Health History Questionnaire for Patients

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held confidential, unless required by law to release. If you have any questions, please ask. Thank you!

Last Name______________________ First Name______________ MI____
Address:______________________ City______________ State___ Zip______
Cell________________ Home______________ Work______________
Email:______________________ Which contact do you prefer to get appt. reminders and messages on? Cell Email Home Work (circle)
Date of Birth____/____/______ Height______ Weight______ Age______ Sex M F
Primary care physician__________________ Approx. date of last visit__________
Whom may we thank for your referral?______________________
Have you tried acupuncture or Chinese medicine before?______________________

Emergency Contact Information:
First Name:______________________ Last Name______________________
Phone: Cell______________ Home______________ Work______________
Relationship______________________________

List your health complaints in order of priority: | How long since it started:

1.______________________ ______________

2.______________________ ______________

3.______________________ ______________

Have you been given a diagnosis for any of the above problems by your physician and if so what are they?______________________
What kinds of treatment or therapy have you tried?______________________
____

To what extent does problem # 1 affect your daily activities (work, sleep, eating, etc.)?_____
____
What makes problem #1 feel better (heat, ice, rest, exercise, etc.)?______________
____
What makes it worse?______________________________

Acupuncture in Vancouver 13215 SE Mill Plain Blvd C-4 Vancouver, WA, 98684
Phone (360)448-7290 FAX (360)718-2659

MEDICATIONS

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SUPPLEMENTS

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MEDICAL HISTORY

__Allergies
__Hepatitis
__Cancer
__Broken bones
__Surgeries
__Rheumatic fever
__High blood pressure
__Venereal disease
__Head injury
__Metal pins/plates
__Epilepsy
__Thyroid disease
__HIV positive
__Fainting
__Pacemaker or other electrical device
__Diabetes
__Seizures
__Miscarriage
__Hospitalization

FAMILY MEDICAL HISTORY

__Cancer
__Diabetes
__Drug abuse
__Heart disease
__Seizures
__High blood pressure
__Stroke
__Alcoholism
__Other___________________
__Asthma
__Abuse

CURRENT AND FORMER SYMPTOMS

Please X for symptoms you experience now (within the last week or so)

Underline those symptoms you have had in the past (a month to a year ago)

__Allergies
__Arm/shoulder pain
__Asthma
__Constipation
__Cough/sneeze/phlegm
__Eczema/Psoriasis/Rash
__Elbow pain
__Fatigue/tired
__Flatulence/gas
__Frequent colds
__Frontal/sinus headache
__Grief/sadness
__Mucus
__Nasal obstruction/discharge
__Sinusitis
__Sense of smell issues
__Sweating issues
__Weak voice
__Wheezing/SOB
__Sciatica
__Low back pain
__Sore throat in AM
__Ears ring (low pitch)
__Urination problems
__Low will power
__Anger/irritability
__Blurry vision/spots
__Brittle/coarse nails/hair
__Distention/bloating
__Eye/vision trouble
__Headaches
__Hemorrhoids
__Irritable bowel
__Migraines
__Nausea/vomiting
__Stiff neck
__Stiff shoulders
__Tension/cramps
__Mouth/tongue sores
__Palpitations
__Poor circulation
__Restlessness
__Upper back pain
__Abdominal pain
__Aching/heavy limbs
__Belching
__Indigestion/acid reflux
__Difficulty focusing
__Hiccups
__Loose stools
__Muscle weakness
__Worry/overthinking
__Fainting
__DIzziness
__Loss of sleep
__Nervousness
__Weight gain/loss

__Back/Knees weak/pain
__Bladder infect./control
__Brittle bones
__Cold/Hot
__Dark/puffy around eyes
__Depression/fear
__Edema/water retention
__Low sexual energy
__Loss/thinning hair
__Premature grey
__Kidney stones or infection
__Diarrhea

__Ears ring (high pitch)
__Anemia
__Anxiety/dread
__Dream disturbed sleep
__Hearing problems
__Heart problems
__Hot flashes
__Hot painful joints
__Insomnia
__Lack of joy/humor
__Poor appetite
__Gallbladder problems

__Confusion
__Autoimmune disorder
__Difficulty breathing
__Slow/Rapid/Irreg. heart
__Low blood pressure
__Swelling of ankles
__Varicose veins
__Foot problems
__Poor memory
__Hernia
__Excessive hunger
__Hepatitis

MALE:

__Pain associated with genitals
__Premature ejaculation
__Impotence
__Discharges

FEMALE:

