Heather's Holistic Health
MASSAGE · SPA · YOGA · ACUPUNCTURE
LICA H. TORBERT, CADC, COUNSELOR

Date: _____

Acupuncture

Client Information

Name: _____ DOB: _____

Occupation: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Questionnaire and Informed Consent

1. Are you now, or have you recently been, on any medications? Yes / No

If yes, please list medication: _____

2. Are you now, or have you ever been, on blood thinners or anticoagulants? Yes/ No

3. Do you bleed easily? Yes / No

4. Have you ever been told that you have a heart problem? Yes / No

5. Do you have a pacemaker, or any other device that has been surgically implanted in your body? Yes / No

6. Have you ever had hepatitis, or has your skin ever turned yellow? Yes / No

7. Do you faint easily? Yes / No

8. Are you pregnant, or are your periods delayed? Yes / No

Acupuncture is an oriental medical procedure that has been practiced for over 3,000 years. In the USA, it is considered therapeutic treatment by the National Institute of Health.

- I, the undersigned, hereby authorize and direct any licensed acupuncturist in this office to administer acupuncture, which involves the insertion of needles at one or more points in the body or the application of other forms or adaptations of oriental medicine.
- I understand that the acupuncturist prior to my receiving the initial treatment will answer any and all questions posed by me regarding the procedures of acupuncture to be used.
- I understand that health insurance may not cover this treatment. A physician referral may be necessary for coverage by HMOs.
- There are almost never side effects from this treatment, however upon occasion, symptoms, which have been experienced in the past, may recur. These symptoms should abate within 72 hours. Sometimes a drop of blood may exit when the needles are removed and slight bruising may be seen. Success of the treatments will also vary among individuals; however studies have

proven acupuncture to be effective in a variety of both acute and chronic illness, and it is especially helpful for pain management and control.

I have read and understood the above statements, and fully consent to the use of acupuncture as a treatment modality.

Signature: _____ Date: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the comments section. Thank you!

1. Have you tried acupuncture or Chinese traditional herbal medicine before? Yes / No

2. Main concern(s) you would like us to help you with: _____

_____

3. To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

_____

4. How long has it been since you first noticed your symptoms? _____

5. Have you been given a diagnosis for the problem? If so, what? _____

6. What kinds of treatments have you tried? _____

Past Medical History

(Please include dates)

Significant Illnesses:

□ Cancer □ Diabetes □ Hepatitis □ High Blood Pressure

□ Heart Disease□ Seizures □ Rheumatic Fever □ Thyroid Disease

□ Venereal Disease □ Other: _____

Surgeries: _____

_____

Significant Trauma: _____

_____

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

_____

Allergies: _____

Other relevant medical history: _____

_____

_____

Family Medical History

▫ Cancer ▫ Diabetes ▫ Heart Disease ▫ Stroke

▫ Seizures ▫ Asthma ▫ Allergies _____

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

_____

Daily Life Condition

Occupation: _____

Occupational Stress Factors (physical, psychological, chemical): _____

_____

Do you follow a regular exercise program? If yes, please describe:

