Rejuvenation Acupuncture & Wellness Clinic
Patient Health History Form

Name: _____ Date: _____
(First) (Middle) (Last)

Date of Birth: _____ Gender (M/F): _____ Marital Status: _____ Social Security: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____ Email: _____

May we leave a message on your answering machine if we cannot reach you? Y / N If yes, which number? _____

Emergency Contact: _____ Telephone: _____ Relationship: _____

How did you hear about us? (Please circle at least one)

Friend / Relative (Who may we thank for referring you? _____)

Website / Internet (Which search engine? _____) Other (If so, please explain: _____)

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. Please take the time to complete this questionnaire as thoroughly as possible. Please print all information and indicate areas of confusion with a question mark. Thank you.

1. 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? _____ For what reason? _____

2. Please identify the health concerns that have brought you to our 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? _____

3. What are your most important health problems? Please list in order of importance:

a. _____ b. _____ c. _____

4. Do you have any reason to believe that you are pregnant? Y N

5. Do you have any chronic infectious diseases? Y N If yes, please explain: _____

6. Are you currently suffering from any chronic illness? Y N If yes, please explain: _____

7. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

_____

8. Please circle any of the following medications that you are currently taking:

Laxatives Pain Relievers Antacids Thyroid Medication Appetite Suppressants

Antibiotics Tranquilizers Sleeping Pills Cortisone Blood Pressure Medication

9. Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking:

_____

10. **Height**: _____ **Weight**: Currently: _____ Past Maximum Weight: _____ When? _____

11. **Blood Pressure**: What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

12. **Hospitalizations and Surgeries**:

Reason	When	Reason	When
_____		_____	

13. **X-Rays/CAT scans/MRI's/NMR's/Special Studies**:

Reason	When	Reason	When
_____		_____	
_____		_____	

14. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension Feeling Depressed Feeling Anxious

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past): Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired hearing Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds

Frequent Sore Throats Teeth Grinding TMJ/Jaw problems Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

    Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

    Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience and underline any that you have experienced in the past):

    Ulcers Changes in Appetite Nausea/vomiting Epigastric pain Passing Gas Heartburn

    Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

    Stool: Diarrhea Constipation Undigested Food / Mucous Blood In Stool

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

    Kidney Disease Painful Urination Frequent Urinary Tract Infections Frequent urination

    Venereal Disease Impaired Urination Kidney Stones Frequent Urination at Night Blood in Urine

21. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past): Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge

    Bleeding Between Cycles Clotting Premenstrual Problems Menopausal Symptoms Difficulty Conceiving

22. **Menstrual/Birthing History**:

    1. Age of First menses: _____ 2. # of Days of Menses: _____ 3. Length of Cycle: _____ 4. Birth Control: _____

    5. # of Pregnancies: _____ 6. # of Miscarriages: _____ 7. # of Abortions: _____ 8. # of Live Births: _____

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

    Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

24. **Musculoskeletal** (please circle any that you experience now and underline 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 (if so, where?): _____

25. **Neurological** (please circle any that you experience now and underline any that you have experienced in the past):

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

26. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

    Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

    Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

    Is there anything else we should know? _____

28. **Family History**:

	Self	Mother	Father	Sister	Brother	Child	Grandparent
Age if living:		_____	_____	_____	_____	_____	_____
Health (G=good, P=poor):		_____	_____	_____	_____	_____	_____
Age at death (if deceased):		_____	_____	_____	_____	_____	_____
Cause of death:		_____	_____	_____	_____	_____	_____

Check any conditions that you or members of your family have had below:

Cancer:	_____	_____	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____	_____	_____
Heart Disease:	_____	_____	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____	_____	_____
Stroke:	_____	_____	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____	_____	_____
Stomach or Intestinal Disorder:	_____	_____	_____	_____	_____	_____	_____
Kidney or Bladder Disorder:	_____	_____	_____	_____	_____	_____	_____

29. **Lifestyle**:

a. Please indicate typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

b. Daily Exercise: _____

c. Sleep Habits: _____

d. Education: _____

e. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y N Why or Why not? _____

f. Nicotine/Alcohol/Caffeine/Recreational Drug Use: _____

g. Have you experienced any major traumas? Y N Please Explain: _____

_____

Thank you for taking the time to fill out this form as thoroughly and honestly as you can. This allows our acupuncturist to customize the best acupuncture and herbal treatment for you.

Financial Policies

Rejuvenation Acupuncture & Wellness Clinic welcomes you and is pleased to offer you quality, effective healthcare and services. Please check with the front desk regarding current fees.

In an attempt to keep health care costs low, we request payment for your treatment at the time of service. This includes any copayment, coinsurance, and deductible that has not been met by the date of your appointment. Payment may be in the form of cash, check, or credit cards. We reserve the right to refuse treatment until all of your account balances are paid for.

