

Acupuncture Associates Health History Questionnaire

Welcome to our clinic! 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 any questions, please ask us. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the comments section. Thank you!

Name _____ DOB ____/____/____ [] M [] F
 Address _____ City _____ State _____
 Daytime Phone _____ Evening Phone _____
 SSN _____ E-mail _____ # to text confirmation _____
 Employer Name _____ Physician Name & Phone _____
 Emergency Contact name and number _____
 Employer's Name and Address _____
 Insurance Carrier _____ Policy # _____ Group # _____
 Referred by _____

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date first noticed:	Use scale below to indicate severity of each symptom, "0" is none (no symptoms) and 10 is severe.	Please check the box below indicating how much of the time you feel the symptom:
1. _____	_____	0 1 2 3 4 5 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
2. _____	_____	0 1 2 3 4 5 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
3. _____	_____	0 1 2 3 4 5 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%
4. _____	_____	0 1 2 3 4 5 7 8 9 10	<input type="checkbox"/> 0-25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 76-100%

LIFESTYLE

Do you exercise regularly? [] Yes [] No If yes, please describe: _____

Occupational stress factors (physical, psychological, chemical): _____

Please describe your average daily diet? _____

Please check the following habits that apply. How much, how often do you use them?

Tobacco Use Coffee, tea or cola Alcoholic Beverages

List medications taken within last two months (vitamins, drugs, herbs, etc.): _____

Please describe any drug use for non-medical purposes: _____

PLEASE PUT A CHECK NEXT TO ANY CONDITION YOU'VE EXPERIENCED IN THE LAST THREE MONTHS, CIRCLE THOSE YOU'VE EXPERIENCED IN THE PAST. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

- | | | |
|----------------------------------------------|---------------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other Significant illness/Trauma (describe) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgeries | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease | _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Birth Trauma (prolonged labor, forceps delivery, etc.) | _____ |
| <input type="checkbox"/> Heart Disease | | _____ |
| <input type="checkbox"/> Seizures | | _____ |

FAMILY MEDICAL HISTORY

- | | | |
|------------------------------------|----------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Other |

GENERAL

- | | | |
|---------------------------------------------|------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweating easily | <input type="checkbox"/> Sudden energy drop (time of day) |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleeding or bruising easily | |

SKIN & HAIR

- | | | |
|--------------------------------------|------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples | <input type="checkbox"/> Changes in texture of hair or skin |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Dandruff | |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | |

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|-------------------------------------------------|------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Headaches (where? when?) |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Jaw clicks |

CARDIOVASCULAR

- | | | |
|----------------------------------------------|----------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Phlebitis |

RESPIRATORY

- | | | |
|--------------------------------------------|----------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Excessive phlegm (color?) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | |

GENITOURINARY

- | | | |
|-----------------------------------------------|-----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Pain while urinating | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sores on genitals |

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

Any particular color to your urine? _____

Any other genital or urinary problems? _____

GASTROINTESTINAL

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

REPRODUCTIVE AND GYNECOLOGIC

- Premenstrual changes
- Menstrual clots
- Painful menses
- Unusual menses
- Heavy menstrual flow
- Light menstrual flow
- Irregular menses
- Other problems
- Premature births
- Miscarriages
- Abortions

Age at first menses: _____

Age at menopause: _____

Number of pregnancies: _____

Time between cycles: _____

Duration of bleeding: _____

First day of last menses: _____

Do you practice birth control? _____

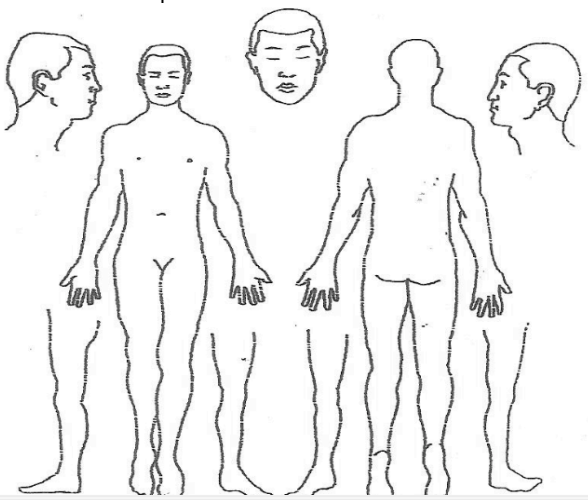
If so, what type? _____

For how long? _____

MUSCULOSKELETAL

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

Please mark painful or distressed areas on the chart below



Please describe the pain:

NEUROPSYCHOLOGICAL

- Seizures
- Dizziness
- Loss of balance
- Areas of numbness
- Poor memory
- Lack of coordination
- Concussion
- 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 or psychological problems? _____

COMMENTS

Please list any other problems you would like to discuss: _____

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT****

I, _____, have received a copy of this office's Notice of Privacy Practices and I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

ACUPUNCTURE ASSOCIATES, PC
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 READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may see and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include acupuncture, moxibustion, cupping, Gua Sha, electrical stimulation and Tui Na (Chinese massage), and Chinese or Western herbal medicine and nutritional counseling.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for your treatment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED-HEALTH INFORMATION to public health authorities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance required by

law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
- The right to request an amendment to your PROTECTED HEALTH INFORMATION.
- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201

877-696-6775 (Toll Free)

Acupuncture Associates PC Cancellation and Office Policies

All appointments require advanced notification of cancellation. Please note that all missed appointments or cancellations made less than 48 hours before the scheduled appointment (9AM Friday for Monday appointments) are the responsibility of the patient, and will be subject to full appointment fee.

All patients, who participate in participating Insurance plans and remit payment to us through insurance, should be advised of the following.

Missed appointments without 48 hrs notice or prior arrangement are the responsibility of the patient. We cannot bill your insurance company for payment. You will be responsible for the regular visit fee.

You should also be aware that even though we may bill your insurance company, you are responsible for payment in the event that payment is refused. You are also responsible for payment if the insurance company at a later date decides that they paid for your treatment in error.

It is your responsibility to know the terms/conditions of your policy and to advise us of them and any changes in them. This may include, but is not limited to, things like: covered diagnosis, limitations in the number of visits, pre-authorizations, referrals and participation in affinity or similar programs. Participation in affinity or discount programs will start after we receive documentation of participation and will not be retroactive.

Patient acknowledgement:

I have read, understand and agree to the above described policies.

Patient signature and date:

Printed Name: