**Seattle Healing Acupuncture, LLC**

Jacqueline R. Close, MTCM, EAMP

1307 N 45th Street, #204, Seattle, WA 98103

Phone: (206) 783-1912

**General Information**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we contact you via email? Yes No Age \_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Health Insurance Information

In order to bill your private health insurance company, please complete the following and provide a copy of your insurance card:

|  |
| --- |
| **Insurance Co. Name**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group/Plan # \_\_\_\_\_\_\_\_\_\_\_\_\_ |

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office. I hereby authorize the insurance company or attorney to remit payment directly to this office. I understand quotes of benefits are NOT a guarantee of payment.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**History Questionnaire**

Have You Been Treated By Acupuncture or Chinese Medicine Before? Yes  No 

**Main Problem(s)** you would like help with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long ago did this problem begin (be specific)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To what extent does this problem interfere with your daily activities (work, sleep, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note the severity of your problem now:**





No Problem Worst Imaginable

**Please note the severity of your problem within the last week:**







No Problem Worst Imaginable

**Indicate painful or distressed areas: Comments:** (Please list any other concerns you would like to discuss in the space below)



P**ast Medical History** (please include date): Cancer \_\_\_\_\_\_\_\_\_ Diabetes \_\_\_\_\_\_\_\_ Hepatitis \_\_\_\_\_\_\_ High Blood Pressure \_\_\_\_\_\_\_ Heart Disease \_\_\_\_\_\_\_ Rheumatic Fever \_\_\_\_\_\_\_ Thyroid Disease \_\_\_\_\_

Seizures \_\_\_\_\_\_\_ Venereal Disease \_\_\_\_\_\_\_\_ HIV/AIDS \_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries** (type of and date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Trauma** (auto accidents, falls, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Significant Dental Work** (type and date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (drugs, chemicals, foods/result) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History** (check): Diabetes  Cancer  High Blood Pressure 

Heart Disease  Stroke  Seizures  Asthma  Allergies 

Other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicines** taken within the last two months (vitamins, drugs, herbs, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational Stress** (physical, chemical, psychological, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a **regular exercise program**? Yes  No  Please Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been on a **restricted diet**? Yes  No  What Kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many **packs of cigarettes** do you smoke per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much **coffee, tea or cola** do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much **alcohol** do you drink per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any use of recreational drugs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any you have had in the last three months:**

**General**

 Poor appetite

 Fevers

 Sweat easily

 Localized weakness

 Bleed or bruise easily

 Peculiar tastes or smells

 Strong thirst (cold or hot)

 Thirst, no desire to drink

 Sudden energy drop – what

time of day? \_\_\_\_\_\_\_\_

 Poor sleep

 Chills

 Tremors

 Poor balance

 Fatigue

 Night sweats

 Cravings

 Change in appetite

 Weight gain

 Weight loss

**Skin and Hair**

 Rashes

 Itching

 Dandruff

 Change in hair or skin

 Ulcerations

 Eczema

 Loss of Hair

 Hives

 Pimples

 Recent moles

 Other hair or skin problems

**Head, Eyes, Ears, Nose, and Throat**

 Dizziness

 Glasses

 Poor vision

 Cataracts

 Ringing in ears

 Sinus problems

 Grinding teeth

 Teeth problems

 Concussions

 Eye strain

 Night blindness

 Blurry vision

 Poor hearing

 Nose bleeds

 Facial pain

 Jaw clicks

 Migraines

 Eye pain

 Color blindness

 Earaches

 Spots in front of eyes

 Recurrent sore throats

 Sores on lips or tongue

 Headaches - where and

when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other head or neck

problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular**

 High blood pressure

 Irregular heartbeat

 Cold hands or feet

 Blood clots

 Low blood pressure

 Dizziness

 Swelling of hands

 Phlebitis

 Chest pain

 Fainting

 Swelling of feet

 Difficulty in breathing

 Other heart or blood vessel

problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory**

 Cough

 Bronchitis

 Difficulty in breathing when

lying down

 Production of phlegm

what color \_\_\_\_\_\_\_\_\_\_\_\_\_

 Coughing blood

 Pneumonia

 Asthma

 Pain with a deep breath

 Other lung problems \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal**

 Nausea

 Constipation

 Black stools

 Bad breath

 Abdominal pain or cramps

 Chronic laxative use

 Vomiting

 Gas

 Blood in stools

 Rectal pain

 Diarrhea

 Belching

 Indigestion

 Hemorrhoids

 Other stomach or intestinal

problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genito-urinary**

 Pain on urination

 Urgency to urinate

 Frequent urination

 Unable to hold urine

 Impotency

 Blood in urine

 Kidney stones

 Sores on genitals

 Other genital or urinary

system problems \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you wake up to urinate?

  Yes  No. How

often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any particular color to your

urine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pregnancy and Gynecology**

Number of pregnancies \_\_\_\_

Number of births \_\_\_\_\_\_\_\_\_

Premature births \_\_\_\_\_\_\_\_\_

Miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_

Abortions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first menses \_\_\_\_\_\_\_

Days between menses \_\_\_\_\_

Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First day of last menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Unusual character (heavy

 or light)

 Painful periods

 Vaginal discharge

 Changes in body/psyche

prior to menstruation

 Clots

 Vaginal sores

 Irregular periods

 Last Pap \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Breast lumps

Do you practice birth control?

  Yes  No

What type and for how long?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal**

 Neck pain

 Back pain

 Hand/wrist pain

 Muscle pain

 Muscle weakness

 Shoulder pain

 Knee pain

 Foot/ankle pain

 Hip pain

**Neuropsychological**

 Seizures

 Areas of numbness

 Concussion

 Bad temper

 Dizziness

 Lack of coordination

 Depression

 Easily susceptible to stress

 Loss of balance

 Poor memory

 Anxiety

 Other neurological or

psychological problems

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_