Asheville Center For Chinese Medicine
70 Woodfin Place Suite West Wing Two 828.258.2777 Asheville, North Carolina 28801

Integrative Health History

Name____________________________Date__________E-mail__________________
Phone________________ (hm) _________________ (wk) __________________ (cell)
Street Address__________________________City/State/Zip_____________________
Emergency Contact__________________________ Phone______________________
Referral Source or Name_______________________ E-mail ______________________
Street Address__________________________City/State/Zip_____________________

What are your primary health concerns? ____________________________________
____

Please list any secondary health concerns you may have:
_____________________________ _______________________________
_____________________________ _______________________________

Who is your current Healthcare Provider? ___________________________________
Address____
Phone_____________________________ Date of Last Physical___________

What is your:
Height _______ Blood Pressure _________ Age_______
Weight _______ Weight, 1 yr ago ________ Date of Birth____________

Personal Health History: Check the appropriate box if you have experienced any of the following:

ÿ Adverse reaction to medical treatment
ÿ Allergies
ÿ Anemia
ÿ Arthritis or rheumatism
ÿ Artificial heart, valve or joints
ÿ Bleeding Disorder
ÿ Blood Disease
ÿ Cancer or Tumor
ÿ Chemical Dependency
ÿ Diabetes
ÿ Eating Disorder
ÿ Eye Disorder
ÿ Gout
ÿ Headaches
ÿ Heart Disease
ÿ Hemophilia
ÿ Hepatitis, jaundice or Liver disorder
ÿ Herpes
ÿ High Blood pressure
ÿ Immune Disorder
ÿ Kidney Disorder
ÿ Low Blood Pressure
ÿ Musculo-skeletal Disorder
ÿ Organ Transplant
ÿ Pacemaker
ÿ Respiratory Disorder
ÿ Rheumatic Fever
ÿ Sciatica
ÿ Seizures/Epilepsy
ÿ Skin Disorders
ÿ Special Diet
ÿ Stomach or Intestinal Disorder
ÿ Stroke
ÿ Thyroid Disease
ÿ Transfusion (before March 1985)
ÿ Tuberculosis
ÿ Ulcer
ÿ Urinary Tract Disorder
ÿ Venereal Disease
ÿ Other: __________________________

Is there anything we should know about your medical history? ____________________________________
____

Major Hospitalizations: If you have even been hospitalized for any serious medical illness or surgery, write in your most recent hospitalizations below. *Check this box ÿ if you have had more than three such hospitalizations.* (Do not include normal pregnancies).

1st Hospitalization____
Year Operation/Illness Hospital/City/State

2nd Hospitalization ____
Year Operation/Illness Hospital/City/State

3rd Hospitalization ____
Year Operation/Illness Hospital/City/State

FAMILY HISTORY: Complete for each family member. Place X in box indicating any illnesses they ever had

	Mother	***Father***	***Grdmother***	***Grdfather***	***Sister***	***Brother***	***Spouse***	***Children***
Allergies								
Anemia/Blood Dis								
Cancer or Tumors								
Chemical Dependency								
Diabetes								
Heart Disease								
High Blood Pressure								
Kidney or Bladder Dis								
Seizures / Epilepsy								
Stomach-Intestinal Dis								
Stroke								
Tuberculosis								
Other								
Age at Death								

Medications & Supplements: Check the box next to any of the following that you are now taking.

ÿ Antacids
ÿ Aspirin
ÿ Cold tablets
ÿ Diet pills
ÿ Diuretics
ÿ Tylenol
ÿ Viagra
ÿ Allergy medication
ÿ Ibuprofen/Advil
ÿ Laxatives
ÿ Oral Contraceptives
ÿ Blood pressure medication
ÿ Prescription pain medication
ÿ DHEA/ melatonin/ Beta HCG
ÿ Sleeping pills
ÿ Tranquilizers
ÿ Herbs
ÿ Vitamins
ÿ Antidepressants
ÿ Hormone replacement therapy
ÿ Cumadin/ Plavix/ anticoagulants

Please list any medications that you are currently taking that are not listed above, indicating purpose:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Please list any medication allergies you have:

__________________ __________________ __________________

__________________ __________________ __________________

Habits: Please mark any of the habits listed below which apply to you. Mark "**X**" for current habits. Mark "ü" for past habits.

Use of tobacco: ÿ Yes ÿ No If yes, # of cigarettes/day _________ age started______

Use of alcohol: ÿ Yes ÿ No If yes, # of drinks per week _______ age started______

Use of Caffeine: ÿ Yes ÿ No # colas / day____ # coffee / day ____ # tea / day____

Previous Pregnancies: Please fill in completely.

	Year	Length of Preg	Labor Hours	Type of Delivery	Sex	Weight	Name
1.							

Complications______________________________

2.______________________________

Complications______________________________

3.______________________________

Complications______________________________

Tell us about your lifestyle:

What sort of diet do you have? (check one) ÿ Standard American ÿ Weight loss type
ÿ Fast/Quick Prep Diet ÿ Vegetarian ÿ Vegan ÿ Low Fat ÿ Low Carbs
ÿ Muscle Building Diet ÿ Balanced Food Groups ÿ Other______________________________

Please show usual foods and beverages:

Breakfast	Snack	Lunch	Snack	Dinner	Snack
_________	_________	_________	_________	_________	_________
_________	_________	_________	_________	_________	_________
_________	_________	_________	_________	_________	_________

Is Nutrition or Diet something you'd like to improve or be evaluated for? ÿ Yes ÿ No

Are you active? (check one) ÿ Sedentary Job w/o exercise ÿ Sedentary Job w/ Much Exercise
ÿ Sedentary Job w/ Some Exercise ÿ Active Job w/o Extra Exercise ÿ Active Job w/ Exercise
What type of exercise do you do? ______________________________
Would you like evaluation for the best form of exercise for your body and health? ÿ Yes ÿ No

How would you characterize your life in terms of stress? (check one)
ÿ High Stress ÿ Much Stress ÿ Fairly Stressed ÿ Mild Stress ÿ Periodic Stress ÿ Not Stressed
Would you like to be handling stress better, or reduce the effects of stress? ÿ Yes ÿ No

Do you experience any of the following moods often? (check all that apply)
ÿ Depression ÿ Anxiety ÿ Insecurity ÿ Anger ÿ Irritability ÿ Phobias ÿ Nervousness
ÿ Mood Swings ÿ Sadness ÿ Short Tempered ÿ Obsessive Thinking ÿ Isolated ÿ Hopelessness
Would you like to be evaluated for possible treatment solutions for these states? ÿ Yes ÿ No

Please check off symptoms you have had in the past 3 MONTHS.
If a *box indicates several symptoms*, please *circle the one you experience*.

Part A:

- q Cough
  - __ acute
  - __ chronic
  - __ dry
  - __ phlegm, white, clear
  - __ phlegm, green or yellow
  - __ blood
- q Sore throat
  - __ itchy
  - __ burning
- q Hoarseness
- q Frequent colds/flu
- q Swollen glands
- q Painful lymph nodes
- q Fever/chills
- q Allergies
  - __ seasonal
  - __ year round
  - __ pollen
  - __ dust
  - __ mold
  - __ pets
  - __ chemicals
  - other ____________
- q Itchy eyes
- q Sneezing
- q Nasal discharge
  - __ white, clear
  - __ green, yellow
  - __ odor
- q Nasal congestion
- q Sinus congestion
- q Sinus pain
- q Shortness of breath
- q Wheezing
- q Chest Oppression/ tightness
- q Grief/ sadness
- q Crave spicy foods
- q Skin rashes, eczema, hives
- q Spontaneous sweating

Part B:
For following symptoms indicate if daily, weekly or monthly:

- q Nausea ________
- q Vomiting ________
- q Bloating ________
- q Gas ________
- q Belching ________
- q Acid regurgitation________
  - __ sour
  - __ thin
  - __ burning
- q Stomach pain
- q Ulcers
- q Bad breath
- q Gum bleeding
- q Large appetite/Excessive hunger
- q # of bowel movements per day ___
  - __ loose
  - __ hard
  - __ painful
  - __ blood or mucus
  - __ difficult
  - __ odorous
  - __ burning
  - __ alternating diarrhea & constipation
  - __ hemorrhoids
- q Fatigue or discomfort after eating
- q Poor appetite
- q Recent weight gain
- q Recent weight loss
- q Bruises easily
- q Slow wound healing
- q Frequently fatigued Time of day ______________
- q Organ prolapse
- q Loss of taste
- q Crave sweets
- q Crave carbohydrates
- q Heavy limbs
- q Weak muscles
- q Easily worried, over thinking
- q Cloudy/ Foggy-headed
- q Edema, water retention
- q Varicose/spider veins

Part C:

- q Irritability
- q Frustration
- q Easily stressed/tense
- q Easily angered
  - __ frequent outbursts
- q Rib side pain
- q Frequent sighing
- q Sensation of something in throat
- q Dizziness
  - __ postural
  - __ empty headed
  - __ heavy headed
- q Vertigo
- q Dry hair, skin, nails
- q Dry eyes, floaters, blurred vision
- q Red eyes
- q Eye pain/strain/sensitivity
- q Neck and shoulder tension
- q Tremors
- q Numbness
- q Hiccups
- q Bitter taste in mouth
- q Clearing throat often

FOR WOMEN:

First day of last period___________

# of days in menstrual cycle_____

# of days of bleeding _______

# of pads/tampons per day________

Color of blood: __ pale__ purple __ bright red __ dark red __ brown

- q Clots
  - __ red
  - __ purple
  - __ small (cottage cheese)
  - __ large
- q Cramping
  - __ before
  - __ during
  - __ end
- q PMS symptoms
  - __ mood changes
  - __ breast tenderness/swelling
  - __ food cravings
  - __ headaches
- q Bleeding in between periods
- q Fibroids
- q Breast lumps/fibrocystic
- q Hot flashes

# of pregnancies ____

# of live births ____

Type of birth control _________________

- q Pregnant
- q Nursing
- q Abnormal pap test
- q History of vaginal warts
- q Vaginal pain
  - ___with sexual intercourse
- q Vaginal discharge
- q Infertility
- q GYN surgeries (date/type) ____________________ ____________________
- q Regular breast exam

Part D:

- q Low back, knee pain
- q Poor hearing/hearing aid # of years ___________
- q Ear ringing
- q Hair loss
- q Premature graying
- q Cold hands & feet
- q Generalized cold feeling
- q Warm body temperature
- q Frequent urination
- q Scanty urination
- q Night urination
- q Urgent urination
- q Profuse urination
- q Color of urination
  - __ Dark __ Straw
  - __ Light/clear__ Cloudy
  - __ Bloody__ Painful
- q Hesitant urination/dribbling
- q Sex drive/libido
  - __Low __High
- q Puffy beneath eyes
- q Dark circles under eyes
- q Fear/ phobias/ inventing worst case scenarios
- q Lack of will/drive/motivation
- q Crave salt
- q Swollen ankles
- q Birth disorders/defects
- q Childhood developmental problems
- q Osteoporosis
- q Poor teeth

FOR MEN:

Last prostate exam______

PSA results _______

- q Prostatitis/BPH
- q Infertility
  - __Low sperm count
  - __Poor sperm mobility
  - __Low sperm progression
- q Erectile Dysfunction (ED)
  - __ Difficulty achieving erection
  - __ Difficulty maintaining erection
  - __ Premature ejaculation

Part E:

- q Palpitations
- q Difficulty falling asleep
- q Wake during night
- q Restless
- q Night sweating
- q Thirst
- q Dry mouth/throat
- q Mouth sores/sore tongue
- q Poor memory
- q Jittery, easily startled
- q Anxiety
  - __ Racing thoughts
  - __ Overwhelm
- q Depression

Headache:

Location:
__ top
__ temples
__ forehead
__ back of head

How long? ______
Time of day: _____

Type of pain:
__ dull
__ sharp/stabbing
__ distended/throbbing
__ heavy headed
__ band like

Visual Problems:
__ see lights
__ see auras

- q Dislike light
- q Dislike noise
- q Worse with stress
- q Worse with fatigue
- q Empty-headed
- q Dizziness
- q Nausea/Vomiting

BODY PAIN:

Date began: __________ Cause: ____

Describe location: ____
____

Type of Pain:
__dull/achy
__sharp/stabbing
__burning
__constant
__intermittent
How often? ______
Time of day______
__radiating
__fixed
__moves around
__severe
__moderate
__mild discomfort

What makes it better?
__Cold
__Heat/hot shower
__Pressure/massage
__Activity/movement
__Rest

What makes it worse?
__Cold
__Cold/damp weather
__Rest
__Activity/movement
__Pressure/massage

- q Numbness (no feeling)
- q Pins and needles

Diagnostic Tests:
(List date/findings)
X-Ray_________________
MRI__________________
CAT__________________
Surgeries (date/type):
____
____

Asheville Center For Chinese Medicine
70 Woodfin Place Suite West Wing Two 828.258.2777 Asheville, North Carolina 28801
Offiice@AcupunctureAsheville.com www.AcupunctureAsheville.com

Consent for Use and Disclosure of Health Information

Section B: To the Patient – Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you DECIDE whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of privacy practices, including any revisions of our Notice, at any time by contacting:

Kath Bartlett
70 Woodfin Place
Suite West Wing Two
Asheville, NC 28801
828-258-2777

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you of to continue treating you if you revoke this Consent.

I, ____, have been informed of, and given the right to review and received a copy of your *Notice of Privacy Practices.* I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ___________________________________ Date: _________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Asheville Center For Chinese Medicine
70 Woodfin Place   Suite West Wing Two   828 258-2777   Asheville, North Carolina 28801
Office@AcupunctureAsheville.com   www.AcupunctureAsheville.com

---

Informed Consent for Traditional Chinese Medical Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Traditional Chinese Medicine (TCM) on me (or on the patient named below, for whom I am legally responsible) by Kath Bartlett, MS, LAc, or any other licensed acupuncturist who now or in the future may treat me while associated with or serving as back-up to Kath Bartlett, including those working at Asheville Center for Chinese Medicine or at any other office or clinic, whether signatories to this form or not.

I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na massage (similar to acupressure) Chinese herbal medicine and nutritional counseling.

Acupuncture's effects include: normalizing physiological function, decreasing pain and treating diseases and dysfunctions of the body. I have been informed that acupuncture is a safe procedure. Occasionally, bruising or tingling or numbness may occur near the needle site which can last up to a few days following acupuncture treatment. Bruising may occur after cupping procedure. On rare occasion, a patient may experience dizziness or fainting during or immediately after acupuncture treatment. Eating within two hours prior to acupuncture treatment will generally prevent occurrence of these symptoms. There have been rare reports of infections and burns (associated with cupping or moxibustion). There have been extremely rarely reported and unusual incidences of spontaneous miscarriage, nerve damage and pneumothorax. Asheville Center for Chinese Medicine uses sterile, disposable needles and maintains a clean and safe clinic environment. Kath Bartlett, MS, LAc is a highly trained and skilled practitioner, certified in Clean Needle Technique by CCAOM. Other than occasional and minor bruising, it is highly unlikely that any of the aforementioned, negative side effects will occur.

Positive side effects to be expected from acupuncture treatment include deep relaxation and sensation of well being, increased energy, decreased feelings of stress, decreased incidences of illness, and improved physiological and mental function of the body, mind and spirit.

Chinese herbal formulas, including plant, mineral and animal sources, are considered safe in the practice of Oriental medicine. Some of the herbs are inappropriate during pregnancy and a few of the herbs are considered toxic when taken in high dosages. Kath Bartlett, MS, LAc is a competent and experienced herbalist, Board Certified in Chinese Herbology and Oriental Medicine by NCCAOM. She is knowledgeable in safe dosing ranges, cautions and contraindications of Chinese herbs.

