Striving FOR Health

New Patient Information

To receive the best possible results, it is important to read and understand the following information:

- Some cases may require treating preliminary items that are contained within a substance, such as a vitamin, mineral, phenolic and/or sugar. For example, sugar may need to be addressed before proceeding with alcohol, grains, or fruit.
- After addressing any preliminary items, patients may choose what order the remaining substances are treated.
- It is possible to treat numerous items in one session if they are all part of the same family. For example, al dairy products (milk, cheese, and yogurt) and calcium may be treated together. But dairy and wheat, or tomatoes and pollens may not be addressed in the same session. The treatment will not be successful.
- We cannot guarantee how many sessions each substance will require to reduce the symptoms associated with that item.
- When addressing a condition, instead of a single substance or family of substances, multiple items may be contributing to the symptoms. Therefore, such conditions may require multiple sessions to relieve the symptoms or condition.

Please adhere to the following guidelines:

- As a courtesy to our other patients who may have strong sensitivities, please do not smoke or wear perfume or fragrances prior to coming into the clinic.
- Do not eat, drink, or chew gum during the session.

Office Policies

- There is a 24-hour cancelation policy for the AAT treatments. Late cancelations or no-shows will be charged $75.
- Please arrive on time for your appointment time. Late arrivals may need to be rescheduled.
- Payment is due at the time services are rendered.

Initial Assessment for :_____

	Amines		Glutamates		Cats		Acids
	Caffeine		Grain / Wheat		Cockroaches		Enzymes
	Calcium		**Iron**		Dogs		
	Chicken		**Minerals**		Dust / Dust Mites		
	Chocolate		Protein		Flowers		
	Coffee		Salicylates		Fungus		
	Corn		Salts / Chlorides		Grasses		
	Dairy/Milk		Soy		Molds / Mildews		
	Eggs		**Sugar**		Plant Phenolics		
	Flavor Enhancers		**Vitamin A**		Plants		
	Food Coloring		**Vitamin B**		Pollens		
	Food Phenolics		**Vitamin C**		Sinus Fungus		
	Food Preservatives		Yeast		Trees		
					Weeds		

Striving FOR Health

Name: _____ Last Name_____ Date:_____

Address:_____Zip_____

Home phone number:_____ Cell number:_____

Email address:_____

Occupation:_____ Age:_____ DOB:_____

Emergency Contact:_____ Phone:_____

Are you currently receiving health care? _____Which modality? MD | DC | L.Ac. | ND | DO

Condition being treated: _____ Is it helping? _____

Name of physician or practitioner: _____

What are the main reasons for your visit today?

1) _____
2) _____
3) _____

Please list tested or suspected allergies or sensitivities and their related symptoms:

Foods:_____

_____

_____

Seasonal:_____

Pets | Drugs | Chemicals | Other:_____

_____

How long have you been having the symptoms? _____

How often are you experiencing the symptoms above? _____

What makes the symptoms better or worse? _____

_____

Are you taking any Medications, Herbs or Supplements? _____

_____

_____

Are you on any specific diet? If so, which one? _____

How often do you consume the following? Please list in the box below.

1= daily 2 = weekly 3 = Monthly 4 = Never

Alcohol	Grains (whole grain)	Smoked Foods
Caffeine	Legumes (beans, lentils, peas)	Soda
Dairy	Meats	Sugary Treats
Fast Food	Nuts / Seeds	Vegetables
Fried Foods	Packaged or Processed Foods	Wheat
Fruit	Salt	Water

How many ounces of water are you drinking each day? _____

Are you constipated?_____ How many bowel movements do you have a day?_____

Do you take any fiber supplements, prebiotics or probiotics? _____

Do you have any current medical condition? (ex: pregnancy, epilepsy, diabetes, etc)_____

_____

What is your daily stress level? _____ Low _____ Medium _____ High

What do you do to relieve stress? _____

Do you exercise regularly? _____ Yes _____ No What type of exercise to you typically do?

