

Acupuncture & Chinese Herb Clinic

15710 NE 24th St. Suite E – Bellevue, WA 98008 – (425) 456-8880

Health History Questionnaire

Name:		Today's Date:	
Address:		Phone (Home):	
City:	State:	Phone (Work):	
Zip:		Phone (Cellular):	
Age:	Sex:	Weight:	Height:
Marital Status:		Occupation:	
Place of Birth:		Date of Birth:	
Family Physician:		SSN:	
In Emergency Notify:		Phone Number:	
Referred By:		Your Email:	
Insurance Company:		Policy Number:	
Have you been treated by acupuncture or Oriental medicine before?			

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with: _____ and assign directly to Acupuncture & Chinese Herb Clinic all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Main problem(s) you would like us to help you with: _____

How long ago did this problem begin (be specific)? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

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

What kinds of treatment have you tried? _____

Past medical history (please include dates): _____

Significant Illnesses: Cancer Diabetes Hepatitis High Blood Pressure Seizures
 Heart Disease Rheumatic Fever Thyroid Disease Venereal Diseases Other

Surgeries: _____

Significant Trauma (auto accidents, falls, etc.): _____

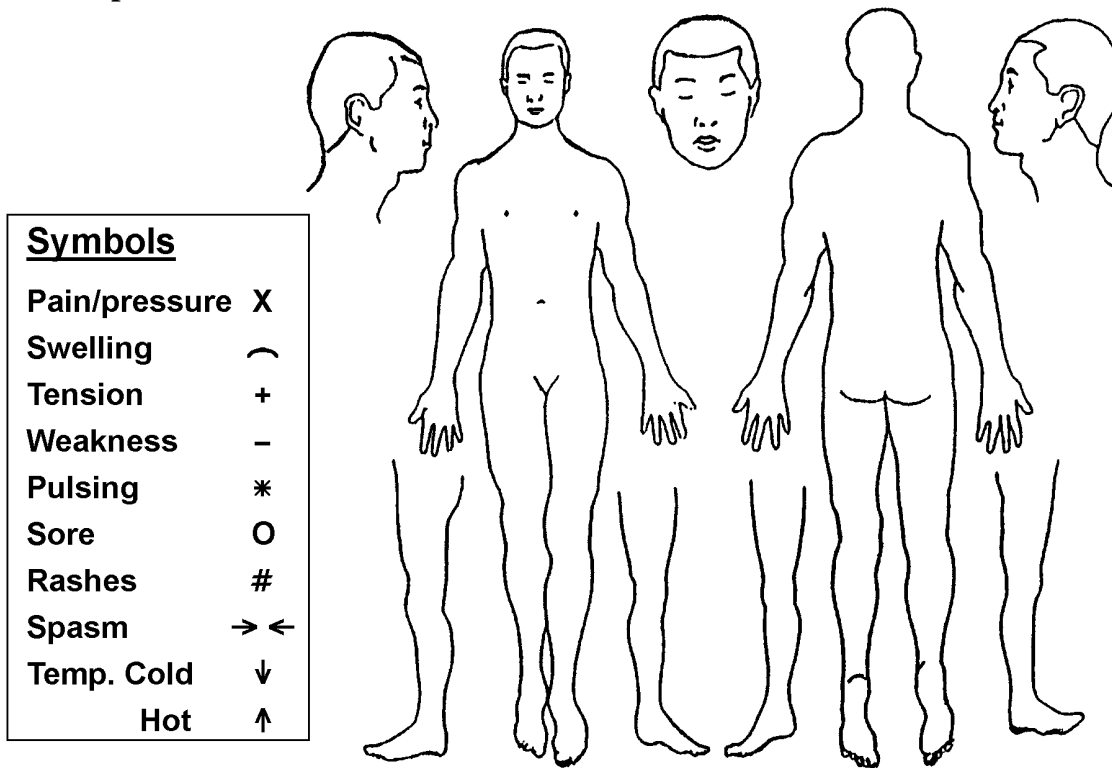
Birth History: (prolonged labor, forceps delivery, etc.): _____

Allergies (drugs, chemicals, foods): _____

Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease
Strokes Seizures Asthma Allergies Other

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

Indicate painful or distressed areas:



