

**Mimi Tagher, LAc, LMT**  
Synergy Holistic Health Center  
7413 US 42 Suite 3, Florence, KY 41042

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Sex:  M  F

Date of Birth: \_\_\_\_\_ Drug Allergies: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Numbers (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home Cell Work

Please circle the phone number(s) above we may use to leave messages and confirm your appointments.

E-Mail Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

How did you hear about me: \_\_\_\_\_

Friend/Family (who): \_\_\_\_\_ Healthcare Provider: \_\_\_\_\_

Internet: \_\_ Yellow Pages: \_\_ Other \_\_\_\_\_

I understand that TCM may affect people on all levels: physical, emotional, mental, and spiritual, because it works within the entire body to restore balance. I understand that the duration of treatment varies person to person, depending on the specific illness and body constitution. I understand that treatment may include the use of acupuncture needles, cupping, mineral heat lamps, herbal formulas (raw and pill form), acupressure, psychological advice, Chinese massage (Tui Na), electrical stimulation, and diet and nutritional counseling. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. If I have heart problems, have an infectious disease, am taking herbs or any drugs, am pregnant or suspect that I am pregnant, I agree that I will inform the practitioner before beginning the treatment. I understand that slight bruising from cupping or needles is a normal side effect, and that the herbal treatment must be administered as prescribed by the practitioner. I state that I have completed the patient information form completely and accurately, and understand and accept the risks involved in the treatment.

I hereby authorize Mimi Tagher to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by this practice. I direct my insurance carrier and/or its intermediaries to issue payment directly to Mimi Tagher. I am aware of the financial policy of Mimi Tagher and I understand that I am financially responsible to this office for any balance not covered by my insurance carrier. I have been advised that all attorney collection fees are my responsibility. A copy of this is as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Who is your primary health care provider? \_\_\_\_\_

In an emergency notify: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Do you smoke?  Yes  No How much? \_\_\_\_\_ Do you drink?  Yes  No How much? \_\_\_\_\_

Are you pregnant?  Yes  No

Main problem you would like us to help you with? \_\_\_\_\_

How long ago did this problem begin? \_\_\_\_\_

Have you been given a diagnosis for this problem? If so, what? \_\_\_\_\_

What kinds of treatment have you tried? \_\_\_\_\_

Have they helped alleviate the condition/problem? \_\_\_\_\_

Are you currently receiving treatment for your problem? \_\_\_\_\_ If so please describe. \_\_\_\_\_

### **Past Medical History:**

Illnesses: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Significant Trauma (i.e Motor Vehicle Accidents, Falls, etc) \_\_\_\_\_

Do you have or have you ever had, any infectious disease? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

Medicines: Include prescription, over the counter drugs, vitamins, herbs. etc. taken within the last three months. \_\_\_\_\_

Average or typical Blood Pressure \_\_\_\_\_ Average Pulse Rate: \_\_\_\_\_

Allergies: \_\_\_\_\_

### **Family Medical. History (General Health):**

Mother's Side: \_\_\_\_\_

Father's Side: \_\_\_\_\_

Siblings \_\_\_\_\_

If any of the above are deceased, what was the cause? \_\_\_\_\_

Personal Birth History (prolonged labor, forceps, Caesarean, etc.) \_\_\_\_\_

Childhood health: \_\_\_\_\_ Location of upbringing: \_\_\_\_\_

Current emotional health: \_\_\_\_\_ Current Quality of Life: \_\_\_\_\_

Current Relationship quality: \_\_\_\_\_ Current predominant emotion: \_\_\_\_\_

Occupation: \_\_\_\_\_ Stress level: \_\_\_\_\_

Have you had any unusual stresses recently? \_\_\_\_\_

Favorite time of year: \_\_\_\_\_ Worst: \_\_\_\_\_

Hobbies and recreational habits: \_\_\_\_\_

Do you have a regular exercise program? \_\_\_\_\_ Please Describe: \_\_\_\_\_

Have you traveled abroad in the past year? \_\_\_\_\_ Where? \_\_\_\_\_

# Personal Medical History

## Significant Illnesses

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Weight Problem | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Mental illness  |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Addictive Disorders | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Herpes         | <input type="checkbox"/> High Blood Pressure |  |

Please check if you have experienced any of the following in the last 3 months.