I understand the herbs may need to be prepared and the teas consumed according to the written and oral instructions provided. The herbs may have an unpleasant smell or taste. Occasional side effects causes by herbs are generally limited to gastro-intestinal symptoms, such as gas, bloating, stomachache, or changes in bowels. More rarely, headache or nausea may occur. On extremely rare occasion, a patient may experience a rash or hives, vomiting, or tingling of the tongue. Any adverse symptoms caused by herbs will stop when the herbs use is discontinues. Generally, the herbal prescription can be modified to prevent any adverse symptoms from continuing. Any symptoms persisting after cessation of Chinese herbal therapy were not caused by the herbal formula. If I experience any gastro-intestinal symptoms, allergic reactions or any other unanticipated or unpleasant effects associated with the consumption of the herbs, I will immediately inform the herbalist.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I will rely on the acupuncturist to exercise professional judgment during the course of treatment, and to act in my best interest based on the available facts then known. If I become pregnant, I will notify the acupuncturist immediately. I understand that results are not guaranteed.

I have read (or have had read to me) the above consent for Traditional Chinese Medical treatment, and my questions have been answered regarding its content. By signing below I agree to receive the above named procedures, and any other techniques comprising Oriental Medicine. I intend this consent form to cover the entire course of treatment for my present condition, and any future condition for which I may seek treatment.

____
Patient's Name

____
Relationship to Patient

____
Patient's Signature (or representative of patient)

____
Date

____
Office Signature (Date)

CANCELLATION POLICY

Notification of cancellation or re-scheduling must be received **by telephone** on weekdays (Monday through Friday) between the hours of 10:30am and 6pm. Acupuncture visits are generally scheduled a week or more in advance. As a courtesy, please give as much notice as is possible to cancel or re-schedule visits so that appointment times will be available for scheduling other patients**.**

If you do not give a full business day's notice of the appointment time change you must pay for the missed visit. If a new, acute condition or illness arises, please keep your previously scheduled acupuncture appointment. The new condition will be treated with Chinese medicine.

SHOULD I KEEP MY APPOINTMENT IF I'M SICK?

Every so often a patient will call to cancel an acupuncture appointment because "I'm sick". This reasoning perplexes acupuncturists, because if you're sick, why not keep your appointment so that your practitioner can treat the acute illness? It makes us realize that patients don't really see us as doctors. But we are, (Chinese) doctors! Most acupuncturists are GP's: General Practitioners. That means that rather that specializing in a particular clinical discipline, such as gynecology, dermatology, infertility, pain management, etc., acupuncturists treat whatever comes through the door. On any given day, we might treat gyn issues, such as PMS, cramping or perimenopausal complaints, followed by digestive problems like acid regurgitation or bowel irregularities next might come headache followed by back, neck or joint pain. We see skin rashes: hives, eczema and herpes, lung conditions including sinusitis, allergies, bronchitis and the common cold and flu, in addition to more complex medical problems.

Acupuncture and Chinese herbs are highly effective for treating acute conditions, such as colds and flu, stomach viruses and headaches. Patients report immediate improvement in symptoms after acupuncture treatment and commencing herbal therapy. An oft-repeated phrase by a happy patient is, "As soon as I started taking the herbs I felt better!"

Many patients call immediately to schedule a treatment when they first notice cold or flu symptoms. These include healthcare practitioners who don't want to get their patients sick, business professionals who are too busy for a sick day or two, and patients who are chronically ill and want to 'get this one over with, quickly'.

So if you're sick, call your acupuncturist and make and appointment. If you have an appointment scheduled, keep it. If you're concerned about being contagious to your practitioner, request an herbal consultation instead of an acupuncture treatment.

