CONFIDENTIAL

Health History Questionnaire

Please take the time to fill out this questionnaire completely and carefully to help us provide you with a complete health evaluation. We realize that some questions may seem irrelevant to your main problem, but they are significant in helping us to make an accurate diagnosis and formulate an appropriate treatment plan. All your answers are absolutely confidential. If you have any questions, please ask. Thank you.
If you need more room, please use the other side of these sheets.

Patient Name _____ Date _____

Street _____ Date of Birth _____ Age _____

City/State/Zip _____ Occupation _____

Phone: Home _____ Cell _____ Work _____
(please circle which number you would prefer we contact you)

Marital Status _____ Height _____ Weight _____ Email _____

Primary Physician _____ Physician's Phone _____

Emergency Contact _____ Phone _____ Referred by _____

Main Complaint (symptoms, diagnosis, duration, etc.)

Have you received acupuncture or Oriental medicine before? yes / no

What is your main complaint?

When did this problem first begin? How often does this bother you?

Severity of the problem on a scale of 0-10 (0 = best; 10 = worst)
When problem is at its best: /10 When problem is at its worst: /10 Today: /10

If there is pain involved, what is the quality of the pain? (Circle all that apply)

Dull Achy Burning Sharp Stabbing Cold Numb Tingling Throbbing Other _____

What makes the problem feel better? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Movement Sitting Lying Massage/Pressure Stress

Other _____

What makes the problem feel worse? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Movement Sitting Lying Massage/Pressure Stress

Other _____

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

Have you been given a diagnosis for this problem? yes / no If so, what?

What kinds of treatment have you tried?

Significant Trauma (physical or emotional)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise
Days per week Length of workout Type of Activity

Diet
Meals per day Snacks Caffeinated Drinks Alcohol per week

Personal History Please check any conditions or symptoms you have now or have had in the past.

- ☐Arthritis
- ☐High/Low Blood Pressure
- ☐Cancer
- ☐Ulcer
- ☐Chronic Fatigue
- ☐Alcoholism
- ☐Gastritis/Pancreatitis
- ☐Bleeding Tendency
- ☐Meningitis
- ☐Liver/Gall Bladder Disease
- ☐Hypo/Hyperglycemia
- ☐Diabetes
- ☐Seizures
- ☐Anemia
- ☐Lyme Disease
- ☐Asthma
- ☐Migraines
- ☐Hepatitis
- ☐Stroke
- ☐Kidney Disease
- ☐Food Allergies/Intolerance
- ☐Hepatitis
- ☐Thyroid Imbalance
- ☐Chronic Pain Condition
- ☐Infertility
- ☐Nervous Disorders
- ☐HIV/AIDS
- ☐Heart Disease
- ☐Elevated Blood Cholesterol
- ☐Diverticulitis/IBS
- ☐Raynaud's Disease
- ☐Respiratory Allergies
- ☐Impotence
- ☐Emphysema
- ☐STD (which? _____)
- ☐Syphilis

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- ☐Diabetes ___
- ☐High Blood Pressure ___
- ☐Seizures ___
- ☐Allergies ___
- ☐Heart Disease ___
- ☐Cancer ___
- ☐Stroke ___
- ☐Asthma ___
- ☐Other_____

Please **check** the box if you have had any of these items listed below in the last year
Please **underline** the symptom if you had this in the past but do not any longer.

General

- ☐Poor Appetite
- ☐Chills
- ☐Cravings
- ☐Bleed/Bruise easily
- ☐Muscle weakness/fatigue
- ☐Poor Sleeping
- ☐Night Sweats
- ☐Localized Weakness
- ☐Weight loss/gain
- ☐Sudden energy drop
- ☐Fatigue
- ☐Sweats Easily
- ☐Poor Balance
- ☐Peculiar tastes/smells
- ☐Strong thirst (hot or cold drinks)
- ☐Fevers
- ☐Tremors
- ☐Change in appetite
- ☐Dental/gum problems

Skin and Hair

- ☐Rashes
- ☐Eczema/Psoriasis
- ☐Skin discoloration
- ☐Dermatitis
- ☐Ulcerations
- ☐Dandruff
- ☐Acne
- ☐Warts
- ☐Hives/Allergic Dermatitis
- ☐Loss of hair
- ☐Change in skin/hair texture
- ☐Fungal Infection
- ☐Itching
- ☐Recent moles
- ☐Face flushing
- ☐Weak or ridged