### General:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Sweat Easily       |
| <input type="checkbox"/> Fevers        | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Bleeding                  | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Strong Thirst      | <input type="checkbox"/> Weight Loss               | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Tremors'      | <input type="checkbox"/> Poor Balance       | <input type="checkbox"/> Weight Gain               | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Cravings      | <input type="checkbox"/> Chills             | <input type="checkbox"/> Joint Pain                | <input type="checkbox"/> Emotional Changes  |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Hearing Loss              | <input type="checkbox"/> Bruising Easily    |

### Skin & Hair:

- |                                       |   |   |                                    |
|---------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Itching                | <input type="checkbox"/> Change in Skin Texture | <input type="checkbox"/> Ulcers    |
| <input type="checkbox"/> Eczema       | <input type="checkbox"/> Hair Loss              | <input type="checkbox"/> Dandruff               | <input type="checkbox"/> Acne      |
| <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Change in Hair Texture | <input type="checkbox"/> Hives                  | <input type="checkbox"/> Psoriasis |

### ENT + Head & Eyes:

- |  |   |                                       |   |  |
|--|---|---------------------------------------|---|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Eye Pain       | <input type="checkbox"/> Earaches     | <input type="checkbox"/> Migraine               | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Glasses        | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Eye Strain             | <input type="checkbox"/> Sores on Lips         |
| <input type="checkbox"/> Gum Problems    | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Vision  | <input type="checkbox"/> Grinding of Teeth      | <input type="checkbox"/> Mouth Ulcers          |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Cataracts.   | <input type="checkbox"/> Floaters               | <input type="checkbox"/> Toothache             |
| <input type="checkbox"/> Facial Pain     | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Concussions  | <input type="checkbox"/> Spots in Front of Eyes |  |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Jaw Click      | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Nose Bleeds            |  |

### Respiratory:

- |                                   |   |                                 |  |  |
|-----------------------------------|---|---------------------------------|--|--|
| <input type="checkbox"/> Cough    | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Painful Breathing |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily Winded       |  |

### Cardiovascular:

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Cold Hands or Feet  | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Phlebitis   | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Swelling of Hands   | <input type="checkbox"/> Shortness of Breath  |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Palpitations     | <input type="checkbox"/> High Blood Pressure |   |

### Gastrointestinal:

- |                                      |                                       |  |   |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea      | <input type="checkbox"/> Bloating     | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Belching    | <input type="checkbox"/> Constipation | <input type="checkbox"/> Black Stools    | <input type="checkbox"/> Vomiting       |
| <input type="checkbox"/> Diarrhea    | <input type="checkbox"/> Hemorrhoids  | <input type="checkbox"/> Bad Breath      | <input type="checkbox"/> Gastric Ulcers |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Parasites    | <input type="checkbox"/> Intestinal Gas  |   |

### Genito-Urinary:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Scanty Urination     | <input type="checkbox"/> Frequent Urination       |
| <input type="checkbox"/> Blood in Urine    | <input type="checkbox"/> Impotence        | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Frequent Night Urination |
| <input type="checkbox"/> Genital Sores     | <input type="checkbox"/> Kidney Stones    | <input type="checkbox"/> Discolored Urine     |   |

### Gynecology & Pregnancy (females only)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> Duration of Flow ___ | # of Pregnancies _____                            | <input type="checkbox"/> Difficult Births   |
| <input type="checkbox"/> Clots            | <input type="checkbox"/> Painful Periods      | # of Births _____                                 | <input type="checkbox"/> Fertility Problems |
| <input type="checkbox"/> Light Flow       | <input type="checkbox"/> Age of First Menses  | <input type="checkbox"/> Miscarriages, # of _____ | <input type="checkbox"/> Breast Lumps       |
| <input type="checkbox"/> Heavy Flow       | <input type="checkbox"/> Date of Last Menses  | <input type="checkbox"/> Abortions # of _____     | <input type="checkbox"/> Vaginal Discharge  |
| <input type="checkbox"/> PMS              | <input type="checkbox"/> Last PAP             | <input type="checkbox"/> Premature Births # _____ | <input type="checkbox"/> Vaginal Sores      |

