



Faiz Healing Designs LLC Holistic Healthcare
Patient Questionnaire

Name: _____ Date: _____

Date of Birth: _____

Home Phone: _____

Cell/Work Phone: _____

Email: _____

Home Address: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

Date of Last Physical: _____

Personal Hobbies/ Activities _____

Occupation: _____

Reason for Today's Visit: _____

Major Injuries and Surgeries?

Any recent injuries? ☐ Yes ☐ No Explain: _____

Do you experience chronic pain? _____

What are your exercise habits? _____

Current Medications and Vitamins?

Any Allergies or skin conditions?

Mark "Y" for Current and Past Conditions that Apply:

- ☐ Chronic Headaches ☐ Dizziness ☐ Vertigo ☐ Joint Pain ☐ Insomnia
☐ Lowered Immunity ☐ Constipation ☐ Irritable Bowel Syndrome ☐ Pacemaker
☐ High Blood Pressure ☐ Pregnancy, If Yes- Trimester? _____ ☐ Recent Miscarriage
☐ Bulging/Prolapsed Disc, If yes-Where? _____ ☐ Cancer, If Yes-Type? _____
☐ Spinal Fusion, If Yes-Where? _____ ☐ Herpes/Shingles ☐ HIV/AIDS
☐ Hepatitis, If Yes-Type? _____ ☐ Recent Fever ☐ Seasonal Allergies ☐ Asthma
☐ Depression ☐ Anxiety ☐ Other Psychiatric Disorder ☐ Stroke: Date _____
☐ Epilepsy/Seizure ☐ Abnormal Weight loss/ gain ☐ Diabetes, If Yes- Type? _____
☐ Urinary Incontinence ☐ Seminal Emission ☐ Osteoarthritis ☐ Osteoporosis
☐ Rheumatoid Arthritis ☐ Numbness Where? _____ ☐ Burning Where? _____

Please List Family History of Illness (Indicate Maternal as "M", Paternal as "P")

What would you like from today's treatment? _____

Personal Health Assessment:

Do you have any persistent emotional symptoms? (Circle any that apply.)
bitter / anxious / weepy / angry / frightened / confused / worry / unable to
concentrate / no motivation other: _____

Comments on the above if necessary:

Personal Dietary Assessment:

Please describe type of food normally eaten and indicate the following:
Seldom (approx. 1-2x per month) as(S) Moderately (approx. 1x per week) as(M)
Heavily (almost daily) as (H).

Meat-

Fresh fruits-

Fish-

Sugar-

Eggs-

Cheese-

Potatoes-

Milk/Dairy Products-

Alcohol-

Coffee-

Tea-

Chocolate-

Malt-

Fried foods-

White bread-

Whole grain foods-

Cooked grains-

Raw vegetables-

Do you have a preference for bitter, sour, sweet, spicy, and/ or salty foods? (circle those that apply)

Do you or have you ever smoked tobacco consistently?__ If so, How long?_____
Quit for _____(days, months, years)

Further Comments or Extension of Answers from above questions:

Are there any concerns or specific requests before we begin treatment?_____



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~General Information About Faiz Healing Medical Practice and Techniques~

Massage Therapy is an ancient healing art that utilizes intentional touch and specific techniques with the hands, such as grasping pulling and stretching muscles, joints, and fascia, that aid in calming heart-rate and blood pressure. Massage therapy increases circulation of blood and lymph in order to release toxins, heal injury, and benefit the immune system. Occasionally the mechanical techniques of massage may create increased inflammation as a healing response in the body. Symptoms may include achiness, tenderness, and fatigue for 24-48 hours. In cases of Auto-immune Disorder, inflammatory processes may be induced and should be discussed thoroughly with a practitioner before receiving this treatment.

CranialSacral Therapy involves balancing the entire nervous system and connective tissue structure of the body with a system of light decompressions and guided movements along the spinal column and limbs. This therapy has proven to release many from the burden of chronic or unexplainable pain, empowering the body with the strength and intelligence to handle recent or possible injuries. By re-organizing the compensation patterns of life, CST has the ability to restore the body to its complete potential and unify the functions of the spinal column.

Acupuncture is a form of traditional Chinese Medicine and has been used successfully for many centuries. Acupuncture can treat a wide amount of pathologies of the bodily systems and is known to be very safe. Treatments are done using fine solid metal needles inserted at specific locations just beneath the skin. All needles are sterile one time use only and disposed of properly in compliance with OSHA standards. Patients may or may not feel the needles upon insertion. Sensations are described as "dull, achy, or with a superficial zing." Some patients have reported feeling dizzy or lightheaded. Occasionally, a bruise may result at the sight of puncture due to the breakage of small capillary beds. Patients who bruise easily or have a condition related to vascular weakness should discuss this thoroughly before treatment. In rare cases, Acupuncture has been found to cause lung puncture (pneumothorax). If this occurs, referral to Urgent Care should be immediate.

