New Patient History Form

All information is treated as confidential and will not be released without consent

Date: ______________

Name: ____ Date of birth: ___________________ Age: __________

Gender ______________ Occupation: ____

Street Address____ Home Phone: _______________________

City, State, Zip: ____ Cell Phone:__________________________

E-mail: ____ Work Phone: _______________________

Emergency Contact: __________________________________ Relationship to you: _____________________

Address: ____ Home phone: _____________________________

Cell Phone: _______________________________________ Work phone: ______________________________

May we thank someone for referring you, or how did you hear of us? __________________________________

Have you ever received acupuncture? ________ If yes, where? _______________________________________

For what conditions? ____

What are you seeking treatment for today?____

Please indicate if any of the following pertain to you:

☐Hepatitis (A,B,C,) ☐HIV ☐ High Blood Pressure ☐ Seizures

____

HEALTH HISTORY

What are your most important health concerns? Please list in order of importance:

1.____ Date of Onset: _____________
2. ____ Date of Onset: _____________
3. ____ Date of Onset: _____________

Date of last physical exam: ______________ Physician: _________________
Physician's phone: ______________

Please list any hospitalizationu and/or surgeries :

Hospitalization/surgery	Date	Reason

Please list any injuries and/or accidents:

Accident/injury	Date	Relation to health

Please list all prescriptionu and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc):

Name	Dosage	Reason for taking	Date began taking

Please indicate if you are taking any of the following:

☐blood thinners (warfarin, Coumadin, etc.) ☐ diet pills (diuretics, appetite suppressants, etc.) ☐pain relievers (Tylenol, aspirin, kdwr tqhgp."etc.) ☐cortisone or other steroids ☐thyroid medication ☐tranquilizers/sedatives ☐ sleeping aids ☐laxatives ☐antacids (Tums, etc)

Approximately how many courses of antibiotics have you taken over the past 10 years? _______________

Please review the following symptoms and mark an X in the appropriate column. Leave blank if you do not experience the symptom.

	Occasional	Frequent		Occasional	Frequent
cough			shortness of breath		
spontaneous sweating			catch colds easily		
nasal congestion/runny nose			allergies		
post-nasal drip			eczema or psoriasis		
enlarged lymph glands			acne or boils		
sinus congestion or infection			ringworm or fungus		
skin rashes or hives			dry nose, throat or skin		
asthma or wheezing			decreased sense of smell		
bleeding gums			hoarse or sore throat or voice		
low appetite			constipation		
loose stool or diarrhea			hemorrhoids		
acid reflux/heartburn			feelings of claustrophobia		
blood in the stool			excessive appetite		
fatigue after eating			gas or bloating after food		
obsession in work or relations			nausea or vomiting		
insomnia			palpitations		
tongue or mouth sores			anxiety		
sadness			vivid dreams or nightmares		
mental restlessness			excessive sweating		
chest pain			laughing for no reason		
irritability			hearing impairment		
bitter taste in the mouth			difficulty digesting oily foods		
muscle spasms or twitching			difficulty making decisions		
neck/shoulder tension			ringing in the ears		
low back pain			decreased sex drive		
sore, cold or weak knees			frequent urination		
hair loss			cold hands and feet		
urinary incontinence or urgency			body feels heavy		
dizziness/fainting			poor concentration		
floaters in field of vision			sticky taste/feeling in mouth		
hot hands and feet			foggy headed		
afternoon fevers			night sweats		
flushed cheeks			edema or ankle swelling		
headaches			cloudy urine		
heat or cold intolerance			bruise easily		
excessive thirst			muscle weakness		
change in weight			numbness/tingling		
nose bleeds			pain on urination		
ear aches or infections			athlete's foot		

Do you have a bowel movement every day? ☐yes ☐ no
Number of bowel movements per day? _____
Are your BMs:
☐Well formed ☐Soft ☐Ribbon-like ☐Loose ☐Contains undigested food ☐Bad smelling
☐Burning upon defecation ☐Burning/heaviness in rectum ☐Incomplete BMs

LIFESTYLE HISTORY

Height ________ Weight: _________ Do you exercise? _________

How many times a week? _____________

What type of exercise? ____

Do you drink coffee/black tea? __________ # 8 oz cups per day/week? _______

Do you drink soda? ________ Is it caffeinated? _________#12 oz glasses per day/week? ______

How much water do you drink per day? ____

Please describe your typical diet:

Breakfast:

____

Lunch:

____

Dinner:

____

Snacks:

____

meals per day: ________ # snacks per day: _______ How often do you eat out (or order in)? ____________

Are you vegetarian, vegan, kosher? Are there other restrictions to your diet?

____

Do you experience any gas, burping, bloating acid reflux or other digestive symptoms after eating any foods?

