Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Personal and Confidential Patient Information

Office Policies Concerning Confidentiality

The confidentiality of your personal information is very important to us. We attempt to meet or exceed HIPAA guidelines concerning your personal and healthcare information. Please read the HIPAA information that we provided to you for more detail on our policies. We respect your right to refuse to give us any personal information, but the more information that we have the easier it is for us to help you. Thank You for your assistance.

Please fill out this information completely and legibly: Circle Yes / No

Full Legal Name:_____

Name or nickname that you would like to be called by us:_____

Home Address: Street:_____

City:_____ State:_____ Zip:_____

Current Occupation:_____

Employer:_____

Social Security Number:_____

Age:_____ Date of Birth:_____ Place of Birth: _____

Home Telephone:_____ May we call you here? Yes / No

Work Telephone:_____ May we call you here? Yes / No

Cell Phone:_____ May we call you here? Yes / No

Best phone to call you for appointment reminders or important information: Home / Work / Cell

Email: _____ Do you want our free email newsletter? Yes / No

Your Personal Medical Doctor:_____

Phone:_____ Address:_____

Other Health Care Provider: _____

Phone: _____ Address:_____

In Emergency Notify: _____

Relationship to You:_____ Phone:_____

How did you find out about our practice? (Please circle all that apply)

Personal Referral / Professional Referral (M.D., DC, etc.) / Flyer / Seminar

Radio: Balancing Point / Medicine Men

Internet: Yelp / Google / Other: _____

Who referred you to us:_____

May we send this person a "Thank You Card" for referring you to us? Yes / No

Have you tried Acupuncture before? Yes / No Providers Name:_____

Have you tried Chinese Herbal Treatments? Yes / No Have you tried Acupressure? Yes / No

Patient Signature:_____ Date:_____

Patient Printed Name: _____

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Patient Name: _____ □ Male □ Female **Date:** _____

Lifestyle and Medications

List vitamins and supplements that you take both regularly and occasionally

Name	Purpose	How long	Dosage	Frequency	Last Dose

List all pharmaceutical drugs that you currently take, regularly & as needed (eg. Nose sprays)

Name	Purpose	How long	Dosage	Frequency	Last Dose

List all other pharmaceutical drugs taken within the past six months

Name	Purpose	How long	Dosage	Frequency	Last Dose

Do you NOW follow a regular exercise program? □ Yes □ No Describe:_____

_____

Describe your typical daily diet:

Breakfast _____

Lunch _____

Dinner _____

Other _____

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Patient Medical History

Major Complaint(s) in order of significance to you:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **Additional:** _____

How do these conditions impair your daily activities:

_____

_____

How was your childhood health? _____

Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)

□ **Physical** □ **Cholesterol** □ **Prostate** □ **Blood (which?)**

□ **HIV/STD** □ **Pap Smear** □ **Mammography** □ **Other:** _____

Test results and date: _____

_____

Check any you have had in the past:

□ **Diabetes**	□ **Allergies**	□ **Glaucoma**	□ **Rheumatic fever**
□ **Heart disease**	□ **CVA (stroke)**	□ **Vein condition**	□ **Thyroid disorder**
□ **Asthma**	□ **Pneumonia**	□ **Tuberculosis**	□ **Emphysema**
□ **Jaundice**	□ **Gonorrhea**	□ **Mumps**	□ **Bleeding tendency**
□ **Syphilis**	□ **Measles**	□ **Chicken pox**	□ **Nervous disorder**
□ **Meningitis**	□ **HIV**	□ **Polio**	□ **Mononucleosis**
□ **Epilepsy**	□ **High fever**	□ **Hepatitis**	□ **Multiple sclerosis**
□ **Paralysis**	□ **Pap Smear**	□ **Migraines**	□ **High blood pressure**
□ **other lung illness**	□ **other liver illness**	□ **other heart illness**	□ **other kidney illness**

□ **Other:** _____

Immunizations: _____

Surgeries: _____

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Patient Profile

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):

Overall Temperature (TCM kidney function)

☐ Cold hands	☐ Cold feet	☐ Hot body temperature (sensation)
☐ Cold fingers	☐ Cold toes	☐ Cold body temperature (sensation)
☐ Sweaty hands	☐ Sweaty feet	☐ Afternoon flushes or night sweats
☐ Perspire easily	☐ Thirsty	☐ Hot flashes any time of day
☐ Lack of perspiration	☐ Take water to bed	☐ Heat in the hands, feet & Chest

Overall Energy (TCM lung/kidney function)

☐ Shortness of breath	☐ General weakness	☐ Difficulty keeping eyes open
☐ Catch colds easily	☐ Low energy	☐ Feel worse after exercise

Overall Blood (TCM liver, spleen, heart function)

☐ Dizziness	☐ See floating black spots

Overall TCM heart function

☐ Palpitations	☐ Anxiety	☐ Sores on tip of tongue
☐ Restlessness	☐ Mental confusion	☐ Chest pain traveling to shoulder
☐ Frequent dreams	☐ Wake un-refreshed	☐ Drink coffee # cups/week_____