Electro Acupuncture involves attaching a mild electric current to needles for a short period of time. Sensation is most often described as a "constant or wave like tingling."

Moxibustion is a therapeutic application of an herb directly or indirectly to the skin, or placed on needles to increase effects. Burn Salve is always used as buffer on the skin for direct moxa applications. Occasionally, redness, or a light burn may result without scarring. Patients with reduced sensation or lack of thermal differentiation should discuss this thoroughly before treatment.

Cupping Therapy is applied utilizing suction cups on specific parts of the body to increase blood and lymphatic flow, in order to release deeper levels of stagnation in the body. Cupping may be applied with stationary, sliding, or "flash" (quick on and off [placement] technique). The techniques of Stationary Cupping most often leaves bruise like marks of a reddish and purple nature on the skin for approximately 1 week after treatment and is an expected result of this technique. Patients who bruise easily or have a condition related to vascular weakness should discuss this thoroughly before treatment.

Herbal Therapy involves formulaic combinations of plants and minerals for internal or topical use. When taken internally, Herbs may sometimes cause GI discomfort such as stomach ache, bloating, gas, and shifts in bowel quality. Topically, herbs may cause skin irritation. If using herbs causes distress or prolonged adverse side effects it is the responsibility of the patient to discontinue use and call the practitioner to discuss the event and future plans for treatment.

By signing below I agree that I have read the above information and understand the information thoroughly. I consent to treatment and authorize any of the above therapies to be utilized while in the care of Faiz Healing Acupuncture and Massage, unless specific restriction and denial of therapeutic techniques is stated by me before treatment begins on this date herein.

Patient Signature: _____ **Date:** _____



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~~Financial and Missed Appointments Policy~~

Faiz healing requires all fees, including insurance co-pays, be due at the time of service. Health Insurance and Motor Vehicle Insurance patients are responsible for the reimbursement of any fees not covered by their insurance carrier and will be billed the difference of the insurance fee claimed up to \$100.00 per hour of service. To be fair, any insurance program subject to a percent discount off of services will be deducted from the insurance fee price of \$100.00 per hour. *Please note* due to the processing time of claims for payment Faiz Healing is not able to guarantee benefit maximums will not be exceeded. It is the patients responsibility to maintain awareness of benefit usage and pay the difference for treatments rendered that are not covered by their insurance plan.

Patients are required to give cancellation notice within 24 hours of their appointment time. Failure to call within the proper amount of time will result in forfeiting the full price of the scheduled appointment. Patients who No Show or Cancel their appointments with less than 24 hr notice, more than twice, will be required to pay a deposit in advance to hold their appointments.

Thank you for your understanding. Faiz Healing strives to accommodate many patients in the community and will continue to be of the utmost service with respect to everyone.

In signing this document I authorize the billing of my insurance and the release of medical information necessary to process the claim. (If the patient is a minor, parent or guardian consent and signature is required)

I acknowledge that I have read the statements above thoroughly and agree to abide by Faiz Healings financial and missed appointment policy to the best of my ability.

Signature _____

Date _____

~~Notice of Privacy Policies~~

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship.

- Faiz gathers personal and health information through patient correspondence, from other health care providers, and from third party payers. This information is used for treatment, payment, and health care operations. You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting an authorization in writing. Please allow 30 days for release of information based on the date your request is received. Faiz maintains the right to charge a fee of no more than \$25.00 for the cost of printing and copying information to be released to a third party at your request. This fee will be due upon the date of written request.
- As required by law this office may use or disclose your protected health information when a subpoena is received for release of information for review-
- Faiz may disclose your protected health information to appropriate authorities if it is believed that you may be a possible victim of abuse, domestic violence, neglect, or other crimes.
- Faiz may disclose your protected health information if we believe that the disclosure is necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Faiz may disclose your protected health information to friends or family in the event of emergency to the extent necessary to help with your health care or with payment of your health care.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information, as well as, restriction regarding phone messages relevant to services being rendered to you, the patient.

I acknowledge that I have reviewed Faiz Healing's Notice of Privacy Policies and understand my rights as a patient to my healthcare information and the disclosure of that information.

Signature: _____ Date: _____