__Painful menstrual periods
__Excessive flow
__Irregular cycle
__Cramps or backache
__Miscarriage
__Vaginal discharge
__Vaginal pain
__Breast pain
__Lumps in breast
__Endometriosis
__Ovarian cysts
__Pregnancy complications
__Hot flashes
__Menopausal symptoms
Number of pregnancies____
Number of live births___
Date of last Pap________.......Was it normal Y N
Date of last mammogram_________
Currently using birth control Y N...Type_______________
Are you pregnant Y N?
Trying to get pregnant Y N

LIFESTYLE

Do you smoke Y N
Have history of smoking Y N
Do you follow a regular exercise program Y N
If yes please describe____
What activities/hobbies do you have:____
How much alcohol do you consume a week__________________caffine drinks per day____
How many hours do you watch TV per day___
Do you have one person in your life with whom you may discuss **anything**? Y N
Do you drink at least 32oz of water a day Y N
What concerns you most about your health?____
____
____
Any other information about your health that you feel is important for me to know about:_____
____
____

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AUTHORIZATION

I certify that I have read and understood the above information to the best of my knowledge. I Understand that by withholding information or giving false information may be dangerous to my health. I authorize Acupuncture in Vancouver to release any information to my insurance company and/or attorney which may be necessary to process my claim. I authorize payment of my benefits directly to Acupuncture in Vancouver for services rendered. I understand that I am personally responsible for any non-covered benefits and services and agree to pay them in a timely manner.

____ Date_____/______/__________

Patient signature

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated by Acupuncture in Vancouver Inc.. I understand that Licensed Acupuncturists practicing in Oregon & Washington are not primary care providers. It is recommended that all patients have a primary care provider and that all patients provide medical records from this provider upon request. All information will be held in strictest confidence according to HIPPA regulation. I have read the above_________(initial)

Acupuncture/TDP lamp: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or by both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I have been made aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the treatment at any time. I have read the above__________(initial)

Electro-Acupuncture/Transcutaneous electro stimulation: I understand that I may be asked to have electro stimulation with the acupuncture or transcutaneous electro stimulation (no needles used). I have been made aware that certain adverse effects may result which may include, but are not limited to electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this/these therapies. I have read the above__________(initial)

Massage/Acupressure/Cupping/Qigong (energetic healing): I understand that I may be asked to have massage, acupressure, cupping, or Qigong healing techniques as part of my treatment. I have been made aware that certain side effects may result. These include, but are not limited to: local bruising, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I am free to stop the treatment at any time. I have read the above___________(initial)

Chinese herbs: I understand that substances from the Oriental materia medica may be recommended to me to treat bodily dysfunction or disease or to modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take the substances but must follow the directions for administration and dosage if I do decide to take them. I have been made aware that certain side effects may result.These could include, but are not limited to:changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I will suspend taking them and call Acupuncture in Vancouver Inc. as soon as possible. I have read the above___________(initial)

I have received a copy of Patient Notification of Qualifications and Scope of Practice which is a required form from the State of Washington (last page of forms). The following statement is also required by the State of Washington: I acknowledge that if I may have a potentially serious disorder, Acupuncture in Vancouver requests a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder. I understand the services and techniques the East Asian medicine practitioner is authorized to provide will not resolve my underlying potentially serious disorder(s). I acknowledge that failure to pursue treatment from my primary health care provider may involve risks, nonetheless, I do not wish to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment._________(initial)

____/____________________

Signature of patient or guardian Date

____

Name {Please Print)

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Effective 11-1-2003

Patient Privacy Notice (short form)
HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT
(HIPPA)

Acupuncture in Vancouver Inc. is dedicated to preserve your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Acupuncture in Vancouver Inc.'s duties with respect to your protected health information.

Acupuncture in Vancouver Inc. may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills, or to conduct health care operations.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information including your demographic information, collected by us, or other health care providers, a health care clearinghouse, or an employer. This PHI relates to your past, present, or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of your disclosures of your medical information, request that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have violated. *All requests and complaints must be made in writing.*

We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under the law. You have the right to receive a copy of your most current NOTICE in effect. Please ask and we will provide you with a copy.

We may revise our NOTICE from time to time. The effective date at the top right hand side of this page indicates the date of the most current NOTICE in effect. If you have any questions please contact Acupuncture in Vancouver Inc. at (360)885-1767.

I have received a short form of the patient privacy policy. I have read and understand my rights contained within this form.

______________________________ ____________________

signature date

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