Overall TCM lung function

☐ Cough	☐ Nose bleeds	☐ Nasal discharge, color_____
☐ Sinus congestion	☐ Sneezing	☐ Allergies, to what_____
☐ Dry mouth	☐ Sore throat	☐ Headache, location_____
☐ Dry nose	☐ Stiff neck	☐ Alternating chills and fever
☐ Dry throat	☐ Stiff shoulders	☐ Overall achy feeling in body
☐ Dry skin	☐ Difficulty breathing	☐ Smoke cigarettes, #/day_____
☐ Dry throat	☐ Sadness	☐ Melancholy

Overall TCM spleen function

☐ Low appetite	☐ Abdominal gas	☐ Gurgling noises in the stomach
☐ Abrupt weight gain	☐ Abdominal bloating	☐ Fatigue after eating
☐ Abrupt weight loss	☐ Easily bruised	☐ Prolapsed organs, which_____
☐ Pensive	☐ Over-thinking	☐ Hemorrhoids
☐ Worry		

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Overall TCM spleen, stomach, large intestine, small intestine function

☐ Loose stools	☐ Constipated	☐ Incomplete defecation
☐ Diarrhea	☐ Blood in stools	☐ Mucous in stools
		☐ Undigested food in stools

Overall TCM dampness trapped in body

☐ Snoring	☐ Nausea	☐ General sensation of heaviness in body
☐ Mental heaviness	☐ Mental sluggishness	☐ Mental fogginess
☐ Swollen hands	☐ Swollen feet	☐ Swollen joints
☐ Chest congestion	☐ Excess fat	☐ Heavy limbs

Overall TCM stomach function

☐ Large appetite	☐ Bad breath	☐ Burning sensation after eating
☐ Mouth sores (canker)	☐ Heartburn	☐ Bleeding, swollen, painful gums
☐ Acid regurgitation	☐ Ulcer (diagnosed)	☐ Belching
☐ Hiccoughs	☐ Stomach pain	☐ Vomiting

Overall TCM liver and gallbladder function

☐ Chest pain	☐ Flank pain	☐ Alternating diarrhea & constipation
☐ Easily angered	☐ Easily frustrated	☐ Tight sensation in chest, constraint
☐ Easily irritated	☐ Easily depressed	☐ Headaches, one-sided temporal
☐ Skin rashes	☐ Bitter taste in mouth	☐ Headaches, top of head
☐ Muscle spasms	☐ Numbness	☐ Frequently unable to adapt to stress
☐ Muscle twitching	☐ Tingling sensation	☐ Sensation of lump in throat
☐ Muscle cramping	☐ Neck tension	☐ Limited range of motion, neck
☐ Seizures	☐ Shoulder tension	☐ Limited range of motion, shoulder
☐ Convulsions	☐ Drink alcohol	☐ Gallstones (history or current)
		☐ High-pitched ringing in ears

☐ Recreational drugs **Which:** _____

Frequency: _____

_____

☐ Sexually transmitted diseases **Which:** _____

_____

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Overall Eyes (TCM liver function)

☐ Itchy	☐ Bloodshot	☐ Hot
☐ Dry	☐ Watery	☐ Gritty
☐ Blurry vision	☐ Near-sighted	☐ Far-sighted
		☐ Decreased night vision

Overall TCM kidney, urinary bladder function

☐ Frequent cavities	☐ Sore knees	☐ Cold sensation in knees
☐ Low back pain	☐ Weak knees	☐ Memory problems
☐ Excessive hair loss	☐ Kidney stones	☐ Lack of bladder control
☐ Bladder infections	☐ Easily broken bones	☐ Low-pitched ringing in the ears
☐ Fear	☐ Easily startled	☐ Wake during the night to urinate

Overall Urination

☐ Color: normal	☐ Color: dark yellow	☐ Color: clear
☐ Color: reddish	☐ Color: cloudy	☐ Discharge
☐ Volume: profuse	☐ Odor: Strong	☐ Burning
☐ Volume: scanty	☐ Odor: None	☐ Urgent
☐ Frequent	☐ Incontinence or loss	☐ Painful

Overall Libido

☐ Normal	☐ Low	☐ High

Men only:

☐ Swollen testes	☐ Testicular pain
☐ Impotence	
☐ Feeling of cold or numbness in external genitalia	☐ Premature ejaculation
☐ Other:	

Women only:

Regular menstrual cycle? ☐ yes ☐ no	Pregnant? ☐ yes ☐ no
Number of children: _____	Number of pregnancies: _____
Age of first menstruation: _____	Age of menopause: _____
Average number of days of flow:	Averages number of days of cycle:
Vaginal discharge? ☐ yes ☐ no	Bleeding between periods? ☐ yes ☐ no

Do you experience any of the following pre-menstrual syndromes?

