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-

Malt-
Fried foods-
White bread-
Whole grain foods-
Cooked grains-
Raw vegetables-

Alcohol-
Coffee-
Tea-
Chocolate -

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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~ Faiz Healing Practices and Techniques Consent Form~

Massage Therapy - intentional touch and specific techniques with the hands or massage tools. 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.

Acupuncture- a form of traditional Chinese Medicine. 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- 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. Occassionally, 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- 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 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.

Embodiment Guidance & Spiritual Family Constellation- The Facilitation of transformative experiences and contemplation to bring resolve and/or deepen insights into one's soul and spirit about one's relationship to self, others, and family. These offerings are not meant to assess, diagnose or treat a client seeking mental health therapy or advocacy for medical reasons.

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 medicinal techniques, guidance, and facilitation to be utilized while in the care of Faiz Healing Holistic Healthcare, unless specific restriction and denial of these techniques is stated by me before beginning care on this date herein.

Patient Signature: _____ **Date**:_____

Print Signature: _____

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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 patient's 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: _____