AcuTherapy Health History Questionnaire

(All documentation and conversation is protected under the HIPAA law and kept completely confidential.)

Name: _____ Birth Date: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Business Phone: _____ E-mail: _____

Occupation: _____ Referred by: _____

Emergency Contact/#: _____

Physician: _____ Physician Phone # _____

It is ok to contact me via e-mail for promotions and updates about the practice: Y / N

Have you ever had Acupuncture? Y / N **Chinese Herbal Medicine?** Y / N

What do you feel is the stress level in your life? (low) 1.....2.....3.....4.....5 (average) 6.....7.....8.....9.....10 (Extreme)

Please circle any painful or tense areas as well as regions that you tend to hold your stress:

Head/face Low back Shoulders Neck Abdomen

Legs/feet Arms/hands Mid-back Other (please describe) _____

Describe your exercise habits: _____

Do you wear contact lenses? Y / N If female, are you pregnant? Y / N How far along? _____

WHAT IS YOUR CHIEF COMPLAINT? _____

_____

_____

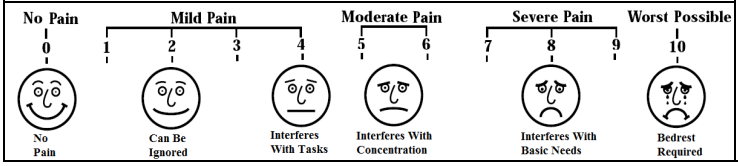
_____

_____

How long has this been going on? _____

Are you in Pain? Y / N Please describe the location:

Please **circle** the severity of the pain (see below):



PLEASE TRY TO DESCRIBE THE TYPE AND QUALITY OF THE PAIN (please circle):

Intense, sharp, hot, dull, cold, sensitive, tender, itchy, shooting, numb, radiating, electrical, tingling, cramping, throbbing, aching, heavy, unpleasant, deep, surface, 'comes and goes', constant, etc.

Have you been given a diagnosis for this problem? If so, what and by whom? _____

_____

Are you currently under a Physician's care? Y / N For what condition(s)?_____

_____

_____

What other kinds of treatment have you tried for this problem? □ Western Medicine □ Acupuncture □ Herbs

□ Massage □ Physical Therapy □ Chiropractor □ Reiki □ Homeopathy □ Other: _____

SECONDARY COMPLAINTS? _____

_____

_____

_____

_____

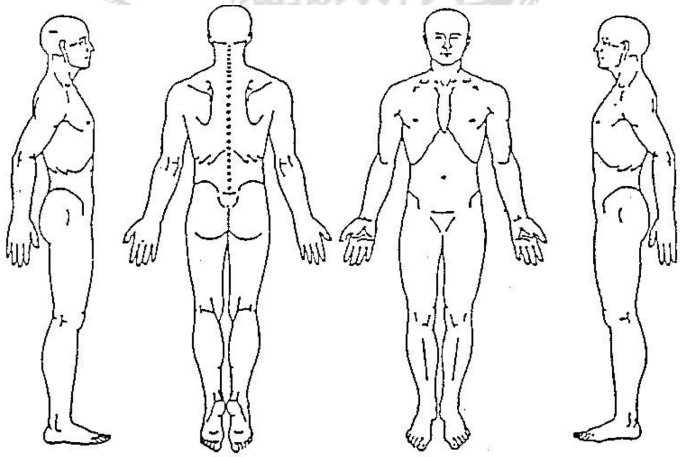
Please list all CURRENT MEDICATIONS /vitamins/supplements/herbs that you are taking and for what conditions? (Or attach a list…)

Medication	Dosage	Reason for taking

HOSPITALIZATIONS/SURGERIES/SIGNIFICANT TRAUMA (i.e. auto accidents, falls, etc.)

Date	Description of Event

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following within the last three months:

Symptom:	Yes	No	Location: Please describe
1. Any areas of infection?			
2. Any areas of swelling, edema or tendency to swell?			
3. Any areas of numbness or abnormal sensation?			

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Milk ☐ Eggs ☐ Peanuts ☐ Pet Dander ☐ Shellfish (crab, lobster, shrimp, etc.)

☐ Wheat ☐ Soy ☐ Ragweed ☐ Mold ☐ Tree Nuts (almonds, walnuts, etc.)

