HEALTH HISTORY QUESTIONNAIRE

ACUPUNCTURE & CHINESE MEDICAL CENTER, LLC.
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Important: Complete this document as thoroughly as possible.
Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

I. General Patient Information

Name: _____ Gender: ❍ M ❍ F Height: ____'____" Weight: _____lbs.

Home phone: (_____)_____ Email:_____

Address: _____ City, State, Zip Code: _____

Social Security Number: _____-_____-_____

Date of Birth: ____/____/____ Age: _____ Guardian (if under 18): _____

Occupation:_____ Employer:_____

Work phone: _____ Cell: _____

Emergency contact: _____ Emergency phone : _____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:	How long	How often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

How do these conditions impair your daily activities?_____

II. Patient Medical History

Are you currently taking any physician prescribed medications? If yes, please list below.

Medication	Prescribed for:	Medication	Prescribed for:

How was your childhood health?_____

Recent tests: (please indicate test results and date below)

❍ Physical ❍ Cholesterol ❍ Prostate ❍ Blood (which?) _____
❍ HIV/STD ❍ Pap smear ❑ Mammography ❍ Other:_____

Test Results and Date:_____

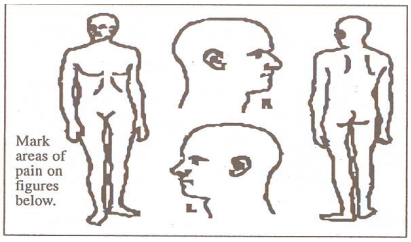
Check any you have had in the past:

❍Diabetes	❍Thyroid disorder	❍Mumps	❍Meningitis	❍Paralysis
❍Allergies	❍Asthma	❍Bleeding tendency	❍HIV	❍Cancer
❍Glaucoma	❍Pneumonia		❍Polio	❍Migraines
❍Rheumatic Fever	❍Tuberculosis	❍Syphilis	❍Mononucleosis	❍High blood pressure
❍Heart Disease	❍Emphysema	❍Measles	❍Epilepsy	
❍CVA (stroke)	❍Jaundice	❍Chicken pox	❍High fever	
❍Vein condition	❍Gonorrhea	❍Nervous disorder	❍Multiple Sclerosis	

Surgeries:_____

III. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):



Is the pain?
❍ Sharp ❍ Burning ❍ Aching ❍ Cramping ❍ Dull
❍ Moving ❍ Fixed ❍ Other:_____

Do the following lessen the pain?
❍ Pressure ❍ Cold ❍ Heat ❍ Exercise ❍ Other:_____

Do the following worsen the pain?
❍ Pressure ❍ Cold ❍ Exercise ❍ Heat ❍ Other:_____

Do you internally feel warm or cold most of the time?
❍ Cold ❍ Warm

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function in Tradition Chinese Medicine):

Spleen/ Stomach Meridian/ Organ Network

- ❍ Low appetite
- ❍ Acid reflex / heartburn
- ❍ Mouth sores
- ❍ Abrupt weight gain
- ❍ Abrupt weight loss
- ❍ Fatigue after eating
- ❍ Easily bruised
- ❍ Burning after eating
- ❍ Diabetes
- ❍ Weak muscles
- ❍ Hemorrhoids
- ❍ Over-thinking
- ❍ Worry
- ❍ Bad breath
- ❍ Stomach pain
- ❍ Nausea
- ❍ Vomiting
- ❍ Passing gas
- ❍ Prolapsed organs(diagnosed)
- ❍ Abdominal bloating
- ❍ Belching
- ❍ Hiccups
- ❍ Stomach gurgling noise
- ❍ Chronic disease
- ❍ Loose stools
- ❍ Difficulty focusing
- ❍ Gastritis
- ❍ Headaches
- ❍ Indigestion
- ❍ Ulcer (diagnosed)
- ❍ Cancer
- ❍ Irritable bowel
- ❍ Excessive appetite
- ❍ Aching heavy limbs
- ❍ Poor memory