HOW TO SPEAK EFFECTIVELY WITH YOUR DOCTOR

Visiting a healthcare practitioner (western medical doctor, acupuncturist, chiropractor, physician's assistant, physical therapist, nurse practitioner) requires good communication skills on behalf of both patients and doctors. Patients need to be able to convey medical information in a clear and concise manner. Practitioners must be able to tell patients in plain English what is causing their symptoms and what must be done to treat the condition effectively. During the discourse, key information often does not get relayed, for a variety of reasons. What can you do to communicate more effectively with your doctor?

1) Treat your doctor visit as a business meeting. You have a short amount of professional time to relay much key information about your condition. Manage the time wisely.
2) It's your responsibility to communicate key information in an orderly fashion: such as medical background and symptomatic progression of medical events. If you have a number of health concerns to discuss, prepare in advance for the meeting with your doctor. Organize your thoughts and perhaps take notes about key symptoms so that you can convey the information as clearly and succinctly.
3) Keep to the symptoms and refrain from anecdotal stories. It's easy to go off on a tangent about your visit to your aunt's when you noticed the ache in your back. These stories waste precious professional time that should be spent discussing your symptoms and treating your disease. Did you really make an appointment with your doctor to talk about your vacation?
4) Be able to answer detailed questions clearly. Be specific and avoid vagaries when describing your symptoms. If the practitioner asks you about something you haven't paid much attention to; rather than providing a list of information unrelated to the question, just say 'I'm not sure', or 'I don't have an answer for that'. Make a mental note to observe your body between visits so you can provide more complete information on a subsequent visit.
5) If you have a number of symptoms that you are managing, keep a log of frequency, severity, time and duration, location and any other characteristics your practitioner typically asks about. It's often difficult to recall this information when the doctor asks, so write it down in advance and even hand your practitioner a copy.
6) If you are on many medications, keep a log of the drugs, dosages and times taken so that you can hand a copy to your medical practitioner. Especially in the western medical community, where you see a different specialist for separate conditions, the doctors are often not aware that a patient is on many other drugs in addition to what s/he is prescribing. This leads to over prescribing and drug interactions. It is vital that all of your healthcare practitioners are aware of your drug use and history.
7) Be honest. Don't lie or withhold information. Don't exaggerate or play down symptoms. Giving inaccurate information will only lead to misdiagnosis and treatment.
8) Don't be embarrassed to talk about your bodily functions. Remember, to your practitioner these are very routine conversations: discussing urine and bowel habits are no different than talking about a blown carburetor.
9) Don't interrupt your doctor's thought process during pauses or while taking notes. S/he is reviewing your case, looking for any holes in the medical history that require further illumination, and mentally arriving at diagnostic and treatment options for you. Use this time to do a self-review of your own. Have you communicated all that you came into say? Was there anything you omitted or feel you should convey differently?
10) When your doctor goes over diagnostic and treatment options for you, be sure you understand what is being said. In the medical community there is a tendency to speak in jargon. Don't be intimidated by words you don't understand. Ask for an explanation of terminology. You may find it helpful to bring a friend to help listen to diagnostic explanations and ask questions for you. Alternatively, take notes or record the conversation.
11) Don't interrupt your practitioner during explanations: often your questions will be anticipated and answered. Your practitioner may forget where s/he left off and this may prevent necessary information from being provided to you.
12) It is vital that you understand your treatment and care. Know what the drugs, herbs or nutritional supplements that are being prescribed are doing. Ask for a timeline so you know what to expect and when in terms of recovery and when therapy should be discontinued.
13) Be sure your practitioner has fully disclosed all possible risks and side-effects of treatment, and know what to be alerted for should treatment go array. This is especially important for drug therapy and recommended surgeries.
14) Organize your questions before your visit. Your doctor has to work within the timeframe of the clinic schedule. Don't corner your practitioner after the visit has concluded with questions you forgot to ask during your appointment. This will delay other patients who are waiting. The time will have to be made up by shortening another patient's treatment.

Your doctor visit is a professional appointment. Treat it as such. Arrive promptly and be prepared for your visit. By following these guidelines you will get the most efficient and effective care possible from your healthcare professional.