_____

How many hours of sleep do you get each night? _____

What is the quality of that sleep?_____

How did you hear about the clinic? _____

Would you like to receive our e-newsletter containing health and treatment tips? _____

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the information listed on the New Patient Information form.

Signature_____ **Date**_____

Striving FOR Health

Authorization to Release Health Information

HIPAA privacy regulations stipulate that health care providers may not use or disclose a patient's health information without his or her authorization, except as described in the Notice of Privacy Practices. That document clarifies the conditions under which a patient's information may be released without his or her authorization, and when an express authorization is required by the patients.

Under certain circumstances, it may become necessary for this office to release a patient's health information to an individual or entity outside of the office. In accordance with the Notice of Privacy Practices, this office via this authorization form, requests that the patients indicate below to authorize the release of his/her health information. This office doesn't accept insurance so the need to have any records released outside of the office is very rare.

I, the undersigned, understand that I have the right to:

- Refuse to sign this authorization
- Receive a copy of the authorization
- Restrict what is disclosed by this authorization
- Inspect or request an amendment of the health information to be disclosed
- Revoke this authorization, by written notice
- Be notified if any records are requested

I recognize that once disclosed, my health information is no longer under the control of this practitioner/clinic. While I understand that the practitioners/clinic will make a good faith effort to release my information only to trusted recipients, my health information may be re-disclosed by subsequent parties, and thus may no longer be protected by this office's privacy practices.

I understand that whether or not I sign this document, it will not affect my treatment at this practice or the payments I incur. If I do experience any such negative repercussions, I have the right to file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. I can find the Office for Civil Right for my state at: http://www.hhs.gov/ocr/regmail.html

I hereby authorize this office to disclose my health information as described in this document.

_____ _____

Name of Client Contact Number

_____ _____

Signature Date

DeBritt Ealey, L.Ac. | 703.707.7777 office | 512.963.8031 cell
451B Carlisle Dr. Herndon, VA 20170
debritt@strivingforhealth.com | www.strivingforhealth.com

Striving FOR Health

Diagnostic Examination Release

As an acupuncturist licensed in the state of Virginia, it is required that I ask if you have received a diagnostic examination within the past six months by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s) that we will be addressing in this office.

I have seen a doctor about my issue(s):_____

_____

If not, I am instructed to recommend that you get a diagnostic examination by a licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Chiropractic (DC) acting within the scope of his/her practice for the issue(s)that we will be addressing in this office.

I have read and understand this information.

_____ _____

Signature Date

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Striving FOR Health

Waiver and Release / Informed Consent

I, _____ (the "undersigned"), hereby consent to treatment at

Striving for Health - Located at 451B Carlisle Dr. in Herndon, VA 20170

I understand that such procedures are non-invasive.

The clinic and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments.

I understand the unpredictable nature of allergies and related symptoms and that the clinic cannot guarantee any results in the reduction of symptoms. The clinic cannot guarantee that new reactions will not develop in the future. While the treatment can address many symptoms associated with allergies and sensitivities, some cases do not respond to treatment.

I also understand that they only known risk factor with the treatment of symptoms associated with allergies and sensitivities, including immunotherapy, is the possibility of increased sensitivity. I assume all responsibility for unpredictable reactions which may lead to increased symptomatology. In this event, I agree to seek immediate medical attention.

I understand that the clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies, allergies resulting in anaphylaxis or any allergies that I have been prescribed an epi-pen.

_____ No, I do not have any life threatening allergies and do not carry an epi-pen

_____ Yes, I have the following allergies that may cause anaphylaxis

_____

I agree to pay the clinic the standard fee for any and all treatments administered.

In witness thereof, the undersigned executed the Agreement as of (Date) _____

_____ _____

Signature of Undersigned Signature of Practitioner

_____

Signature of Parent or Legal Guardian