Acupuncture Wellness Center

PATIENT HEALTH HISTORY

Name: ____ Date: ______________
(First) (Middle) (Last)

Address: ____

City/State/Zip: ____

Home Telephone: ____________________ Work Telephone: ____________________

Employer: ____________________ Occupation: ____________________

Date of Birth: __________ Age: ____ Gender: ____ Marital Status: ______ SS#__________

Emergency Contact: ______________ Telephone: __________ Relationship: __________

Referred by: ____________________ Relation: ____________________

Are you currently receiving health care? ❑ Yes ❑ No

If yes, where and from whom? ____

If no, when and where did you last receive health care? ______________________________

Please identify your health concerns that have brought you to the Clinic below:

Condition	Past Treatment
a. ____________________	____________________

How does this condition affect you? ____

b. ____________________	____________________

How does this condition affect you? ____

c. ____________________	____________________

How does this condition affect you? ____

d. ____________________	____________________

How does this condition affect you? ____

1. For females, do you have any reason to believe that you are pregnant? ❑ Yes ❑ No
2. Do you have any chronic infectious diseases? ❑ Yes ❑ No

   If yes, please explain: ____
3. Do you have any chronic illnesses? ❑ Yes ❑ No

   If yes, please explain: ____
4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to:

   ____
5. Please list any prescription medications, over-the-counter medications, vitamins, supplements, and herbs that you are currently taking and the reason for taking them:

   ____

   ____

6. Height: ______ Weight: Currently: ______ Past maximum weight: ______ When? ____________________

7. Blood Pressure: What is your most recent blood pressure reading? ____________ When? ____________________

8. Childhood Illnesses (please circle any that you have had):

❑ Scarlet Fever ❑ Diphtheria ❑ Rheumatic Fever ❑ Mumps ❑ Measles ❑ Chicken Pox

9. Hospitalizations, Surgeries, X-Rays, CAT scans, MRI's (please state the reason and when):

____

____

10. Family History:	Mother	Father	Brothers	Sisters	Spouse	Children
Age if living:	______	______	______	______	______	______
Health: (G=good, P=poor)	______	______	______	______	______	______
Age at death: (if deceased)	______	______	______	______	______	______
Cause of death:	______	______	______	______	______	______

Have any members of your family had any of the below diseases? If so, which ones?

Cancer: ____

Diabetes: ____

Heart Disease: ____

High Blood Pressure: ____

Stroke: ____

Mental Illness: ____

11. Emotional (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Mood Swings ❑ Nervousness ❑ Mental Tension

12. Energy and Immunity (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Fatigue ❑ Slow Wound Healing ❑ Chronic Infections

13. Head, Eye, Ear, Nose, Throat
(please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Impaired Vision ❑ Eye Pain/Strain ❑ Glaucoma ❑ Glasses/Contacts ❑ Tearing/Dryness

❑ Impaired Hearing ❑ Ear Ringing ❑ Earaches ❑ Headaches ❑ Frequent Sore Throats

❑ Sinus Problems ❑ Hay Fever ❑ Nose Bleeds ❑ Teeth Grinding ❑ TMJ/Jaw Problems

14. Respiratory (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Pneumonia ❑ Frequent Common Colds ❑ Persistent Cough ❑ Difficulty Breathing

❑ Emphysema ❑ Pleurisy ❑ Asthma ❑ Tuberculosis ❑ Shortness of Breath

15. Cardiovascular (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Heart Disease ❑ Chest Pain ❑ Heart Murmurs ❑ Palpitations/Fluttering

❑ High Blood Pressure ❑ Stroke ❑ Varicose Veins ❑ Swelling of Ankles ❑ Rheumatic Fever

16. Gastrointestinal (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Ulcers ❑ Changes in Appetite ❑ Nausea/Vomiting ❑ Epigastric Pain ❑ Passing Gas

❑ Heartburn ❑ Belching ❑ Gallbladder Disease ❑ Liver Disease ❑ Hepatitis B or C

❑ Hemorrhoids ❑ Abdominal Pain ❑ Diarrhea ❑ Constipation

❑ Undigested Food in Stool ❑ Mucous in Stool ❑ Blood in Stool

17. Genito-Urinary Tract (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Kidney Disease ❑ Painful Urination ❑ Frequent Urinary Tract Infections

❑ Frequent Urination ❑ Sexually Transmitted Disease ❑ Kidney Stones

❑ Impaired Urination ❑ Frequent Urination at Night ❑ Blood in Urine

18. Female Reproductive/Breasts (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Irregular Cycles ❑ Breast Lumps/Tenderness ❑ Nipple Discharge ❑ Heavy Flow

❑ Bleeding Between Cycles ❑ Vaginal Discharge ❑ Clotting ❑ Premenstrual Problems

❑ Menopausal Symptoms ❑ Difficulty Conceiving

19. Menstrual/Birthing History:

Age of First Menses: ____ Number of Days of Menses: ____ Length of Cycle: ____

Birth Control: ____ Number of Pregnancies: ____ Number of of Live Births: ____

Number of Miscarriages: ____ Number of Abortions: ____

20. Male Reproductive (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Sexual Difficulties ❑ Prostate Problems ❑ Testicular Pain ❑ Penile Discharge

21. Musculoskeletal (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Neck/Shoulder Pain ❑ Muscle Spasms/Cramps ❑ Arm Pain ❑ Upper Back Pain

❑ Mid Back Pain ❑ Low Back Pain ❑ Leg Pain ❑ Joint Pain

22. Neurological (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Vertigo/Dizziness ❑ Paralysis ❑ Numbness/Tingling ❑ Loss of Balance ❑ Seizures/Epilepsy

23. Endocrine (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Hypothyroid ❑ Hypoglycemia ❑ Hyperthyroid ❑ Diabetes Mellitus

❑ Night Sweats ❑ Feeling Hot or Cold

24. Other (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

❑ Anemia ❑ Cancer ❑ Rashes ❑ Eczema/Hives ❑ Cold Hands/Feet

25. Is there anything else I should know? ______________________________

____

26. Lifestyle:

a. Have you experienced any major traumas? If yes, explain: ______________________________

____

b. Interests and Hobbies: ______________________________

Acupuncture Wellness Center

INFORMED CONSENT TO ACUPUNCTURE CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or patient named below, for whom I am legally responsible) by acupuncturist Nicole Peterson, L.Ac. and/or other acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for Nicole Peterson, L.Ac, including those working at the Acupuncture Wellness Center or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify Nicole Peterson, L.Ac. or any member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The 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, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Nicole Peterson, L.Ac. or a clinical staff member if I am or become pregnant.

I do not expect the acupuncturist or the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist and the clinical staff to exercise judgment during the course of treatment which the acupuncturist or clinical staff thinks at the time, based on the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PATIENT'S NAME SIGNATURE DATE

MINOR'S NAME GUARDIAN'S SIGNATURE & RELATIONSHIP DATE

Acupuncture Wellness Center

FINANCIAL POLICIES

Please read carefully and then acknowledge your understanding by signing where indicated. If you need clarification or have any questions, please ask.

PAYMENT OF SERVICES
Payment is due at the time of service unless arrangements are made in advance. Payment can be made with cash, check, debit card, Visa or Mastercard. The standard fee is $130 for the initial visit and $75 for follow up visits. If you foresee any financial challenges, be sure to address them with me prior to your appointment.

APPOINTMENT CHANGES
A minimum of 24 hours advance notice is required in order to cancel or reschedule your appointment. Please note that a charge of $75 will be billed to your account for all missed appointments and all appointments cancelled or changed without 24 hours notice.

OFFICE HOURS
My office hours are Tuesday through Friday from 10am to 6pm.

I have read, I understand, and I agree to the above information.

Signature: ____ Date:_________________