

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Personal Information

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail _____

Occupation _____ Person responsible for your account _____

Who should we thank for referring you to this office? _____

Sex: Male__ Female __ Height _____ Weight _____ Birth date _____ Age _____

Marital Status: Married__ Single__ Divorced__ Widowed__ Number of children _____

Have you received acupuncture therapy before? Yes__ No__

When? _____ With whom? _____

Please indicate any significant illness you or a blood relative (grandparent, parent or sibling) have had:

Illness	You relative	Your date	Approx.	Illness	You	Your relative	Approx. date
Cancer	_____	_____	_____	Diabetes	_____	_____	_____
Hepatitis	_____	_____	_____	Heart Disease	_____	_____	_____
High blood pressure	_____	_____	_____	Seizures	_____	_____	_____
Rheumatic Fever	_____	_____	_____	Emotional Disorders	_____	_____	_____
Infectious Disease	_____	_____	_____	Tuberculosis	_____	_____	_____

Sexually Transmitted Diseases: Gonorrhea__ Syphilis__ AIDS__ HPV__ Chlamydia__
Herpes__ Date _____

List any medications and supplements you are currently taking(continued on back if necessary)

Medicine and Dosage	Reason	How long?	Prescribed by	Date of last check up
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Please indicate the use and frequency of the following:

	Yes	No	How much?
Coffee/black tea	_____	_____	_____
Non-medical drugs	_____	_____	_____
Tobacco	_____	_____	_____
Alcohol	_____	_____	_____
Water intake	_____	_____	_____
Soda drinks	_____	_____	_____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities or food cravings that you have.

List any accidents, surgeries, or hospitalizations (include date).

Lab Results (please include copies)

How do you feel about the following areas of your life? (please check the appropriate spaces and indicate any problems you may be experiencing)

	Great	Good	Fair	Poor	Bad
Significant other	_____	_____	_____	_____	_____
Family	_____	_____	_____	_____	_____
Diet	_____	_____	_____	_____	_____
Sex	_____	_____	_____	_____	_____
Self	_____	_____	_____	_____	_____
Work	_____	_____	_____	_____	_____
Exercise	_____	_____	_____	_____	_____
Spirituality	_____	_____	_____	_____	_____
Your Comments:					

Women

Age of first period (menarche) _____ Age of last period (menopause) _____
Number of days between periods _____ Number of days of flow _____
Color of flow _____ Clots? Yes ___ No ___ Color _____
Average number of pads you use per day:
1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____
Have you been diagnosed with: Fibroids _____ Fibrocystic Breasts _____
Endometriosis _____ Ovarian cysts _____ PID _____ Other _____
Location of pain: Lower abdomen _____ Lower back _____ Thighs _____ Other _____
Nature of pain (please indicate before, during or after menses):
Cramping _____ Stabbing _____ Burning _____
Aching _____ Dull _____ Bloating _____
Constant _____ Intermittent _____
Bearing down sensation _____
Other symptoms related to menses:
Discharge _____ Vaginal Dryness _____ Headache _____
Nausea _____ Constipation _____ Diarrhea _____
Swollen Breasts _____ Mood swings _____ Ravenous appetite _____
Poor appetite _____ Hot flashes _____ Night sweats _____
Increased libido _____ Decreased libido _____ Insomnia _____
Are you pregnant? Yes ___ No ___ # of pregnancies _____ # of live births _____
of abortions _____ # of miscarriages _____
Date of last: Gynecologic exam _____ Pap smear _____ Mammogram _____
Bone Density scan _____ Results _____

For Men

Date of last prostate check up _____ PSA results _____
Manual prostate exam results _____
Lab Results:
Frequency of Urination: daytime _____ Nighttime _____
Color of urine: clear _____ murky _____ Odor: _____
Symptoms related to prostate:
Prostate problems ___ Delayed stream ___ Dribbling ___
Rectal Dysfunction ___ Incontinence ___ Retention of Urine ___
Back pain ___ Increased Libido ___ Decreased Libido ___
Premature Ejaculation ___ Impotence ___ Groin pain ___
Testicular pain ___ Other: _____

