WHOLE LIFE HEALTH AND WELLNESS CENTER
ACUPUNCTURE CARE

PATIENT NAME_____ BIRTHDATE_____

To help us meet all your healthcare needs, please fill out both sides of this form completely in ink. This is confidential recc of your medical history and will be kept in this office.

Please check "Yes" or "No" to indicate if you have had any of the following:

Measles	☐Yes	☐ No	Tuberculosis	☐Yes	☐ No	Hives or eczema	☐Yes	☐ No	Hemorrhoids	☐Yes	☐
Diabetes	☐Yes	☐ No	Cancer	☐Yes	☐ No	AIDS or HIV+	☐Yes	☐ No	Pacemaker	☐Yes	☐
Mumps	☐Yes	☐ No	Venereal Disease	☐Yes	☐ No	Mononucleosis	☐Yes	☐ No	Asthma	☐Yes	☐
Chickenpox	☐Yes	☐ No	Bronchitis	☐Yes	☐ No	Pinched Nerve	☐Yes	☐ No	Anemia	☐Yes	☐
Whooping	☐Yes	☐ No	Back trouble	☐Yes	☐ No	Osteoporosis	☐Yes	☐ No	Bleeding tendency	☐Yes	☐
Scarlet fever	☐Yes	☐ No	Prosthesis	☐Yes	☐ No	Stroke	☐Yes	☐ No	Arthritis	☐Yes	☐
Diphteria	☐Yes	☐ No	Psychiatric Care	☐Yes	☐ No	Hepatitis	☐Yes	☐ No	Parkinson's disease	☐Yes	☐
Smallpox	☐Yes	☐ No	Stroke	☐Yes	☐ No	Ulcer	☐Yes	☐ No	Glaucoma	☐Yes	☐
Pneumonia	☐Yes	☐ No	Suicide Attempt	☐Yes	☐ No	Kidney disease	☐Yes	☐ No	Arthritis	☐Yes	☐
Bladder Infections	☐Yes	☐ No	Thyroid Disorders	☐Yes	☐ No	Tumors/Growths	☐Yes	☐ No	Hernia	☐Yes	☐
Polio	☐Yes	☐ No	Thyroid disease	☐Yes	☐ No	Epilepsy	☐Yes	☐ No	Low blood pressure	☐Yes	☐
Rheumatic Fever	☐Yes	☐ No	Multiple Sclerosis	☐Yes	☐ No	Mitral Valve Prolapse	☐Yes	☐ No	High blood pessure	☐Yes	☐
Heart disease	☐Yes	☐ No	Herniated Disk	☐Yes	☐ No	Migraines	☐Yes	☐ No	Any other disease (please l		

_____
_____
_____

Has any blood relative had any of the following: (circle "no" or "yes", leave blank if uncertain)

		Relationship			Relationship
Cancer	☐ No	☐ Yes_____	Ulcer	☐ No	☐ Yes_____
Tuberculosis	☐ No	☐ Yes_____	Depression	☐ No	☐ Yes_____
Diabetes	☐ No	☐ Yes_____	High cholesterol	☐ No	☐ Yes_____
Heart disease	☐ No	☐ Yes_____	Kidney Disease	☐ No	☐ Yes_____
High blood pressure	☐ No	☐ Yes_____	Glaucoma	☐ No	☐ Yes_____
Stroke	☐ No	☐ Yes_____	Gout	☐ No	☐ Yes_____
Epilepsy	☐ No	☐ Yes_____			
Allergies	☐ No	☐ Yes_____			
Anemia	☐ No	☐ Yes_____			
Bleeding tendency	☐ No	☐ Yes_____			
Asthma	☐ No	☐ Yes_____			
Chronic lung disease	☐ No	☐ Yes_____			
Drug or alcoholic Problem	☐ No	☐ Yes_____			
Mental illness	☐ No	☐ Yes_____			
Leukemia	☐ No	☐ Yes_____			
Migraine headaches	☐ No	☐ Yes_____			
Obesity	☐ No	☐ Yes_____			
Thyroid disease	☐ No	☐ Yes_____			