Heart /small intestine Meridian/ Organ Network

- ❍ Mental confusion
- ❍ Restlessness
- ❍ Sores on tip of tongue
- ❍ Drink coffee #__cup/day
- ❍ Abdominal pain
- ❍ Phobias
- ❍ Muscle tone
- ❍ Inflammatory conditions
- ❍ Insomnia
- ❍ Tongue/speech problem
- ❍ Urinary problem
- ❍ Shortness of breath
- ❍ Palpitations
- ❍ Dizziness
- ❍ Wake unrefreshed
- ❍ Dream disturbed sleep
- ❍ Hot flashes
- ❍ Spontaneous sweating
- ❍ Nightmares
- ❍ Cold limbs
- ❍ Lupus
- ❍ Poor circulation
- ❍ Psychosis
- ❍ Cardiac pain
- ❍ Chest to shoulder pain
- ❍ Vertigo
- ❍ Difficulty falling asleep
- ❍ Pain down the arms
- ❍ Anemia
- ❍ Disturbed thinking
- ❍ Heart problem
- ❍ Hot painful joint
- ❍ Rheumatoid arthritis
- ❍ Sleep problem
- ❍ Epilepsy
- ❍ Anxiety
- ❍ Hearing problem
- ❍ Upper back pain
- ❍ Bitter taste in mouth

Liver / Gall Bladder Meridian / Organ Network

- ❍ Chest pain
- ❍ Tightness in chest
- ❍ Anger easily
- ❍ Frustration
- ❍ Depression
- ❍ Irritability
- ❍ Skin rashes
- ❍ Tingling sensation
- ❍ Numbness
- ❍ Muscle spasms
- ❍ Brittle/coarse nails or hair
- ❍ Sensitivity to greasy foods
- ❍ Repetitive strain disorder (please List)_____
- ❍ Muscle twitching
- ❍ Hiccups
- ❍ Gall stones history
- ❍ PMS symptoms
- ❍ Substance abuse
- ❍ Distention/bloating
- ❍ Irritable bowel
- ❍ Vertigo
- ❍ Flushed face
- ❍ Nausea
- ❍ Parkinson's Disease
- ❍ Pain in ribs
- ❍ Tendonitis
- ❍ Migratory pain
- ❍ Belching
- ❍ Chronic fatigue
- ❍ Sour regurgitation
- ❍ Seizures
- ❍ Fibromyaglia
- ❍ Convulsions
- ❍ Floaters
- ❍ Headache at temples
- ❍ Tinnititis
- ❍ Migraines
- ❍ Insomnia
- ❍ Drink alcohol
- ❍ Sighing
- ❍ Tremors
- ❍ Muscle cramping

Kidney/ Urinary Bladder Meridian /Organ Network

- ❍ Frequent cavities
- ❍ Memory problems
- ❍ Easily startled
- ❍ Sciatica
- ❍ Spinal column diseases
- ❍ Decreased will power
- ❍ Osteoarthritis
- ❍ Afternoon flushes
- ❍ Lack of perspiration
- ❍ Unusual urine out-put (explain) _____
- ❍ Cold sensation in knees
- ❍ Heat in chest
- ❍ Other dental problems
- ❍ Excessive hair loss
- ❍ Cold body temperature
- ❍ Kidney stones
- ❍ Frequent night urination
- ❍ Cold hands or feet
- ❍ Multiple Sclerosis
- ❍ Heat in hands or feet
- ❍ Lower back pain
- ❍ Fear
- ❍ Premature gray hair
- ❍ Hot Flashes
- ❍ Infertility
- ❍ Hot body temperatures
- ❍ Perspire easily
- ❍ Easily broken bones
- ❍ Night sweats
- ❍ Excessive thirst
- ❍ Cerebral palsy
- ❍ Depression
- ❍ Lack of bladder control
- ❍ Fatigue/lethargy
- ❍ Muscular Dystrophy
- ❍ Sterility

Lung function / Large Intestine Meridian/ Organ Network

- ❍ Difficulty breathing
- ❍ Loose stools
- ❍ Dry skin
- ❍ Excess phlegm
- ❍ Tuberculosis
- ❍ Sweating problems
- ❍ Smoke (#___per day)
- ❍ Sadness
- ❍ Sensitivity to: ❍ smells ❍ noise ❍ clothing ❍ energy ❍ other (list)_____
- ❍ Difficulty concentrating
- ❍ Frequent colds/flu
- ❍ Psoriasis
- ❍ Sinusitis
- ❍ Shortness of breath
- ❍ Cough
- ❍ Rapid, quick thinking
- ❍ Slow healing skin
- ❍ Pulmonary diseases
- ❍ Nasal problems
- ❍ Constipation
- ❍ Melancholy
- ❍ Asthma
- ❍ Breast fed
- ❍ Mucus in stool
- ❍ Diarrhea
- ❍ Chest congestion
- ❍ Wheezing
- ❍ Emphysema
- ❍ Bottle fed
- ❍ Other_____

For Women:

Regular menstrual cycle? ❍Y ❍N Pregnant? ❍Y ❍N
Number of children:_____ Number of pregnancies:_____
Age of first menstruation:_____ Age of menopause (if applicable):_____
Average number of days of flow:_____ Average number of days of entire cycle:_____
❍Vaginal discharge ❍ Bleeding between periods
❍ When was your last period:_____

Do you experience any of the following pre-menstrual syndromes?

❍ nausea ❍ vomiting ❍ water retention ❍ breast swelling
❍ food cravings ❍ headaches ❍ migraines ❍ breast tenderness
❍ depression ❍ irritability ❍ anxiety ❍ other emotions:_____
❍ dull pain, where?_____ ❍ sharp pain, where?_____

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 (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

For Men:

❍ Swollen testes ❍ Testicular pain ❍ Impotence ❍ Premature ejaculation
❍ Feeling of coldness or numbness in external genitalia ❍ Other_____

Patient Signature: _____

Acupuncturist Signature: _____

Patient Health Information Consent Form

HIPAA Privacy Information

We are very concerned with protecting your privacy. While the law requires us to give you a copy of our privacy notice, please understand that we have and always will respect the privacy of your health information. At your request, we will give you a copy of our complete Privacy note. Acupuncture & Chinese Medical Center LLC, does reserve the right to change your policy practices as described in the notice. If any future changes are made to our privacy practices, we will notify you in writing.

Marketing Authorization

From time to time, our office may mail you information to make you aware of special offers relates to products or services, and evens that may interest you. Your authorization is required to provide the following products and/or services to you; birthday cards, congratulations cards; food-drives, newsletters, coupons, coupon books, brochures, surveys, etc.

Consent for use or Disclosure of Health Information

Following are possible circumstances in which we may have to use or disclose your PHI (Patient Heath Information):
• We may have to disclose your PHI to another health care provider or hospital if it is necessary to refer you to them for Diagnosis assessment or treatment of your health condition.
• We may have to disclose you PHI and billing records to another party if they are potentially responsible for the payment of your services.
• We may need to use your PHI within our office for quality control to other operational purposes.

Appointment Reminders and Health Care Authorization

Authorized staff of Acupuncture & Chinese Medical Center LLC, may need to use your name, address, phone number, billing information and your clinical records to contact you with appointment reminders, information about treatment alternatives or other PHI. If this contact is made by phone and you are not home, a message will be left on your answering machine or voice mail. By signing this form, you are giving us authorization to contact in this manner. As well, you may restrict the individuals or organizations to which your PHI is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to our office. We will not be able to honor your revocation request if we have already released your PHI before we receive your request to your insurance company for benefit verification or claims processing. You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you but if may affect reimbursement by your insurance company.

Consent To Treatment

I voluntarily consent to receive Acupuncture & Chinese Herbal Medicine treatment administered by practitioners of Acupuncture & Chinese Medical Center, LLC who are certified by the State of Wisconsin. I understand his/her training is in Acupuncture & Oriental Medicine and that (s)he is not, nor claims to be, a medical doctor.

I understand that the evaluation given to me is an energetic assessment of the functioning of any organs and the Qi moving in the Acupuncture Meridian Network; it is in no way purports to be, or replaces allopathic (western) medical evaluation, diagnosis, or treatment. I have provided a full history and description of complaints, which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary. I understand that no guarantee has been made concerning the use and effects of Acupuncture & Chinese Herbal Medicine. I understand that I may stop treatments at any time.

I understand that Acupuncture is the insertion of fine sterile needles, with or without the addition of electrical stimulation, through the skin, and/or the application of heat to regulate and balance Qi (energy), improve organ function and improve health.

I acknowledge that, although rare, certain side effects may result from Acupuncture, heat therapy and Chinese Herbal Medicine. These may include minor bruising, minor bleeding, some pain at the site of needle insertion, infection, needle sickness (dizziness or fainting), or broken needles. These events are unusual and of short duration. Rare but potential side effects of heat therapy include heat discomfort or burning. Side effects of Chinese Herbal Medicines are rare but may include allergic reactions. Strong cleansing responses to Acupuncture and Chinese Herbal Medicine may also occur. Potential effects will be addressed.

I am choosing Acupuncture and/or Chinese Herbal Medicine treatment as an exercise of my right to freedom of choice in the healing arts.

I understand that if I miss/cancel an appointment without a minimum of **24** hours notice, there will be a **$40** service charge.

_____

Patient Name (signature) Patient Name (Printed) Date

_____

Authorized Provider Representative (signature) Date