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

NO MARK () = NEVER EXPERIENCE CHECK MARK (✓) = SOMETIMES EXPERIENCE

PLUS SIGN (+) = FREQUENTLY EXPERIENCE

lack of appetite excessive appetite loose stool or diarrhea
 digestive problems, indigestion vomiting belching, burping
 heartburn/ reflux feeling the retention of tendency to become obsessive
food in stomach in work, relationships ...

insomnia, difficulty sleeping heart palpitations cold hands and feet
 nightmares mentally restless laughing for no apparent
reason
 angina pains abdominal pains chest pain
 sciatic pain headaches pain or coldness in the genital
area

cough shortness of breath decreased sense of smell
 nasal problems skin problems feeling of claustrophobia
 bronchitis colitis or diverticulitis constipation
 hemorrhoids recent use of antibiotics eye problems
 jaundice (yellowish eyes or skin) difficulty digesting oily foods gall stones
 light colored stool soft or brittle nails easily angered or agitated
 difficulty in making plans/decisions spasms or twitching of muscles
 low back pain knee problems hearing impairment
 ear ringing kidney stones decreased sex drive
 hair loss urinary problems fatigue
 edema blood in stool black tarry stool
 easily bruised difficult to stop bleeding asthma
 tendency to catch colds easily intolerance to weather changes allergies
 hay fever dizziness tendency to faint easily
 high cholesterol levels sudden weight loss

CHIROPRACTIC AND ACUPUNCTURE INFORMED TO CONSENT TO TREAT

INFORMED CONSENT:

I hereby request and consent to the performance of acupuncture and chiropractic treatments and other procedures within the scope of the practice of acupuncture and chiropractic on me (or on the patient named below, for whom I am legally responsible) by the practitioner named below and/or other licensed practitioner who now or in the future treats me while employed by, working or associated with or serving as back-up for the doctor named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese message), Chinese herbal medicine, and nutritional counseling. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risk may occur. The herbs and nutritional supplements (which are from plants, animal and mineral sources) that have been recommended are traditionally considered safe in a practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time based upon the facts then known, is in my best interests.

I have had an opportunity to discuss with the doctor of chiropractic and acupuncture named below and/or with other office of clinic personnel the nature and purpose of a chiropractic adjustments, procedures, and acupuncture adjustments. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask question about its consent, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature

Date

Provider Signature

Date

Notice of Privacy Practices for HIPAA Regulations

This note describes general office practices regarding confidentiality of your medical information.

Office Practices:

- All information regarding patients, their treatments, diagnosis and appointments is kept strictly confidential within the confines of the practitioner and office assistant. Patient chart and financial data will be seen only by practitioner and office assistant.
- Electronic data transfer from this office is limited strictly to electronic claims filing for insurance reimbursement.
- For treatment purposes, information will be provided to another practitioner only after your written consent is given.
- Discussion of treatment is confined to the consultation room or the treatment room, and will never be held in the presence of other individuals.

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how medical information may be used and disclosed in this office and have been informed on how I may gain access to and control this medical information.

Signature of Patient or Patient Representative

Print Name of Patient or Patient Representative

Description of Personal Representative

Date

FINANCIAL AGREEMENT

Assignment of Benefits for Insurance

I authorize payment of benefits be made directly to the above-named 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 claims in conjunction with my treatment(s) by this provider.

Cancellation Policy

Please be respectful of the time set aside for your treatment. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week so that the effects from the treatments are not interrupted.

All scheduled appointments require a 24 hour cancellation notice, otherwise the patient will be charged a \$ 65.00 missed appointment fee.

Returned Check Policy

All returned checks will be subject to an additional charge of \$ 25.00.

If chiropractic and acupuncture are performed on the same day patient is responsible for both copayments

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for ALL charges stated above.

Patient Signature

Date