Present age or age of death. If living, health (good, fair, poor). If deceased, cause of death)

Father_____
Mother_____

Siblings_____
_____
_____

Spouse_____
Children_____
_____
_____
_____

WHOLE LIFE HEALTH AND WELLNESS CENTER

PATIENT REGISTRATION INFORMATION

Today's date_____
Last Name _____
First Name_____
Date of Birth _____
Marital Status: ☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated
Sex: ☐ M ☐ F
Street Address_____
City_____ State_____ Zip_____
Home Phone (_____) _____
Cell Phone (_____) _____
E-mail address _____
Social Security #_____
Place of birth_____
Occupation:_____
Patient employer_____
Employer street address_____
City _____State _____Zip_____
Work phone (_____) _____
Spouse's name _____
Who we may thank for referring you? _____
Reason for visit _____

Name _____
Relationship _____
Phone number (home) _____
Phone number (work or cell)

ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed _____

Responsible party:_____
Date of Birth:_____/_____/_____
Relationship to patient: ☐Self ☐Spouse ☐Oth
Social Security # _____-_____-_____
Responsible party's home phone (_____)_____
Street address _____Apt.#____
City _____State _____Zip _____
Employer's name _____
Phone number _____
Address _____
City _____State _____Zip _____

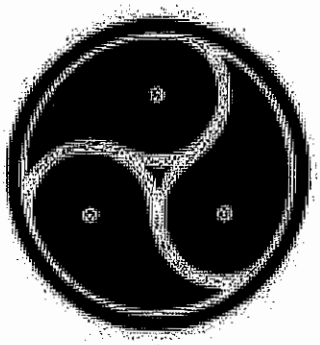
If patient is a child, other parent's name _____
Home address _____ Apt.#____
City _____State _____Zip _____
Home phone (_____) _____
Work or cell phone ( )

PRIMARY insurance company's name _____
Name of insured _____
Date of Birth _____/_____/_____
Relationship to insured: ☐Self ☐Spouse
☐Child ☐Other
Insurance ID number _____
Group number _____

SECONDARY insurance company's name_____
Name of insured _____
Date of Birth:_____/_____/_____
Relationship to insured: ☐Self ☐Spouse
☐Child ☐Other
Insurance ID number:_____
Group number:_____

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTION

18205 Biscayne Boulevard Suite 2214
Aventura, Fl 33160



Cancellation Policy/ No Show Policy

For Appointments

1. Cancellation/ No Show Policy For Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five dollar ($25) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

we understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____	_____	___/___/___
Print Name	**Signature Patient/Guardian**	**Date**

Patient Account # _____

(Office Use Only)

Dr. Sherwood S. Swartz, DOM, MMQ
P 305.407.0120 F 305.932.2223

WHOLE LIFE HEALTH AND WELLNESS CENTER

Informed Consent/Authorization to Treat

I hereby consent to an integrative, alternative, holistic biological assessment and treatment. This means that the treatment may go beyond conventional allopathic therapy. Treatments may utilize such substances as herbs, homeopathic remedies, vitamins, minerals and various other therapeutic modalities, which will be discussed in full before implementation.

I am responsible for the decision to seek a therapeutic program that includes the physical, psychological, environmental and spiritual aspects of my illness.

I certify that no guarantee or assurance has been made as to the results that may be obtained.

I am fully informed that this approach to healing differs from, and may not be recognized by traditional medical standards and may not be approved by the Food and Drug Administration (FDA). I also understand that many of the therapies used at Whole Life Health and Wellness Center may not be acceptable to doctors practicing traditional/conventional medicine. I am fully informed that no owner, employee or agent of Whole Life Health and Wellness Center has counseled me, encouraged or otherwise suggested to me that I should not seek recognized/conventional medical advice, care and/or treatment. Furthermore I am fully informed that no owner, employee or agent of Whole Life Health and Wellness Center has counseled me, encouraged or otherwise suggested to me that I not continue with any recognized/conventional treatments that I am currently undergoing, have been advised to undergo or have been prescribed to undergo.