All supplements, herbs, and products purchased are non-refundable.

We require a **twenty-four hour notice** to change or cancel any appointment or a fee will be charged.

Please note that a $50 fee will be charged for all One Hour appointments missed or changed without 24-hour notice; and a $70 fee for all 90-minute appointments missed or changed without twenty-four hours notice.

A finance charge of 1.5% per month (18%APR) will accrue on all accounts not paid within 30 days of the invoice date.

I understand that it is my responsibility to find out and keep track of my acupuncture benefits from my insurance company. Benefits may be checked in our office only as a courtesy, and should not be regarded as a guarantee of benefits. I am financially responsible for all charges incurred at this office, including my insurance deductible, co-payment/ co-insurance, and any services not paid or covered by my Health Insurance, PIP, L&I or private establishment.

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

_____ _____

Signature Today's Date

Informed Consent for East Asian Medicine Treatment

Purpose of treatment: The purpose of the treatment is to resolve your complaint, *i.e.*, the reason you are seeking treatment. "East Asian Medicine" is a health care service utilizing East Asian Medicine diagnosis and treatment to promote health and treat organic or functional disorders.

Nature of treatment: The scope of East Asian Medicine practice includes acupuncture, electroacupuncture, point injection therapy or aquapuncture, moxibustion, acupressure, cupping, Gua Sha (dermal friction), infrared, laserpuncture; dietary advice and health education based on East Asian medical theory; herbal, vitamin and nutritional supplements; breathing, relaxation and exercise techniques; Qi gong; East Asian massage and Tui na; and heat and cold therapies.

Benefits of treatment: Acupuncture and East Asian Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health Organization lists over 40 conditions which are effectively treated by acupuncture. These include muscular-skeletal injuries, digestive difficulties, respiratory diseases, women's health issues, etc. This record does not allow a guarantee of any individual course of treatment.

Risks of treatment: East Asian Medicine procedures have been shown to be relatively safe. There are some uncommon but potential risks, which include discomfort during and after treatment; "needle sickness," which includes dizziness or fainting; localized but minor bruising or swelling; nerve damage; minor burns from moxibustion; infection (which is rare with the use of disposable needles); broken needle; and temporary aggravation of symptoms that existed prior to treatment.

Please notify the acupuncturist if you have any adverse effect from treatment. We will be glad to work with you to overcome any adverse effect.

Special situations: You should inform the acupuncturist if you have a severe bleeding disorder or are wearing pacemaker or other electronic medical device. In addition, some herbs and acupuncture points are contraindicated during pregnancy. Notify the acupuncturist if you are pregnant, or if you might be pregnant.

Confidentiality or medical records: Your medical records are not released to anybody without your written consent.

Required consultations: Washington State Law requires acupuncturists to receive a written diagnosis or to consult with a primary care provider (MD, DO, ND, PA, ARNP) before treating patients with any of the following potentially serious disorders: cardiac conditions, including uncontrolled hypertension; acute abdominal symptoms; acute, undiagnosed neurological changes; unexplained weight loss or gain in excess of 15% of body weight within three months; suspected fracture or dislocation; suspected systemic infection; any serious, undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history or diagnosis. This consultation requires your authorization; if you refuse the authorization or do not provide a recent diagnosis from the physician, you will have to sign a waiver so that treatments may continue.

The Consent Part

By signing below you requested and consent to the performance of acupuncture and Oriental medicine treatments. You are free to withdraw your consent and stop treatment at any time.

You understand that your signature indicates that you have read and understand the preceding information and that you will ask the acupuncturist if you have any questions about it.

You release the Acupuncture Clinic and its licensed acupuncturists from any and all liability that may occur in connection with the treatments, except for failure to perform the procedures with appropriate medical care.

Your signature indicates that you have read and understand the HIPAA Privacy Policy and also authorizes the release of any medical information necessary to process a claim for insurance benefit coverage. It does not authorize release of medical information for any other purpose. You may request a current copy of the Privacy Policy at any time.

Your signature also indicates your understanding that you are ultimately responsible for all financial obligations for treatments.

Patient's Name (Please Print) _____

Patient's Signature _____

Date Signed _____

Qualifications:

Cindy Wu is licensed by the State of Washington to practice East Asian Medicine, including acupuncture and Chinese herbs, and have obtained additional certification to practice point injection therapy. Her license number is AC 00002799, first awarded in 2005. She was awarded a Master's Degree in Acupuncture & Oriental medicine by Oregon College of Oriental Medicine, and was certified by NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine) with a Diplomat in Oriental Medicine. Cindy also furthered her training and practiced Acupuncture and Chinese medicine in Beijing, China for nine months.