_____

_____

Have you ever been on a restricted diet? If so, what kind? _____

Please describe your average daily diet: _____

Morning	Afternoon	Evening
_____	_____	_____
_____	_____	_____

Do you smoke? If so, how many packs per day? _____

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

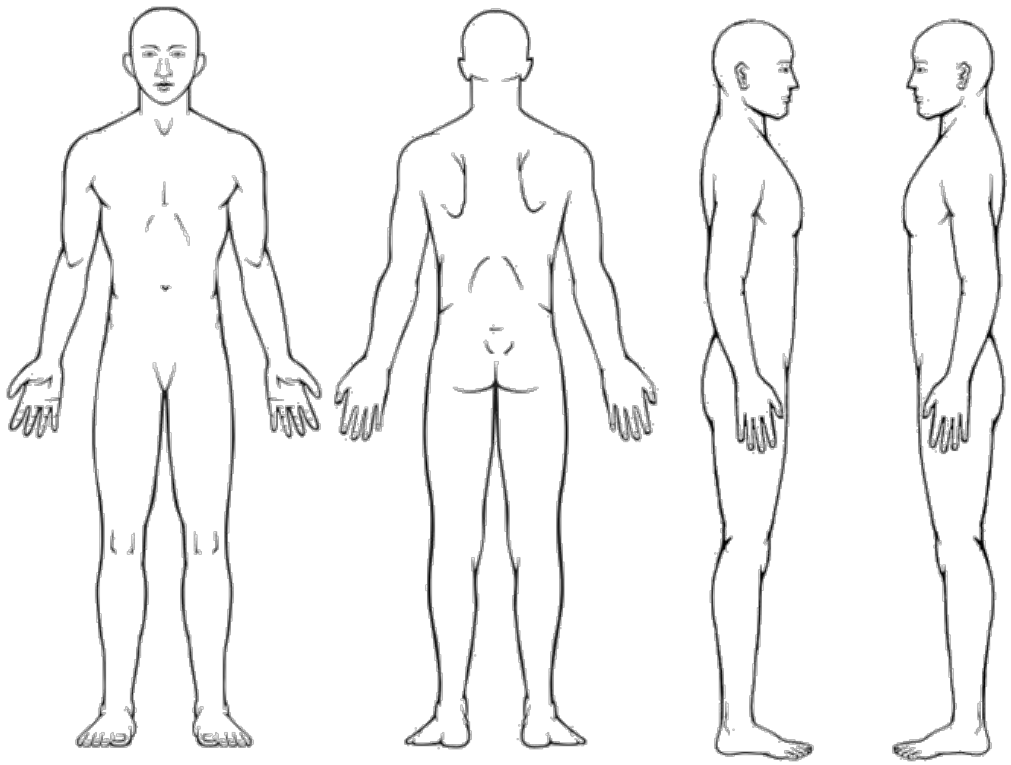
How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

_____

Symbol	**Reaction**
Pain on Pressure	
X	Little
XX	Moderate
XXX	Strong
Swelling	
^	Slight
^^	Moderate
^^^	Severe
Tension/Weakness	
U	Weak
	Normal
#	Tense
Spontaneous Pain	
!	Slight
!!	Moderate

!!!	Severe
Pulsing	
O	Slight
OO	Moderate
OOO	Strong
Temperature	
-	Cold
	Normal
+	Hotter



Physical	
( )	Sores
| |	Rashes
><	Spasms

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

General

▫ Poor appetite ▫ Poor sleeping ▫ Poor balance ▫ Localized weakness
▫ Strong thirst ▫ Night Sweats ▫ Weight loss ▫ Sudden energy drop
▫ Fever ▫ Sweat easily ▫ Tremors ▫ Bleed/bruise easily
▫ Cravings ▫ Chills ▫ Weight gain ▫ Change in appetite

Any other unusual/abnormal conditions you have noticed in your general sense of health?

_____

_____

Skin and Hair

▫ Rashes ▫ Ulcerations ▫ Hives ▫ Itching
▫ Eczema ▫ Pimples ▫ Dandruff ▫ Loss of hair
▫ Recent moles ▫ Change in hair/skin texture

Any other hair or skin problems?

_____

_____

Head, Eyes, Ears, Nose, and Throat

▫ Dizziness ▫ Concussions ▫ Migraines ▫ Glasses
▫ Spots in vision ▫ Eye pain ▫ Poor vision ▫ Night blindness
▫ Color blindness ▫ Cataracts ▫ Blurry vision ▫ Earaches
▫ Ringing in ears ▫ Poor hearing ▫ Eyestrain ▫ Sinus problems
▫ Nose bleeds ▫ Grinding teeth ▫ Facial pain ▫ Recurring sore throat
▫ Teeth problems ▫ Jaw clicks ▫ Lip/tongue sores ▫ Headaches (when and where)

Any other problems?

