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Health History Questionnaire

Name:	Gender: M F	Age:	
Address:	City:	State:	Zip Code:
Home Phone:	Mobile Phone:	Email:	
Date of Birth:	Place of Birth:	Height:	Weight:
Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Living w/partner ☐ Other :			
Employer:	Occupation:		
Physician	Physician's Phone Number:		
Emergency Contact Name:	Emergency Contact Phone Number:		
Referred By:	Have you previously been treated for acupuncture or Oriental Medicine? ☐ Yes ☐ No ____/____/____		

What is your main concern today?

When did this problem/condition begin? (Please be specific)

What do you think is the cause? Is the cause still present?

What treatments have you already tried? What were the results?

Have you received a diagnosis for this problem/condition? If so, what is the diagnosis?

To what extent does the problem/condition interfere with your daily activities? (work, sleep, eating, etc.)

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How severe is your problem/condition right now? (Please mark the below scale)

No Problem | Moderate | Severe

How severe is your problem/condition right now? (Please mark the below scale)

No Problem | Moderate | Severe

Past Medical History (please indicate by dates)

Cancer	_____	High Blood Pressure	_____	Rheumatic Fever	_____	Venereal Disease	_____
Diabetes	_____	Heart Disease	_____	Seizures	_____	Allergies	_____
Hepatitis	_____	Stroke	_____	Thyroid Disease	_____	Pacemaker	_____
Other:	_____						

Surgeries (type and date):

Significant Trauma (auto accident, falls, etc.)

Birth History (prolonged labor, forceps delivery, caesarian section, other):

Allergies (drugs, food, animals):

Family Medical History

☐ High Blood Pressure	☐ Alcoholism	☐ Cancer	☐ Allergies
☐ Heart Disease	☐ Seizures	_____	_____
☐ Arteriosclerosis	☐ Asthma	_____	_____
☐ Stroke	☐ Diabetes	_____	_____

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

Do you exercise regularly? Y or N
Please describe:

Comments (please list any other problems you would like to discuss):

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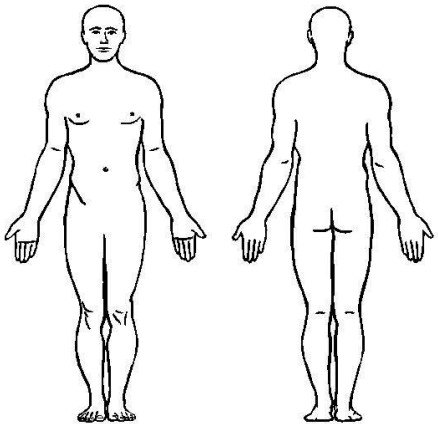
Indicate Painful or Distressed Areas



What are Your Treatment Goals?

- ☐ Temporary relief of symptoms/pain control
- ☐ Eliminate root or cause of the problem (if possible)
- ☐ Lessen/eliminate habits which caused the condition or made it worse
- ☐ Maintenance care (periodic balancing/tune-up to keep in good health)

Please check any boxes of symptoms you have had in the past month.

General

- ☐ Chills
- ☐ Fever
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (hot/cold)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
- ☐ Time of day:
- ☐ Edema

Where:

- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
- ☐ Gain/Loss

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems:

Head, Eyes, Ears, Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
- ☐ When:

Where:

- ☐ Facial Pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blur vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throat
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head/neck problems:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems:

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing while lying down
- ☐ Phlegm

Color?

- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

Other lung problems:

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps

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☐ Gas
☐ Rectal pain
☐ Hemorrhoids
Other stomach or intestinal problems:

Genito-Urinary

☐ Pain on urination
☐ Urgency to urinate
☐ Frequent urination
☐ Blood in urine
☐ Decrease in flow
☐ Dribbling
☐ Kidney stones
☐ Impotency
☐ Change of sexual drive
☐ Sores on genitals
Do you wake to urinate?
☐ Yes ☐ No
How often?
Urine color?
Other genital or urinary system problems?

Pregnancy and Gynecology

of pregnancies:
# of births:
# of premature births:
# of miscarriages
# of abortions
Age at first menses:
Length of full cycle:
Length of menses:
Last menses start date:

Last pap smear:

☐ Heavy periods
☐ Light periods
☐ Painful periods
☐ Irregular periods
☐ Changes in body/psyche prior to menstruation
☐ Clots
☐ Vaginal discharge
☐ Menopause

Age: Year:
☐ Postcoital bleeding
☐ Vaginal sores
☐ Breast lumps
☐ Nipple discharge
Practice birth control?
☐ Yes ☐ No
What type?

How long?

Musculoskeletal

☐ Neck pain
☐ Shoulder pain
☐ Back pain
☐ Elbow pain
☐ Hand/wrist pain
☐ Hip pain
☐ Knee pain
☐ Foot / ankle / heel pain
☐ Muscle pain
☐ Muscle weakness
Other pain?

Neuropsychological

☐ Seizures
☐ Areas of numbness
☐ Weakness
☐ Sleep disorder
☐ Concussion
☐ Violence potential
☐ Vertigo
☐ Lack of coordination
☐ Bad temper
☐ Depression
☐ Easily stressed
☐ Loss of balance
☐ Poor memory
☐ Anxiety
☐ Substance abuse
Have you ever been treated for emotional problems?
☐ Yes ☐ No

Habits

Please indicate below: None, Minimal, Moderate, Excessive

	None	Minimal	Moderate	Excessive	Add comments/quantities when appropriate
Alcohol	☐	☐	☐	☐	
Coffee	☐	☐	☐	☐	
Tea	☐	☐	☐	☐	
Tobacco	☐	☐	☐	☐	
Drugs	☐	☐	☐	☐	
Water intake	☐	☐	☐	☐	
Vitamins	☐	☐	☐	☐	
Sugar intake	☐	☐	☐	☐	
Food intake	☐	☐	☐	☐	
Appetite	☐	☐	☐	☐	
Sleep	☐	☐	☐	☐	

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Habits (con't)

	None	Minimal	Moderate	Excessive	Add comments/quantities when appropriate
Exercise	☐	☐	☐	☐	
Energy level	☐	☐	☐	☐	
Stress level	☐	☐	☐	☐	
Dental Problems	☐	☐	☐	☐	

Other:

Diet

Please give a general description of the food you consume during a "typical" day:

Morning:

Afternoon:

Evening:

Between meals:

Before bed:

Medicine

Please list all medications you are taking, and for what condition. Please include prescriptions, vitamins, over-the-counter, etc.)

Medicine	**Condition**

Consent for Treatment

I, the undersigned, understand acupuncture may involve the use of needles, electric stimulation TDP heat therapy, cupping, gua sha, etc. The risks, although limited, include puncturing organs in the abdomen and chest cavities, and bruising. Acupuncture and/or massage therapy can affect people on all levels: physical, emotional, mental, and spiritual because it works with the whole body to create balance. The duration and course of treatment varies from person to person depending on their specific condition and overall constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or course of treatments.

Signature _____ Date _____

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For Patient Review Regarding Diagnostic Exam

Please Sign one of the two options listed below.

Option 1:

I have received a diagnostic exam by a physician or chiropractors within the last six months regarding the condition for which I am seeking treatment.

_____

Patient Signature

_____

Date

Option 2:

I have NOT received a diagnostic exam by a physician or chiropractor within the last six months regarding the condition for which I am seeking treatment. Ohio law requires that a Licensed Acupuncturist recommend that ou receive a diagnostic examination from a physician or chiropractor regarding the condition for which you are seeking tratment.

I understand this recommendation.

_____

Patient Signature

_____

Date

_____

Licensed Acupuncturist Signature

_____

Date

CC: Patient file
Provided to patient

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below 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 have an unpleasant smell or taste. I will immediately notify a 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. 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 lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE