# Providence Wholistic Healthcare

*Integrative Natural Family Medicine & Acupuncture*

*Carol L. Seng, MAOM,DA,LAc • Sheila M. Frodermann, MS,ND,DHANP,CCH*

*144 Waterman Street, Suite #3 Providence, RI 02906*

*www.providencewholistic.com*

*(401) 455-0546*

## MEDICAL HISTORY

THIS INFORMATION IS CONFIDENTIAL

Name:____________________________________ Referred By:____________________________

Address:___________________________________________________________________________

Home Phone:______________________________ Work Phone:_____________________________

Birth Date: ____________________ Height _____________ Weight __________________

Describe your chief complaint: ________________________________________________________

___________________________________________________________________________________

What has your M.D. diagnosed? ________________________________________________________

___________________________________________________________________________________

List any issues with your birth? ______________________________________________________

Vaccination history (What types of Vaccinations) _______________________________________

Reactions to vaccinations? __________________________________________________________

Childhood or Adolescence illnesses, including surgery or accidents. (Please list age and type of illness)

___________________________________________________________________________________

___________________________________________________________________________________

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___________________________________________________________________________________

Adult illness including accidents or surgery: List age and type of illness)

___________________________________________________________________________________

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List any medication (prescribed or over the counter). Also list any vitamins and herbs you take even if you take them once in awhile.

**Family History:** indicate if you or members of your close family have had the following

| | Self | Mother | Father | Brother | Sister(s) | Grandparents (MGP) | Grandparents (PGP) |
|---|---|---|---|---|---|---|---|
| Cancer | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Diabetes | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Heart Disease | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| High Blood Pressure | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Stroke | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Epilepsy | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Mental Illness | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Asthma/Allergies | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Anemia | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Kidney Disease | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Bowel Disease | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Ulcer | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Tuberculosis | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Osteoporosis | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Thyroid disease | ______ | ______ | ______ | ______ | ______ | ___/__ | ___/__ |
| Age if living | | ______ | ______ | ______ | ______ | ___/__ | ___/__ |

Do you have any scars? Please describe the location of scars from injury or operations. (Even small minor scars).

_______________________________________________________________

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The following is a list of symptoms that you have now or may have had in the past. Please take the time to **(circle)** any problems, disease or symptoms you are **having now.** Any problems you have had **in the past** please check **(X)**

**Heart and Vascular:**

Fast pulse (over 100 beats/min
Slow pulse (less than 60 beats/min)
Palpitation
irregular pulse
Pressure in Chest
Shortness of breath
Chest pain
Dizziness
Migraine headache w/ nausea
Cold hands/cold feet
Raynaud's disease
Flushed face
Anemia
High blood pressure
Low blood pressure
Cold sweats
Red face
Feel dizzy or faint when standing up quickly or long periods of time.

**Gastrointestinal:**

Constipation
Diarrhea
No appetite
Stomach pain
Indigestion
Heartburn
Intestinal gas
Belching
Ulcer
Gastritis
Lack of stomach acid
Hemorrhoids
Peritonitis
Ileocecal valve spasm
Pancreatitis
Irritable bowel
Polyps
GI tumors

**Respiratory:**

Asthma
Bronchitis
Emphysema
Cough
Wheeze
Pneumonia
Lung abscess

Please take the time to **(circle)** any problems, disease or symptoms you are **having now.** Any problems you have had **in the past** please check **(X)**

**Ear, nose & throat:**

Deafness
Tinnitus (ring in ears)
itchy ear
Ear pain
Frequent ear infections
Sinus headaches
Yellow mucus
Stuffy nose
Post-nasal-drip
Dry throat
Itchy throat
Sore throat
Constant sinus congestion
Streptococci throat infections

**Oral disease:**

Bleeding gums
periodontitis
dental abscess
Stomatitis (inflammation of the mouth)
TMJ
Toothaches without cavities.

**Skin:**

Eczema
Acne
Skin rashes
Dermatitis
Furuncles
Fungal infections
Warts
Psoriasis

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**Autoimmune and inflammatory conditions:**

Hashimoto's disease (thyroid) Rheumatism Colitis
Systemic lupus erythematosus Alopecia (balding) Chron's
Allergy Food allergy Sinus allergy Cellulitis
Vulvitis Atopic dermatitis Neurodermatitis
Low immunity

**Effects of focal infections:** rheumatic disease rheumatic fever arthritis skin disease

**Connective tissue or ligament diseases:** Myofascial pain syndrome fibromyalgia tendonitis
pericarditis constant slight fever glomerulonephritis
Plantar fasciitis scarlet fever ear infections
Streptococci infections staphylococci infections
Easily catch cold or sore throat swollen glands

**General:** insomnia psychosomatic weakness exhaustion
Emotional problems (angry, irritable, depressed, anxious)
Difficult concentrating on a task moody in the mornings
Easily get car sick, seasick or airsick, no appetite for breakfast
Unusual sweating (palms, soles of feet or elsewhere) never sweat

Before noontime: no energy feel spacey scattered mind
Energetic all evening through midnight, but hate to wake early in am
Long shower or bath makes you feel dizzy or faint

Please take the time to **(circle)** any problems, disease or symptoms you are **having now.** Any problems you have had **in the past** please check **(X)**

**Hormonal imbalance:** low thyroid overactive thyroid diabetes hypoglycemia

**Female:** menstrual problems cramping heavy/light/irregular periods PMS
Emotional reactions menopause symptoms tubal ligation infertility
Low libido

**Male:** impotence premature ejaculation prostate gland problems
Vasectomy infertility

**Medication and drugs:** Birth control pill cigarettes alcohol cocaine
Marijuana

**Other:**

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## Declaration of Informed Consent and Financial Policies

I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica, administered by Carol L. Seng D.Ac licensed in the state of Rhode Island**.**

I understand that acupuncture is performed by the insertion of needles through the skin, or by the application of heat to the skin (moxa), or by both, at certain points on or near the surface of the body in an attempt to treat bodily imbalances or dis- ease, to modify or prevent the perception of pain, and to make normal the body's physiological functions. The procedure has been fully explained to me.

Although rare, certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment.

I am also aware that acupuncture is licensed in Rhode Island and many other states, and has been safely practiced for centuries. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

I understand that Carol L Seng may recommend substances from the Oriental Materia Medica to treat bodily imbalances or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I decide to take them.

I have been made aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to, changes in bowel movement, temporary abdominal pain or discomfort, and the possible temporary aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Carol L. Seng.

Payment is required at time of service. Initial Consultations are one and half-hours and is $150.00. Follows up visits are one hour and are $70.00. In times of financial difficulty, we may be able to arrange a payment plan for office visits. I do not deal with any insurance companies at this time. You may choose to submit this to your insurance company if you are attempting to seek reimbursement; they may or may not accept the claim. **Missed appointments will be charged a $45.00 fee with less than 12 hours notice. Please make every effort to reschedule appointments at least 24 hours in advance.**

**I have carefully read and I understand all of the foregoing and so am fully aware of what I am signing**

____________________________________________

Signature of Patient, Parent or Guardian Date