My medical files are strictly confidential. They are intended to be read only by myself or the Center staff, based on my right of privacy. These files will not be transmitted to anyone else without written permission from me or an authorized agent. I have been provided a copy of the HIPPA "Notice of Privacy Practices".

I, the undersigned patient, hereby authorize Whole Life Health and Wellness Center (and appointed staff) to administer such treatment as is necessary, and to perform services and/or procedures as are considered necessary on the basis of findings during the course of said treatment.

Regardless of the jurisdiction in which this Patient Declaration is signed by me, it shall be deemed to have been signed by me in Dade County, Florida. Any dispute arising from, out of or as consequence of this Patient Declaration or the treatment given by the Center shall be subject to laws of the State of Florida and this Patient Declaration shall be interpreted and construed in accordance with the laws of that jurisdiction. I hereby submit to jurisdiction of the state courts in the city of Miami, Dade County, Florida, for resolution of any dispute arising out of or relating to this Patient Declaration and the treatment performed by the Center.

I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reason why the treatment is necessary, it advantages and possible complications, if any, as well as possible alternative modes of treatments which were explained to me.

Patient Name (please print)_____ Date_____

Patient or Guardian Signature_____ Relationship to patient_____

18205 Biscayne Boulevard Suite 2214
Aventura, Fl 33160

WHOLE LIFE HEALTH AND WELLNESS CENTER
ACUPUNCTURE CARE

1. Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing):
_____
_____

2. What would you like to accomplish in this session? (What are your goals?)
   a. Minimum_____
   b. Average_____
   c. Miraculous_____

3. When was the last time your felt good?_____

4. What prevents you from doing, getting, having,, being healthy right now?_____
_____
_____

5. Is it ok with you if your condition disappears even though you do not know why? _____

Hobbies:
Meditation_____
Practices_____
Exercise_____

Smoking (type and amount per day)_____
If former smoker, date of quit_____

Alcohol (type and amount per week)_____

Caffeine (type and amount per day)_____

Street drugs (type and amount per day)_____

Usual weight_____

Date of last dental exam and cleaning_____

Please list all allergies (foods, drugs, environment) _____
_____
_____

When was your last physical exam?_____
Name of doctor_____
Phone_____

Please list all serious illnesses, operations, and other hospitalizations you have experienced _____
_____
_____
_____

Please list all medicines are you currently taking (include nonprescription drugs)_____
_____
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred)_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorre information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes on r (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need

X_____ _____
Signature of patient or parent if minor Date

Physician's Comment

_____

Physician's Signature

_____

18205 Biscayne Boulevard Suite 2214
Aventura, Fl 33160

WHOLE LIFE HEALTH AND WELLNESS CENTER
ACUPUNCTURE CARE

Please check "Yes" or "No" to indicate if you have any of the following:

HEART
- Circulation problems ☐Yes ☐ No
- Cold hands or feet ☐Yes ☐ No
- Bleed easily ☐Yes ☐ No
- Bruise ☐Yes ☐ No
- Sleep problems ☐Yes ☐ No
- Pale completion ☐Yes ☐ No
- Mental problems ☐Yes ☐ No
- Poor memory ☐Yes ☐ No
- Poor sense of taste ☐Yes ☐ No
- Speech problems ☐Yes ☐ No
- Anxiety ☐Yes ☐ No
- Nervous ☐Yes ☐ No
- Lack of strength ☐Yes ☐ No
- Depression ☐Yes ☐ No
- Unusual dreams ☐Yes ☐ No
- Nightmares ☐Yes ☐ No