Occupation: _____ Occupational stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? _____ Please describe: _____

Have you ever been on a restricted diet? _____ What kind? _____

Please describe your average daily diet:

Morning

Afternoon

Evening

Do you smoke? _____

What is the amount of cigarettes that you smoke in a day? _____

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Please describe any use of drugs for non-medical purposes

Please check if you have had (in the last three months):

General

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Sweat Easily | <input type="checkbox"/> Tremors | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Bleed or Bruise Easily | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Peculiar Tastes or Smells | | |
| <input type="checkbox"/> Strong Thirst (cold or hot drinks) | | |
| <input type="checkbox"/> Sudden Energy Drop (What time of day)? | | |

Skin and Hair

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture | | |
- Any hair or skin problems?

Head, Eyes, Ears, Nose, and Throat

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in Front of Eyes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Jaw clicks | |
- Headaches (Where and when?)
- Any other head or neck problems?

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Swelling of Feet |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Difficulty in Breathing |
- Any other heart or blood vessel problems?

Respiratory

- | | | |
|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain With a Deep Breath |
| <input type="checkbox"/> Difficulty in Breathing When Lying Down | | |
| <input type="checkbox"/> Production of Phlegm (What color?) | | |
- Any other lung problems?

Gastrointestinal

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | | |
| <input type="checkbox"/> Chronic Laxative Use | | |

Any other problems with your stomach or intestines?

Genito-Urinary

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain When Urinating | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Decrease in Flow | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sores on Genitals |

Do you wake up to urinate? How often?

Any particular color of your urine?

Any other problems with your genital or urinary system?

Pregnancy and Gynecology

- | | | |
|---|--|--|
| __ Number of Pregnancies | __ Number of Births | __ Premature Births |
| __ Miscarriages | __ Abortions | __ Age at First Menses |
| __ Period Between Menses | __ Duration | __ First Date of Last Menses |
| <input type="checkbox"/> Unusual Character (Heavy or Light) | | |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Clots | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Last PAP |
| <input type="checkbox"/> Changes in Body/Psyche Prior to Menstruation | | <input type="checkbox"/> Breast Lumps |

Do you use birth control? What type and for how long?

Musculoskeletal

- | | | |
|---|--|---|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Muscle Pains | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Foot/Ankle Pains |
| <input type="checkbox"/> Hand/Wrist Pains | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Hip Pain |

Any other joint or bone problems?

Neuropsychological

- | | | |
|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Poor Memory |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bad Temper | <input type="checkbox"/> Easily Susceptible to Stress | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Comments

Please tell us of any other problems you would like to discuss:

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Informed Consent For Treatment

I, _____, hereby authorize the private practitioners of Acupuncture & Chinese Herb Clinic to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special disposable needles through the skin into underlying tissues at specific points on the surface of the body. I understand there may be possible bruising, achiness, and bleeding as a result of acupuncture.

Cupping: a technique used to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device. Cupping may cause bruising or blisters.

Heating Lamp or Pad: produces heat on the acupoints and meridians.

Electrical Acupuncture: use of electrical device to produce electrical stimulation on the acupuncture needles.

Herbs: may be given in the form of pills, powders, tinctures, pastes, or plasters. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: bruising, discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of the symptoms following the acupuncture treatment.

Potential Benefits: drugless relief of present symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the present problem and the strengthening of the constitution.

Notice to Pregnant Women: We do not use labor stimulating acupuncture points unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from the primary care provider authorizing or recommending such a treatment. All female patients must alert the doctor if they know or suspect that they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Acupuncture & Chinese Herb Clinic or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that Acupuncture & Chinese Herb Clinic may have a precept student for observation only. I understand that a record will be kept of my health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative of if it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three years, but no more than eight years after the date of my last treatment.

A full appointment charge will be charged for all subsequent no shows. Please let us know if you are unable to make your future appointments. Please give us at least 24 hours notice if you need to cancel.

I have read and understood the Acupuncture & Chinese Herb Clinic's HIPAA Privacy Policies (which can be read at <http://www.DrAmyChen.com/hipaa>) or which a copy can be requested in person at our office.

Date

Signature of Patient, Patient Representative, or Guardian