Have you ever had any allergy not listed above? If so, please explain: _____

_____

_____

DIET

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)? □ No □ Yes

If Yes, what type of diet? _____

DESCRIBE YOUR AVERAGE DAILY FOOD INTAKE:

Morning: _____

Afternoon: _____

Evening: _____

Food Cravings? _____ Food Intolerances? _____

How many cups of caffeinated coffee, tea, or cola do you drink per week? _____

How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per week? _____

Do you smoke? □ No □ Yes If Yes, how many cigarettes or cigars per day? _____

Please describe any use of drugs for non-medical purposes: _____

FAMILY MEDICAL HISTORY: (check all that apply)

□ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures

□ Thyroid □ Hepatitis □ Rheumatic Fever □ Thyroid disease □ Venereal Disease □ Other: _____

GENERAL

□ Fevers □ Chills □ Fatigue □ Sweat Easily □ Poor Sleeping □ Night Sweats □ Weight Loss □ Cravings

□ Weight Gain □ Change in appetite Strong thirst for: □ Hot Drinks □ Cold Drinks □ Peculiar Tastes/Smells

□ Bleed/Bruise Easily □ Sudden Energy Drop, if so what time of day? _____

SKIN & HAIR

□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Psoriasis □ Dandruff □ Hair Loss □ Recent Moles

□ Hives/Dermatitis □ Acne □ Change in hair or skin texture □ Hirsutism (excess body hair) □ Face Flushing

□ Fungal Infection □ Skin Discoloration □ Warts □ Weak/Ridged Nails □ Cancer of the Skin

□ Any other skin or hair problems? _____

HEAD, EYES, EARS, NOSE & THROAT

□ Dizziness □ Concussions □ Glasses □ Spots in front of eyes □ Eye Strain □ Eye Pain □ Poor Vision

□ Night Blindness □ Color Blindness □ Cataracts □ Glaucoma □ Blurry Vision □ Earaches

□ Ringing in Ears □ Poor Hearing □ Clogged/Popping □ Ear Pain □ Sinus Problems □ Nose Bleeds

□ Recurrent Sore Throats/Colds □ Difficulty Swallowing □ Teeth Problems □ Grinding Teeth □ Clenching Jaw

□ Bleeding Gums □ Facial Pain □ Sores on Lips/Tongue □ Jaw Clicks/Locks □ Sinusitis □ Post Nasal Drip

□ Whiplash □ Neck Pain □ Cancer (please circle) of the Sinus, Throat, Trachea, Esophagus

□ Headaches/Migraines, where and when? _____

CARDIOVASCULAR

□ Heart Disease □ High Blood Pressure □ Low Blood Pressure □ Chest Pain/Pressure □ Pacemaker

□ Palpitations □ Palpitations at rest □ Dizziness □ Fainting □ Difficulty Breathing □ Shortness of Breath

□ Spontaneous Sweating □ Blood Clots □ Phlebitis □ Cold Hands or Feet □ Swelling of Hands/Feet

□ Irregular Heart Beat □ Varicose or Spider Veins □ Diabetes □ Hepatitis □ Cancer of the Blood/Related Tissues

□ Other Heart/Blood Vessel Problems? _____

RESPIRATORY

□ Asthma □ Bronchitis □ Chest Tightness □ Cough/Wheezing □ Coughing blood □ Pneumonia

□ Difficulty Inhale/Exhale □ Difficulty Breathing when Lying Down □ Pain with Deep Inhalation

□ Phlegm Production, what color? _____ When? _____ □ Cancer of the Lungs

GASTROINTESTINAL

□ Poor Appetite □ Excessive Appetite □ Indigestion □ Bloating/Edema □ Acid Reflux/GERD □ Bad Breath

□ Slow Digestion □ Food Stagnation □ Abdominal pain/Cramps □ Gas □ Belching □ Nausea □ Vomiting

□ Diarrhea □ Constipation □ Chronic Laxative Use □ Loose Stools □ IBS/Diverticulitis □ Crohn's Disease

□ Colitis □ Black stools □ Blood in Stools □ Rectal Pain □ Hemorrhoids □ Ulcers □ Hernia

□ Cancer (please circle) of the Liver, Gallbladder, Small/Large Intestines, Colon/Rectal, other: _____

□ Any other problem with Stomach or Intestines _____

MEN'S HEALTH

□ Impotence □ Erectile Dysfunction □ Low Libido □ Excess Libido □ Premature Ejaculation □ Discharge

□ Nocturnal Emmission □ Prostatitis □ Enlarged Prostate □ Frequent Urination □ Incontinence □ STDs

□ HIV+/AIDS □ Genital/Testicular Pain/Cancer □ Other _____

GENITO-URINARY

□ Frequent Urination □ Blood in Urine □ Painful Urination □ Urgency to Urinate □ Unable to hold urine

□ Burning Urination □ Kidney Stones □ Copious Flow □ Dribbling □ Decrease in flow □ Bladder Infections

□ Urinary Tract Infection □ Impotence □ Herpes □ Sores on Genitals □ Cancer (please circle) of the Bladder, Kidney

□ Any particular color to your urine? _____ □ Nighttime Urination How many times a night? _____

□ Any other problems with your genital or urinary systems?_____

GYNECOLOGY

Age at first menses: _____ Time period between menses: _____ Duration of menses: _____

