HEALTH HISTORY

Date: ____ / ____ / ______

Name:			Sex:	Age:
Address:	City:		State:	Zip Code:
Phone #1: Home Cell Other	Phone #2: Work Cell Other	Email:		
Date of Birth:	Emergency Contact: *(name & relationship)*	Phone #:		
Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other :__________		
Occupation:	Employer:			
How did you hear of our clinic?: ☐ Word of Mouth ☐ Internet ☐ Yellow Pages ☐ Craigslist ☐ Flyer ☐ Walk / Drive by ☐ Print Ad ☐ Other :__________	Referred by:			
Physician:	Phone #:	Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____		

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 ______________________

When did this start? ______________ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |——————|——————| 10

2 ______________________

When did this start? ______________ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |——————|——————| 10

3 ______________________

When did this start? ______________ ago

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise / Activity:	better	no change	worse

1 |——————|——————| 10

HEALTH HISTORY

Circle the 🯅 if you have / had the condition and note the year it started.
Circle the 🯅🯅🯅 if there is a family history of the condition.

Condition	YOU	Year	FAMILY
Cancer *type(s)?*	🯅	______	🯅🯅🯅
Diabetes	🯅	______	🯅🯅🯅
Hepatitis	🯅	______	🯅🯅🯅
High Blood Pressure	🯅	______	🯅🯅🯅
Heart Disease	🯅	______	🯅🯅🯅
Stroke	🯅	______	🯅🯅🯅
Seizure Disorder	🯅	______	🯅🯅🯅
Thyroid Disease	🯅	______	🯅🯅🯅
Asthma	🯅	______	🯅🯅🯅
Pacemaker	🯅	______	🯅🯅🯅
Osteoporosis	🯅	______	🯅🯅🯅
Herpes	🯅	______	🯅🯅🯅
AIDS / HIV	🯅	______	🯅🯅🯅
Other STD	🯅	______	🯅🯅🯅
Rheumatic Fever	🯅	______	🯅🯅🯅
Alcoholism	🯅	______	🯅🯅🯅
Allergies *type(s)?*	🯅	______	🯅🯅🯅
Mental Illness	🯅	______	🯅🯅🯅
Kidney Disease	🯅	______	🯅🯅🯅
Anemia	🯅	______	🯅🯅🯅

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea		
Soda		
Tobacco		
Alcohol		
Drugs		

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No

If so, what and how often:

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)

Describe w/ dates:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

Client Contact Information

Please list the names of family members or other persons, if any, whom this office may inform about your health condition and your treatment:

____

____

IN CASE OF EMERGENCY, please list the names of family members or other persons, if any, whom this office may inform about your health condition:

Name ____________________________ Phone # ____________________

Name ____________________________ Phone # ____________________

Please print the address **<u>if other than your home</u>** where you would like any correspondence from this office to be sent:

____

____

Please indicate if you would like all correspondence from this office in a sealed envelope marked "CONFIDENTIAL": YES ______ NO ______

Please provide the telephone number **<u>if other than your home phone</u>** where you would like to receive calls about your health care information:

____

Can this office leave confidential messages regarding appointment days and times on your telephone answering machine or voicemail? YES ______ NO ______

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Rights and have had the opportunity to ask questions about it. All of my questions have been fully answered.

______________________________ _______________
Patient Name (please print) Date Signed

______________________________ _______________
Signature of Patient (or Guardian) Date Signed

______________________________ _______________
Office Signature Date Signed

Informed Consent

I, ______________________________________, voluntarily consent to be treated with acupuncture and other procedures within the scope of practice of acupuncture administered by Elizabeth Isom, M.Ac., A.P., licensed by the state of Florida.

I understand that acupuncture is performed by the insertion of sterile, disposable needles through the skin and/or the application of heat to the skin at certain points on or near the surface of the body. I understand that such treatment is intended to improve body function and to relieve pain. I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, Tui-Na (oriental massage), Zero Balancing (bodywork), Chinese herbal medicine, and nutritional counseling.

I have been informed that although rare, side effects may result. These could include, but are not limited to, temporary pain or discomfort, some local bruising, slight bleeding, fainting, nausea, burns, pneumothorax, spontaneous miscarriage and the temporary aggravation of pre-existing conditions. Bruising is a common side effect of cupping.

Any recommended herbs (which are from plant, animal, and mineral sources) are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify my acupuncturist if I am or become pregnant. Some of the possible side effects of taking Chinese herbs are nausea, gas, stomachache, headache, diarrhea, rashes, and hives. I will immediately notify my acupuncturist of any unpleasant effects associated with the consumption of herbs.

I understand that if my condition worsens, or if it does not improve in the time estimated by my acupuncturist, or if a new condition arises, that I should consult my personal physician.

I accept that No Guarantee is made concerning the results of my treatment and I understand that I am free to discontinue treatment at any time.

I understand that there will be a charge for appointments cancelled with less than 24 hours notice.

I consent to the use and disclosure of my protected health information for treatment, payment, and/or clinic operations. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

I have carefully read and understand all of the foregoing information and am fully aware of what I am signing. I have felt free to ask any questions. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

______________________________________ ____________________

Signature of Patient (or Guardian) Date Signed

______________________________________ ____________________

Office Signature Date Signed