Head, Eyes, Ears, Nose and Throat

- ☐Dizziness
- ☐Eye Strain
- ☐Color Blindness
- ☐Ringing in ears
- ☐Nose bleeds
- ☐Sores on lips/tongue
- ☐Difficulty swallowing
- ☐Eye pain
- ☐Cataracts
- ☐Poor hearing
- ☐Recurrent sore throats/colds
- ☐Dental problems
- ☐Migraines
- ☐Poor vision
- ☐Blurred vision
- ☐Spots in front of eyes
- ☐Grinding teeth
- ☐Jaw clicks/locks
- ☐Glasses
- ☐Night Blindness
- ☐Earaches
- ☐Sinus problems
- ☐Facial pain
- ☐Headaches

Cardiovascular

- ☐Chest pain or pressure
- ☐Cold hands/feet
- ☐Shortness of breath
- ☐Low blood pressure
- ☐Irregular heart beat
- ☐Swelling of hands/feet
- ☐Varicose/spider veins
- ☐High blood pressure
- ☐Palpitations at rest
- ☐Blood clots
- ☐Pressure in chest
- ☐Spontaneous sweating
- ☐Fainting
- ☐Phlebitis
- ☐Dizziness
- ☐Raynaud's Disease

Respiratory

☐Cough/Wheezing ☐Coughing blood ☐Asthma ☐Bronchitis
☐Pneumonia ☐Pain with deep inhalation ☐Tight sensation in chest ☐Difficult inhale/exhale
☐Difficulty breathing when lying down ☐Production of phlegm… what color? _____

Gastrointestinal

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Gas ☐Belching ☐Black stools ☐Blood in stool
☐Indigestion ☐Bad breath ☐Rectal pain ☐Hemorrhoids
☐Bloating/Edema ☐Chronic laxative use ☐Loose stools (>2 per day) ☐Abdominal pain/cramps
☐Changes in appetite ☐Acid reflux/GERD ☐Hernia ☐Poor appetite
☐Excessive appetite ☐Significant thirst (hot or cold drinks) ☐IBS/Crohn's Disease

Genito-Urinary

☐Pain on urination ☐Frequent urination ☐Blood in urine ☐Urgent urination
☐Unable to hold urine ☐Kidney stones ☐Scanty flow ☐Copious flow
☐Impotence ☐Sores on genitals ☐Urinary tract infection ☐Burning urination
☐Premature ejaculation ☐Decreased libido ☐Prostatitis ☐Dribbling after urination
☐Nocturnal emission ☐Pain in testicles ☐Herpes ☐Infections
☐Night urination… What time?_____ How often?_____ ☐Excessive libido ☐Low libido

Gynecological/Reproductive (Women Only)

☐Difficult/Painful intercourse ☐Ovarian cysts ☐Age of first menses_____
☐Vaginal dryness/itching ☐Endometriosis ☐Date of last menses_____
☐Vaginal sores ☐Uterine Fibroids ☐Date of last PAP/Pelvic_____
☐Vaginal discharge(color/amount/odor_____) ☐Painful menstruation
☐Polycystic Ovarian Syndrome ☐Fibrocystic breast tissue ☐Irregular menstruation
☐Infertility ☐PMS
☐Number of pregnancies____ ☐Number of live births_____ ☐Number of ectopic pregnancies_____
☐Number of miscarriages_____ ☐Sexually transmittted disease

Do you practice birth control?_____What type?_____ How long?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (describe size: large, small, black, purple, red, other)							
Vomiting/nausesa (check if yes)							
PMS (what symptoms, duration of symptoms)							
Other							

Men only:

☐Swollen testes ☐Premature Ejaculation ☐Feeling of coldness or numbness in external genitalia
☐Testicular pain ☐Impotence ☐Difficult urination (weak stream or dribbling)
☐Enlarged prostate ☐Cancer (prostate or testicular) ☐Sexually transmitted disease

Musculoskeletal

☐Neck pain ☐Shoulder pain ☐Hand/wrist pain ☐Carpal Tunnel
☐Knee pain ☐Sprains/Strains ☐Sciatica ☐Foot/ankle pain
☐Hip pain ☐Muscle pain ☐Muscle weakness ☐Tendonitis
☐Back pain Low___ Middle___ Upper___ ☐Bursitis ☐Rotator Cuff
☐Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

☐Seizures ☐Loss of balance ☐Vertigo/Dizziness ☐Areas of numbness
☐Lack of coordination ☐Poor memory ☐Concussion ☐Depression
☐Anxiety/Panic attacks ☐Bad temper/irritable ☐Easily susceptible to stress ☐Seasonal Affective Disorder
☐Nervousness ☐ADD/ADHD ☐Manic Depression
☐Other _____

Have you ever been treated for emotional problems? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No
Have you ever been treated for substance abuse? ☐Yes ☐No

Comments Please inform me of any other problems you would like to discuss.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient Signature: _____ **Date:** _____

Informed Consent for Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below named licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, intradermal needles, ear pressballs, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese herbal medicine, and nutritional counseling.