Do you practice birth control? Y / N If yes, what type? _____ How long? _____

Are you pregnant? Y / N Is it possible that you are pregnant? Y / N

Number of pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions _____

Premature births: _____ Last PAP: _____ □ Irregular Periods □ Painful Periods

□ Clots □ Breast Lumps □ Vaginal Sores □ Vaginal Discharge □ Vaginal Dryness □ Endometriosis

□ Uterine Fibroids □ Polycystic Ovarian Disease □ Fibrocystic Breast Tissue □ Low Libido □ Excess Libido

□ Unusual Character of Blood (heavy, scanty) _____ □ HIV+/AIDS □ STDs

Are you Perimenopausal? Y / N Symptoms_____

Are you Menopausal? Y / N Symptoms_____

MUSCULOSKELETAL

□ Neck Pain □ Shoulder Pain □ Rotator Cuff □ Hand/Wrist Pain □ Carpal Tunnel □ Knee Pain □ Hip pain

□ Sciatica □ Bursitis □ Back pain: Low__ Middle___ Upper__ □ Foot/Ankle pain □ Muscle Pain/Spasms

□ Muscle Weakness □ Sprains/strains □ Tendonitis □ Soreness/weakness of lower body

□ Cancer of the Bones/Marrow □ Arthritis (indicate location/s): _____

NEUROLOGICAL & PSYCHOLOGICAL

□ Seizures □ Dizziness/Vertigo □ Loss of Balance □ Areas of Numbness □ Poor Memory □ Concussion

□ Poor Coordination □ Difficulty concentrating □ Irritable □ Anxiety/Panic Attacks □ Depression

□ Easily Susceptible to Stress □ Nervousness □ ADD/ADHD/OCD □ Manic Depression □ Lack of Willpower

□ Unmotivated □ Fear □ Cancer of the Brain □ Difficulty falling asleep □ Restless □ Disturbed Sleep

□ Dreams □ Waking up at am/pm_____Do you take sleeping pills? What kind?_____

Considered or attempted suicide? Y / N Do you take antidepressants? What kind?_____

Have you ever been treated for emotional problems? Y / N Have you ever been treated for substance abuse? Y / N

Any other neurological or psychological problems? _____

I verify that all information provided in this Health History Questionnaire is correct and current to the best of my knowledge. I understand that any information provided by the practitioner is for educational purposes only and is not prescriptive or diagnostic in nature, unless specific to a Differential Diagnosis in Traditional Chinese Medicine for Acupuncture and Chinese Herbal Medicine.

Signature: _____ Date: _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

Informed-Consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent should not be considered all-inclusive in defining other methods of care and risks encountered. Standards of acupuncture are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the information carefully and have all of your questions answered before signing the Consent for Acupuncture Treatment.

I, _____, hereby authorize Wyatt LaCoss, Lic.Ac., Licensed Acupuncturist, to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following: ***(Please check any boxes you give your consent for…)***

- □ Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.

- □ Heat treatments using Artemesia vulgaris (moxibustion, "moxa") or a conventional heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle or on top of a barrier such as salt or a slice of ginger. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.

- □ A massage technique called "gwa sha". This treatment leaves redness on the skin that can last for 1-5 days. Slight bruising and tenderness may persist after the treatment.

- □ Cupping may be used to promote the circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting for 1-5 days.

- □ Electrical stimulation of the needles may be used which produces a vibration or tapping sensation or ion pumping cords may be attached to the needles.

- □ Shiraku, alone or in conjunction with cupping, may be used to improve circulation in specific meridians With the use of lancets gently inserted into the skin, a few drops of blood are expressed from the acupoint to relieve stagnation of the channel.

- □ Chinese Herbal Medicine, in various forms such as pills, capsules, extract powders, and raw herbs, to be administered orally and/or topically. Some patients may experience side effects from their particular prescription. Please inform your practitioner of any adverse effects you may be experiencing.

An acupuncture treatment involves the insertion of acupuncture needles into the body. In Oriental Medicine, the meridian pathways of Qi flow throughout the entire body from the soles of the feet up to the face and head; consequently an acupuncture treatment addresses the entire body constitutionally. An acupuncture treatment involves the patient in an organic, gradual process that is customized for each individual. This treatment incorporates the entire body and constitutional issues of health. Every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture treatment. Although the majority of patients do not experience the following complications, you should make sure you understand the risks, potential complications, and consequences of acupuncture…

Bleeding/Bruising: It is possible that you may have bleeding. Should post-acupuncture bleeding occur, it would usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise or hematoma, which will resolve itself, especially after a cupping technique, but will not be painful and should disappear within a few days.

Infection: It is ***VERY UNUSUAL*** after acupuncture as I maintain a very clean/sterile environment. Should an infection occur, additional treatment, including antibiotics, may be necessary.

Damage to Deeper Structures: ***RARELY*** are deeper structures such as blood vessels and muscles damaged during the course of an acupuncture treatment. If this does occur, the injury may be temporary or permanent.

Needle Shock: This is a ***RARE*** complication of acupuncture: a cardio-vascular collapse including a sudden drop of blood pressure with fainting.

Allergic Reactions: In ***RARE*** cases, local allergies to topical preparations have been reported. Systemic reactions, which are more serious, may occur to herbs used. Allergic reactions may require additional treatment. Please inform your practitioner if you have a metal allergy and please indicate all food allergies on this form.

Unsatisfactory Result: There is a possibility of a poor result from acupuncture, and you may be disappointed with the results. If at any point you are not satisfied, please speak with your practitioner for further understanding of creating balance within the scope of this natural medicine.

I recognize that during the course of acupuncture, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above Acupuncturist to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my Acupuncturist at the time the procedure is begun.

I acknowledge that no guarantee has been given by anyone as to the results that may be obtained and I have been informed that I have the right to refuse any form of treatment as outlined above.

I hereby give my consent to receive Acupuncture and/or Chinese Herbal Medicine from the practitioners affiliated with AcuTherapy, LLC and will not hold them responsible for any personal injury or loss of property.

Patient (or Authorized Guardian)	Signature of Practitioner
Patient Signature (or Authorized Guardian)	Date

NOTICE OF PRIVACY PRACTICES
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully…

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care 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. An example would be an internal quality assessment review.

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.

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:

- 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 a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the *Notice of Privacy Practices* currently in effect. We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (CONT'D)

You have recourse if you feel that your privacy protections have been violated. 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.

Please contact us for more information about HIPAA or to file a complaint:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 (or 1-877-696-6775)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (**HIPAA**), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

HIPAA CONSENT

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

CLINIC POLICIES

GENERAL POLICIES

- **Payment for each appointment is required and expected at the time of your visit. If payment is forgotten, receipt of payment is required within four days. We do accept credit cards, however there will be the processing fee of 2.75%.**
- All contact information will be kept confidential and may only be used for contact purposes, unless expressed consent is given.
- Returned checks will incur a $35.00 fee, due and payable immediately along with the fee of the original service.
- Chinese Herbal Prescriptions must be paid for in full when picking up herbs. This cost is separate from your appointment fee. Chinese Herbal Prescriptions and Patents are non-refundable.
- As Chinese raw and powdered herbs are mixed specifically for the patient, the patient is responsible for the cost of all prescriptions filled in the patient's name, utilized or not. Prescriptions need to be picked up within two weeks. Prescriptions not picked up after two weeks will be charged to the credit card associated with the patient's account.
- As a courtesy to others in the office receiving therapy, please silence your cellphones. If you must keep the phone on because of medical reasons or for the need to communicate with children, an exception can be made.

CANCELATION POLICY

We take your health seriously and make every effort to provide the very best healthcare. To ensure that we can continue to see all our patients within a reasonable time period, AcuTherapy, LLC has the following cancellation policy for all providers:

- 24-hour notice is required to cancel an appointment.
- Individuals who do not call to notify the clinic within the required 24 hours will be responsible for the full appointment fee. The fee may be charged to the credit card associated with the patient's account or billed directly to the patient payable within 30 days of the mailing of the invoice.
- It is important to keep in mind that insurance companies do NOT pay for missed appointments. In this case, it is the patient's sole responsibility to pay for missed/cancelled appointments under these guidelines.

LATE POLICY

- The current clinic policy for late patients is 30 minutes. The decision to accommodate a patient who is less than 30 minutes late is at the discretion of the practitioner. If a patient is late and treated, the appointment will be shortened and end according to the original start time of the appointment, or according to an agreement between the practitioner and the patient.
- Late patients will be charged the full fee regardless of the length of the visit.

REQUEST FOR MEDICAL RECORDS

Our office follows HIPAA regulations for processing medical records release at all times. A signature form is required to process any/all request for the release of records. Records being forwarded to a medical facility for concurrent medical care are not assessed a fee. Personal request for copies of medical records are assessed a fee of $0.25 per page or $30.00 for a complete chart. Records will be sent by USPS priority mail to the home address on record, unless otherwise requested, and postage fees are applied. Patient is responsible for total fees prior to processing records. Records are processed weekly, however additional time may be required if the records are archived or abnormally large. Policies and procedures may be altered at any time and will be posted within the office as notification.

If you fail to adhere to these requirements, we reserve the right to deny any requests for future appointments until outstanding balances with your account have been paid. I have read and understood the terms for the clinic's General, Cancelation and Late Appointment Policies and agree to follow its guidelines.

Signature: _____ Date: _____

Patient or Authorized Guardian