### Neuro-Psychological

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Seizures       | <input type="checkbox"/> Areas of Numbness    | <input type="checkbox"/> Concussion     | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness      | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Depression     | <input type="checkbox"/> Mood Swings     |
| <input type="checkbox"/> Stress         | <input type="checkbox"/> Poor Memory          | <input type="checkbox"/> Anxiety        | <input type="checkbox"/> Irritable       |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Easily Angered | <input type="checkbox"/> Headache        |

Have you ever received psychiatric treatment? \_\_\_\_\_

Any nervous habits? \_\_\_\_\_

Do you smoke?  Y  N Intake? Mild Moderate Heavy

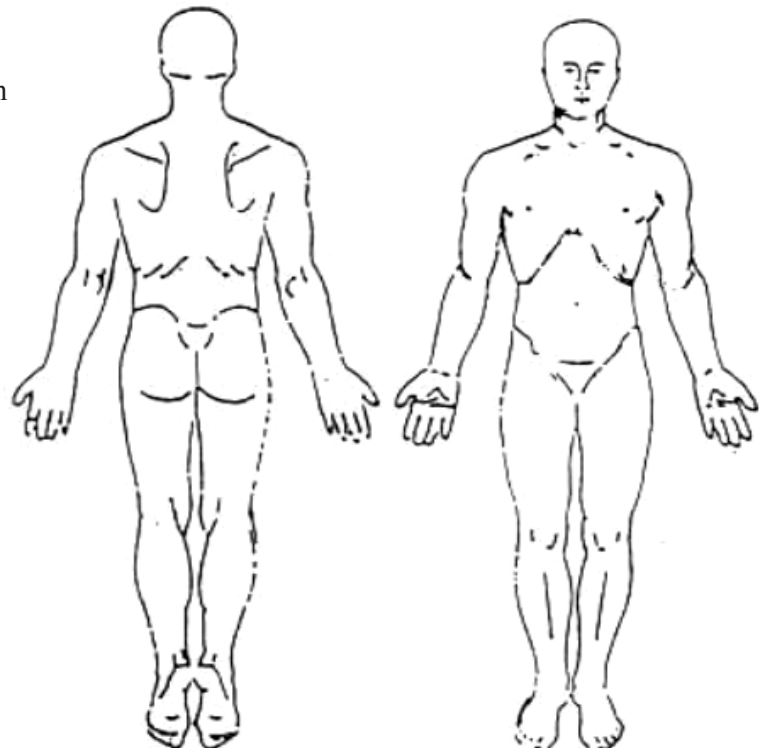
Any other problems you would like us to be aware of? \_\_\_\_\_

### Musculo-Skeletal

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> Neck Pain      | <input type="checkbox"/> Back Pain     | <input type="checkbox"/> Joint Pain      | <input type="checkbox"/> Muscle Spasms    | <input type="checkbox"/> Hand/Wrist Pain |
| <input type="checkbox"/> Scoliosis      | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain       | <input type="checkbox"/> Muscle Cramping  |  |
| <input type="checkbox"/> Hip Pain       | <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Soreness  |  |
| <input type="checkbox"/> Recent Sprains | <input type="checkbox"/> Weak Joints   | <input type="checkbox"/> Injuries        | <input type="checkbox"/> Foot/ Ankle Pain |  |

Please circle areas of pain or injury

Please be prepared to describe the type and quality of pain



# PHYSICIAN CARE FORM

Date: \_\_\_\_\_

I have been diagnosed with the following condition(s): (Check all that apply)

- Hypertension (high blood pressure)
- Cardiac condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am currently under the care of a physician for: (Check all that apply)

- Hypertension (high blood pressure)
- Cardiac condition
- Acute, severe abdominal pain
- Undiagnosed neurological changes
- Unexplained weight loss or gain of more than 15% of body weight in last 3 months
- Suspected bone fracture or dislocation
- Suspected systemic infection
- Serious hemorrhagic (bleeding) disorder
- Acute respiratory distress without a previous history
- Pregnancy
- Cancer
- Other: \_\_\_\_\_

I am aware that I should not replace treatment from a physician with acupuncture, or any other holistic modality.

Primary Care Physician's Name

\_\_\_\_\_

Emergency Contact's Name

\_\_\_\_\_

Primary Care Physician's Phone #

\_\_\_\_\_

Emergency Contact's Phone #

\_\_\_\_\_

Your Name \_\_\_\_\_

Please Print

Your Signature \_\_\_\_\_ Date \_\_\_\_\_