LUNGS
- Skin problems ☐Yes ☐ No
- Dry brittle hair ☐Yes ☐ No
- Hair loss ☐Yes ☐ No
- Excess sweating ☐Yes ☐ No
- No sweating ☐Yes ☐ No
- Nasal obstruction/ runny nose ☐Yes ☐ No
- Cough ☐Yes ☐ No
- Frequent colds ☐Yes ☐ No
- Horse voice ☐Yes ☐ No
- Weak voice ☐Yes ☐ No
- Cold hands ☐Yes ☐ No
- Stiffness of chest ☐Yes ☐ No
- Poor sense of smell ☐Yes ☐ No
- Sadness/grief ☐Yes ☐ No

KIDNEYS
- Sexually Active ☐Yes ☐
- Exhaustion ☐Yes ☐
- Heat in chest, palms and soles ☐Yes ☐
- Afternoon fever ☐Yes ☐
- Night sweats ☐Yes ☐
- Seminal emission ☐Yes ☐
- Sexual dreams ☐Yes ☐
- Back pain ☐Yes ☐
- Knee pain ☐Yes ☐
- Cold limb ☐Yes ☐
- Impotency (men) ☐Yes ☐
- Frigidity (women) ☐Yes ☐
- Premature gray hair ☐Yes ☐
- Hearing problems
  - Tinnitus ☐Yes ☐
  - Deafness ☐Yes ☐
- Lack of will power ☐Yes ☐

SPLEEN
- Poor appetite ☐Yes ☐ No
- Abdominal distention ☐Yes ☐ No
- Loose stool ☐Yes ☐ No
- No energy ☐Yes ☐ No
- Retain fluid ☐Yes ☐ No
- Phlem ☐Yes ☐ Np
- Prolapsed organs ☐Yes ☐ No
- Hemorrhoids ☐Yes ☐ No
- Bloody stool ☐Yes ☐ No
- Red purplish skin ☐Yes ☐ No
- Weak muscles ☐Yes ☐ No
- Tiredness ☐Yes ☐ No
- Excess Thirst ☐Yes ☐ No
- Dry pale lips ☐Yes ☐ No
- Over thinking ☐Yes ☐ No
- Over studying or.... Poor memory ☐Yes ☐ No

LIVER
- Weak nails ☐Yes ☐
- Eye site ☐Yes ☐
- Itchy eyes ☐Yes ☐
- Blurred vision ☐Yes ☐
- Anger ☐Yes ☐
- Spasm ☐Yes ☐
- Convulsion ☐Yes ☐
- Numbness 4 limbs ☐Yes ☐
- No menses ☐Yes ☐
- Scanty or infrequent Menstrual flow ☐Yes ☐
- Emotional ☐Yes ☐
- Depression ☐Yes ☐
- Weeping ☐Yes ☐
- Dream, disturbed sleep ☐Yes ☐
- Dizziness and vertigo ☐Yes ☐
- Mental irritation ☐Yes ☐
- Distending pain of chest ☐Yes ☐

18205 Biscayne Boulevard Suite 2214
Aventura, Fl 33160

Sherwood Swartz, AP
18205 Biscayne Blvd, Suite 2214,Aventura, FL 33160
Tel:(305) 466-1977, Fax:(305) 932-2223

Acupuncture Injection Therapy Consent Form

The benefits of acupuncture injection therapy have been explained to me. I understand that the products to be injected are safe and effective treatment for my condition.

I understand that the following side effects or local reactions may occur: local inflammation or swelling, bruising, bleeding under the skin at the injection site (hematoma), possible fainting or lightheadedness, possible localized pain/discomfort, allergic reaction, skin rash, redness, heat sensation and heaviness at the injection site, possible exacerbation of symptoms.

I stipulate that I am not currently taking any anti-coagulant (blood thinning) therapy and that I voluntarily consent to acupuncture injection therapy as explained to me by my practitioner.

_____ _____

Print Name Date

_____

Signature

_____

Witness