☐ Nausea	☐ Vomiting	☐ Water retention
☐ Breast swelling	☐ Food cravings	☐ Migraines

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

☐ **Breast tenderness** ☐ **Depression** ☐ **Irritability**

☐ **Anxiety**

☐ **Other emotions:** _____

☐ **Sharp pain, where?** _____

☐ **Dull pain, where?** _____

Menstrual Chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/Cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

All please fill out:

Other comments: _____

_____

Patient Signature: _____

Acupuncturist Signature: _____

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to treatment with acupuncture and other Oriental Medicine procedure modalities on me, by John Nieters and/or other licensed acupuncturists who now or in the future treat me while employed by, working, or associated with, or serving as a back-up for John Nieters, including those working at this office or any other office or clinic.

I understand that treatments may include, but not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), CranioSacral, herbal treatments, supplements, guasha, far infared heat lamps, nutritional counseling, and life style modifications.

I understand that I have the opportunity and am encouraged to discuss with the treating acupuncturist or clinic personnel the nature and purpose of acupuncture treatments and other procedures at any time.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain disease or dysfunctions of the body. I have been informed that acupuncture is generally a safe method of treatment, but there may be bruising or tingling near the needle sites that may last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. If you choose to have a cupping treatment, there will be bruising, which is normal for that modality.

The herbs and nutritional supplements are from plant, animal and mineral sources. I understand that some herbs may be inappropriate during pregnancy, while others do not combine well with the drug treatments. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist. It is important to inform the acupuncturist of all the pharmaceuticals, supplements, or other medications so that appropriate herbs can be selected. I agree to inform my acupuncturist of all changes in pharmaceutical usage.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest.

I understand the clinical, administrative staff, and medical consultants may review my medical records and lab reports, but all my records are confidential and are handled according to HIPPA regulations.

I understand lab reports to help assess my condition may be ordered. These are not a substitute for lab reports that my medical doctor may order. These test are for different diagnosis criteria and may not be evaluated in the same manner as a medical doctor and do not replace diagnosis or treatment by my Medical Doctor.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about it's content and by signing below I agree to the above named procedures. 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. I understand that this is a general consent and it is always, at every treatment, my choice to accept, deny, or ask about any treatment offered to me.

To be completed by the patient

Patient's Name_____

Patient's Signature_____

Date Signed_____

Are You Pregnant? ☐ Yes ☐ No

To be completed by the patients representative

Name of Patient_____

Patients Representative_____

Relationship of Authority of Patient_____

Witness_____

Alameda Acupuncture Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

Policies and Office Procedures

Office Policies:
The purpose of these office policies is to create an environment that supports the balance and health of our patients. Please read the following information and sign and date the bottom of the form, if you fully understand and agree to these policies. If you feel that you need more information, please speak to a staff member or your attending practitioner for clarification.

Professional Fees:
All fees are subject to change without notice. A full listing of current fees can be found on our "Attending Practitioners Statement". At the present time our discounted fees for payment at the time of service are as follows:

New Patient Consultation and Examination…….……	$250
Established Patient Acupuncture Treatment with Consultation……	$180
Established Patient Acupuncture Treatment with Lab Review…….	$180
Established Patient Follow Up Acupuncture Treatment..……..…….	$95
Herbs or Supplements (if necessary)……..……..	$9 - $60 each

There is full charge for missed appointments not cancelled two business days in advance.
Missed appointments severely impact our practice. Maintaining this missed appointment policy allows us to serve our patients, and keep patient fees as low as possible.

Payment for Services:
Payment is due at the time of service. We accept Cash, Check, MasterCard, Visa, and American Express. Workers Compensation & Personal Injury patients require prior approval by our office.

Patient Comfort and Safety:
Some of our patients are allergic to fragrances. To make their office visit a pleasant and healthy experience we ask that you not wear scented items to the office (perfume, colognes, lotions, etc.).

Please turn off your cell phone in our office for the safety and harmony of you and others.
If you expect to receive an **urgent call**; give our office number and we will alert you if called.

Confidentiality:
Our policies and conduct are designed to meet or exceed HIPAA requirements for confidentiality. Please read our HIPAA policies. Our walls are not completely soundproof, so in the interest of your confidentiality, the comfort of other patients, and to maintain a harmonious and healthy atmosphere, we ask that all conversations be kept at low volume. Thank You!

Urgent Care and Telephone Policy:
We do **not** have 24-hour availability or phone access. For medical emergencies call 911 or your medical doctor. For general inquiries, a staff member should return any call, received Monday through Friday during business hours, within 24 hours. Any questions about your specific health care needs or problems can be addressed at your next appointment with the Acupuncturist.

If you suspect that herbs or supplements are causing unpleasant or unexpected results, discontinue them immediately and then call our office.

Prior to signing please read this form in its entirety

Signature:_____ Print Name:_____ Date:_____