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I understand that if I wish to change the dosages of my medications, Dr. Potter recommends that this happen gradually and with consent of my prescribing physician(s). I know Dr. Potter does not treat cancer or epilepsy.

Sign:

Date:



Consent to Treatment

Dr. Dawn Potter-Balusik AP, DOM
2431 Estancia Blvd, A-2,
Clearwater, FL 33761
(727) 475-4710

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 above 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 above, including those working at the clinic or office listed above 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, moxabustion, cupping, electrical stimulation, Tui-na (Oriental massage), oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may be 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 generally a 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 or 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 moxabustion 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 Oriental 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 the 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.

(Date)

PATIENT SIGNATURE:
(or guardian) _____
(indicate relationship)

(Date)

OFFICE SIGNATURE: _____

Office Policies



Dr. Dawn Potter-Balusik AP, DOM
2431 Estancia Blvd, A-2,
Clearwater, FL 33761
(727) 475-4710

Welcome to our Practice!

We have implemented these office policies & procedures to ensure safety & the highest level of care.

1. We do not dispense herbal medicine or supplements to those who are not active patients of Dawn Potter-Balusik (meaning you have been seen for treatment within the last 3 months.)
2. We are available for communication primarily via phone and e-mail. Please do not text, instant message, Facebook, or otherwise attempt communication, as these may not be received. Likewise, if you e-mail and do not receive a return e-mail within 24 hours, please call the office; phone is the most reliable route of communication for our office.
3. Dawn Potter-Balusik is available for communication with active patients for quick questions that can be answered briefly. If you have a more complex question or lengthy explanation, or if your question requires an in-depth answer, we may ask that you schedule an appointment.
4. We try to return phone calls and e-mails within a few hours, but sometimes that is not possible. However, we will always return phone calls by 8pm on Monday, Wednesday, and Friday, for sure, and perhaps other days as well.
5. We **do not** practice emergency medicine. If you have an emergency, please call 911 or report to your local emergency room or urgent care clinic. If you have an urgent situation that you think does not require an emergency room visit, and you think Dawn Potter-Balusik may be able to help, please phone us. We will do what we can for you, but if your situation worsens or if you do not hear back from us within a time-frame that is appropriate for your situation, please call 911 or report to your local emergency room or urgent care.
6. We keep your health information private. If you would like a copy of our Privacy Practices, please let us know.

I have read and agree to the above Office Policies:

Signature

Date



Financial Policies

(Revised 3.19)

Dr. Dawn Potter-Balusik AP, DOM
2431 Estancia Blvd, A-2, Clearwater, FL 33761

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Payment Methods Accepted: Cash, Check, Visa, Mastercard, Discover & American Express are accepted.

Returned Checks: Each returned check will incur a fee of \$35.

Cancellations or Missed Appointments: We require a notice of 24 hours if you need to cancel an appointment, or you will be billed at the rate of \$65 for your missed appointment.

If you have a Health Savings Account: Acupuncture treatment is allowable under all HSA's. You will need to check with your specific HSA to find out if herbal medicine prescribed by a health professional is an allowable expense.

If Your Health Insurance Policy Covers Acupuncture: We do not bill insurance. At your request, we will provide you a superbill/receipt form which contains all the procedure & diagnostic codes prudent to your visit. You can submit a copy of this form to your insurance company for them to reimburse you directly.

If You are an Auto Injury Patient: Unfortunately, Florida PIP does not cover acupuncture services, but you may submit your paid receipts to your PI attorney for reimbursement from your eventual settlement or lawsuit.

If You are a Medicare Patient: At this time, Medicare does not cover acupuncture services.

Fee Schedule:

New Patient (60-90 mins):	\$150 - \$175 (depending on severity)
Acupuncture Follow-up (45-60 mins):	\$85 (see package discounts below)
Childbirth Preparation (60 mins):	\$100 initial, then same as Follow-up
Herbal / Nutritional Only Follow-up (30 mins):	\$65
Pediatric (12 & under) Follow-Up:	\$65
Phone Consult (for active patients only):	\$30 per 15 minute increment
Herbal Medicine / Supplements:	varies

Discounts for Follow-Up Acupuncture Visits:

- \$5 off your visit when paying by Cash.
- Packages: ***** Packages must be purchased with Check or Cash only.*****
 - 3 visits for \$240 (This is \$5 off each visit.)
 - 6 visits for \$450 (This is \$10 off each visit.)

Note: If you request a refund on a partially used package, the fees for the completed treatments reverts back to the usual \$85 fee, and your refund will be calculated accordingly.

I have read and agree to the above Financial Policies.

Signature _____

Date _____