Heat therapy using moxa (Artemisia), a dried herb, that is lit and burned on the needles or on the skin, or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of a burn ointment which will conduct the heat and prevent burns. On rare occasions, a blister may occur. The practitioner will explain the procedure as it is done and the patient is asked to let them know the status of the heat at all times.

Application of stainless steel pressballs onto various points in the ear. These are applied with adhesive tape and may be left in the ear for up to 7 days or as suggested by the practitioner.

Electrical stimulation of the needles using a battery operated machine to create a current through the needles may be used. This creates a constant vibration through the needles that would be adjusted according to patient comfort.

Cupping is a technique used to resolve muscle tightness or help clear the lungs in respiratory conditions. A glass cup is applied to the skin and then a pump suctions the skin and muscle into the cup. The amount of suction is adjusted according to patient comfort. Depending on how tight the muscles are and the amount of restricted blood flow, the cups can leave a reddish or purplish mark on the skin that clears up in a few days, similar to a bruise.

Gua sha is a technique similar to cupping where a flat tool is used to scrape the skin to relieve muscle tension and congested blood flow. It leaves a similar bruise-like "rash" that lasts for a few days.

Herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. I also understand that any evaluation given to me in no way replaces western (allopathic) medical evaluation diagnosis and treatment. _____

initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____

initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation.

_____

initials

Patient's Printed Name | Patient's Signature | Date Signed

Are you Pregnant?

CONFIDENTIAL

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation and will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____ _____

Signature of Patient or Legal Representative Date

OFFICE POLICIES

Turning Leaf Acupuncture

The following policies and procedures are in place to insure that your care is as efficient and effective as possible.

APPOINTMENTS: We make every effort to remain on schedule. We believe that respect between patient and practitioner includes respect for each other's time. If you are late, your remaining time may not be sufficient for a full treatment, so treatment will be tailored to fit within the time available or you have the option to reschedule. Occasionally, there are situations that arise that cause us to run over. If we are late, it will not effect the time of your treatment. If you have time constraints, please let us know.

It is recommended that you wear loose fitting clothing to appointments for your comfort and to make acupuncture points accessible. You may bring a pair of shorts or loose undershirt to change into.

CANCELLATION/LATE ARRIVAL POLICY:
Your appointment time is reserved solely for you, consequently, a **24-hour cancellation policy** applies to your appointment. You may leave a message on our voice mail system at any time of day to cancel your appointment, and it will date and time stamp your call. If you are unable to cancel your appointment 24-hours in advance, a cancellation charge for the **full treatment fee** will apply. (If you must cancel due to an emergency, please explain to the clinic.)
Please do your best to arrive on time for your appointment. If you find that you are running late, please call the clinic to let your practitioner know and we will do our best to accommodate you, depending on schedule availability.

CONFIDENTIALITY: All information gathered within the context of treatment is held in strict confidence and will NOT be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

PAYMENT: Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash, check, credit cards and flex spend cards. Acupuncture is covered by worker's compensation, auto insurance and a number of private insurance policies. Should you have coverage, we can discuss the procedure for billing and payment.

I have read and agree to the policies outlined above.

Signature of Patient: X _____ Date: _____

PROTECTING YOUR CONFIDENTIAL HEALTH INFORMATION

Turning Leaf Acupuncture

Your health information in this office will not be shared with anyone who does not require it. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payment and conducting health care operations. Your personal information will not be used for other purposes unless we have asked for and have been given your permission.

Your health information will be used:

1. To provide treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the practitioner and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories or other health care personnel providing your treatment.

2. To obtain payment: We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail.

3. Inspect and copy your health information: You have the right to read, review and copy your health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you to duplicate and assemble your copy.

4. Amend your health information: You have the right to ask us to update or modify your records if you believe they are incorrect or incomplete. We will accommodate you as long as our office maintains this information. Please make your request in writing and inform us of the reason for the change in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.

5. Documentation of your health information: You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or health care operations. We will be able to provide you a copy of your health information upon request, as long as it is not 7 years or older.

6. Request a paper copy of this notice: You have the right to obtain a copy of this privacy notice policy for your records.

I acknowledge that I have read and agree to the above:

Signature of Patient: X _____ Date _____

Printed Name _____

NOTICE OF PRIVACY PRACTICES

Turning Leaf Acupuncture

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We may use and disclose health information about you for treatment, payment, and healthcare operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Healthcare Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

PATIENT RIGHTS
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

Access: You have the right to inspect and copy your protected health information.

Restriction: You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

Alternative Communication: You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Disclosure Accounting: You have the right to receive an accounting of disclosures of protected health information.

Electronic Notice: If you receive this Notice on our website or by electronic mail, you are entitled to obtain a paper copy of this Notice upon request.

Questions and Complaints

If you want more information about our privacy practices, please contact us.

You have recourse if you feel that we have violated your privacy rights. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.