_____

_____

Cardiovascular

▫ High blood pressure ▫ Low blood pressure ▫ Chest pain ▫ Irregular heartbeat
▫ Fainting ▫ Cold hands/feet ▫ Hands swelling ▫ Feet swelling
▫ Blood clots ▫ Difficulty breathing ▫ Phlebitis

Any other heart/blood vessel problems?

_____

_____

Respiratory

▫ Cough ▫ Coughing blood ▫ Asthma ▫ Bronchitis

▫ Pneumonia ▫ Difficulty breathing while lying down ▫ Pain with deep breaths

▫ Production of phlegm (If so, what color?) _____

Any other lung problems?

_____

_____

Gastrointestinal

▫ Nausea	▫ Vomiting	▫ Diarrhea	▫ Constipation
▫ Gas	▫ Belching	▫ Black stools	▫ Blood in stools
▫ Indigestion	▫ Bad breath	▫ Rectal pain	▫ Hemorrhoids
▫ Abdominal pain/cramps		▫ Chronic laxative use	

Any other stomach/intestinal issues?

_____

_____

Genito-Urinary

▫ Pain on urination ▫ Frequent urination ▫ Blood in urine ▫ Urgency to urinate

▫ Unable to hold urine ▫ Kidney stones▫ Decrease in flow ▫ Impotency

▫ Sores on genitals

Do you wake up at night to urinate? If so, how often? _____

Any particular color to your urine? _____

Any other problems with your genital/urinary system? _____

Reproductive/Gynecologic

___ Number of Pregnancies ___ Number of Births ___ Premature Births ___ Miscarriages

___ Abortions

___ Age of first menses ___ Length between menses

___ First date on last menses ___ Duration

▫ Unusual period (heavy/light) ▫ Clots ▫ Painful periods

▫ Irregular period ▫ Last PAP _____ ▫ Discharge ▫ Vaginal sores

▫ Breast lumps ▫ Menopause (age: _____)

▫ Changes in body/psyche prior to menstruation: _____

Do you use birth control? If so, what type and for how long?

_____

Musculoskeletal

▫ Neck pain	▫ Muscle pain	▫ Knee pain	▫ Back pain
▫ Muscle weakness	▫ Foot/ankle pain	▫ Hand/wrist pain	▫ Shoulder pain
▫ Hip pain			

Any other joint/bone problems? _____

Neuropsychological

▫ Seizures ▫ Loss of balance ▫ Areas of numbness ▫ Lack of coordination
▫ Poor memory ▫ Depression ▫ Anxiety ▫ Bad temper
▫ Easily susceptible to stress

Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological/psychological problems? _____

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

_____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your health record

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination, test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others maybe be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that compiled it, but the content is about you and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use of disclose your health information.

Our responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if

we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits.

Other than for reasons described in this notice, this office agrees not to use or disclose our health information without your authorization.

To receive additional information or report a problem:

For further explanation of this notice you may contact the secretary of U.S. Department of Health and Human Services at:
The Hubert Humphrey Bldg
200 Independence Ave.
SW, Washington DC 20201

Worker's Compensation: This office will release information to the extent authorized by law in matters of worker's compensation.

Public Health: This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correctional Facilities: This office will release medical information on incarcerated individuals to correctional agents or institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this notice of privacy practices will not be extended to incarcerated individuals.

Law Enforcement: Your health information will be disclosed for law enforcement purposes as required under state law or in response to a valid subpoena. Provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in an event that a staff member or business associate of their office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger on or more patients, workers, or the general public.

NOTICE OD PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posted where registration occurs. All individuals receiving care will be given a hard copy.

Client comments: _____

_____

If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human services with no fear of retaliation by this office.

Your health information will be used for treatment, payment, and health care operations.

Treatment: Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician/acupuncturist recording their own expectations and those of others involved in providing your care. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment: Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations: The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Signature: _____ Date: _____