____

Do you use tobacco? ________ How many times per day/week? ______________________

Have you used tobacco in the past? ________ When did you stop? ___________________

Do you drink alcoholic beverages? _________

How many drinks do you have per day/week? ____________

Do you use recreational drugs? ____________ How many times per day/week/month/year? ______________

Have you been treated for drug/alcohol addiction? _____________________________________

hours you sleep per night: _____________ Do you sleep well? ____________________

Do you awake feeling rested? ___________________________

What is your average stress level (*1 is low, 10 is high*)? 1 2 3 4 5 6 7 8 9 10

What is your average energy level (*1 is low, 10 is high*)? 1 2 3 4 5 6 7 8 9 10

At what time of day is your energy typically at its best? ____________ At its worst? ______

How do you feel about the following areas of your life?

	great	**good**	**fair**	**poor**	**bad**
significant other					
family relations					
friendships					
living arrangements					
self image					
sex					
work					
vacations/time off					
exercise					
spirituality					

How much change are you willing to/able to make at this time to improve your health?

(Please circle) Minimal Some Complete

FAMILY HISTORY

Please indicate whether you or any family member has, or ~~has~~ ever had any of the following conditions:

Disorder/Illness	**Which family member (include yourself; give important details)**	**Date**
Alcoholism/addictions		
Allergies/asthma		
Alzheimer’s disease		
Anemia		
Arthritis		
Autoimmune disorders		
Bell’s Palsy		
Birth defects		
Bleeding disorders		
Blood clots		
Cancer (specify type)		
COPD		
Crohn’s disease		
Depression/anxiety		
Diabetes		
Epilepsy		
Fibromalygia		
Gallbladder problems		
Glaucoma		
Heart disease		
Heart murmurs		
Hepatitis		
High cholesterol		
High blood pressure		
HIV/AIDS		
Infectious disease		
Infertility		
Irritable bowel		
Kidney disease		
Kidney stones		
Mental illness		
Osteoporosis		
Pacemaker/defibrillator		
Polycystic Ovary		
Restless Leg		
Shingles		
Stroke		
Thyroid dysfunction		
Tuberculosis		
Ulcers		
Urinary tract infections		
Yeast infections		

INFORMED CONSENT

This is to inform you that Acupuncturists are not licensed to practice medicine in the state of Illinois; an Acupuncturist is not making a medical diagnosis of your condition; if you want to obtain a medical diagnosis, contact a licensed Medical Doctor.

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 needlg"uites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including pneumothorax (lung puncture). Infection is another possible risk, although the clinic uses sterile, one-time use, disposable needles and maintains a clean and safe environment.

By signing below, I show that:

- I have read and understand the possible risks and complications involved in treatment. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand I can request more information at any time, if desired.
- I consent to receivg treatment that involves the above procedures.
- I understand that I have the right to refuse or discontinue treatment at any time.

Patient or Guardian's **Signature**____**Date**_________

Practitioner's Signature____**Date**_________

Payment and Late Cancellation/No Show Policy

Payment is due at the time of treatment. We accept cash, checks, and credit cards. We are happy to provide an itemized bill for submission to your insurance company.

Please contact us at least 24 hours in advance to cancel or reschedule your acupuncture appointment. Late cancellations and missed appointments will be charged for the total amount of the scheduled services. Emergencies and illness are taken into consideration. If you are unable to reach us directly by phone, please leave a message on the voicemail, which is time stamped.

If you are running late to your appointment, please let us know immediately. In many cases, we can accommodate up to 20 minutes past the scheduled appointment time. In this event, you will be seen only for the remainder of your appointment time. In the event we need to reschedule, you will be charged the late cancellation fee.

You will not be required to pay using this card at the time of service. You will be contacted prior to any charges being placed on your card due to our late cancellation policy. We appreciate your understanding and cooperation with our policies.

I, ___________________________________, have read the above policy and acknowledge I will be charged the full amount and am responsible for payment for the above mentioned circumstances. My card will be on file and charged the same day of my scheduled appointment.

____

Signature

____

Printed Name of Policyholder

________________________	__________	__________	______________
Credit Card Number	*Exp. Date*	*CVV Code*	*Billing Zipcode*

**Your credit card information will be stored in a secure site and you will be notified of any charge placed to meet the policies above.*

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This notice is to inform you that we are in compliance with the law concerning privacy of your health information, HIPAA. This is a short summary; the full length explanation of HIPAA is available to you upon request. If you are concerned about how we may use your information, please read the long version called, "Notices of Privacy Practices." **By signing this form, you acknowledge the understanding of this Notice.**

We, at this clinic, do not share your protected health information (PHI) with anyone other than with an entity that you agree to share information with. By signing this form, you agree to allow us to use your information for pertinent reasons: products and services, healthcare operations, and billing for payment of products and services. These reasons are fully described in the "Notices of Privacy Practices." This type of information includes your name, social security number, birthdate, address, insurance company, phone numbers, your health history questionnaire, and any and all related medical charting in regards to products or services we provide to you.

Patients can request to have anyone accompany them in the room during treatment. The patient then acknowledges that personal health information may be shared with this person. We do not share your PHI with anyone else in the clinic other than those listed here or pertinent staff of the clinic for the purpose of clinic operations.

We have the right to contact you by phone, mail, or email if you list this information in your consent form. This contact could be regarding scheduling, promotions, or other pertinent reasons of the clinic, but we will not give PHI to anyone else as a result of these types of contact.

______________________________________ ______________________

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