Health History Questionnaire

The following information is important to the maintenance of your account and/or your care. Please complete to the best of your ability. Some of the questions may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

Do not hesitate to ask for assistance, we will be happy to help.

All information is strictly confidential.

Last Name:	First Name:	Middle:	
Phone (H):	Phone (W):	Phone (C):	
Address:			
City:	State:	Zip:	
E-Mail Address:	Date of Birth:	Place of Birth:	
Referred By: Friend_ Doctor_ Insurance_ Web_ Yellow Pages _Our Patient_ Name_____ Other_____			
SSN:	Living With: Spouse:__ Partner:_ Parents:_ Children:__		
Age:	Sex: M F	Height:	Weight:
Employer:		Occupation:	
Family Physician:		Physician Contact Phone:	
In Emergency Notify:		Phone Number:	
Have you been treated by acupuncture or Oriental medicine before? Yes____ No____			

Major Complaints: List them in the order of importance:

1) _____
2) _____
3) _____
4) _____

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

Are there other Physicians/therapists for this condition? (circle one) YES NO

If YES, what is the result of treatment? _____

Name of your Physician(s):_____

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.):

_____

_____

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? _____ How many packs of cigarettes do you smoke 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 ANY YOU HAVE HAD IN THE LAST THREE MONTHS:_____

General

__ Chills
__ Fevers
__ Sweat Easily
__ Night Sweats
__ Localized Weakness
__ Bleed or Bruise Easily
__ Peculiar tastes or smells
__ Strong Thirst (cold or hot)
__ Thirsty, no desire to drink
__ Fatigue
__ Sudden Energy Drop
Time of day?_____
__ Edema
Where_____
__ Poor sleeping
__ Tremors
__ Poor Appetite
__ Weight Loss
__ Weight Gain
__ Peculiar Tastes or Smells

Skin and Hair

__ Rashes
__ Ulcerations
__ Hives
__ Itching
__ Eczema
__ Pimples
__ Dandruff
__ Loss of Hair
__ Recent moles
__ Change in hair or skin
texture
Any hair or skin problems?

Head, Eyes, Ears, Nose, and Throat

__ Dizziness
__ Concussions
__ Migraines
__ Glasses
__ Eye Strain
__ Eye Pain
__ Poor Vision
__ Night Blindness
__ Color Blindness
__ Cataracts
__ Blurry Vision
__ Earaches
__ Ringing in Ears

__ Poor Hearing
__ Spots in Front of Eyes
__ Sinus Problems
__ Nose Bleeds
__ Recurrent Sore Throats
__ Grinding Teeth
__ Facial Pain
__ Sores on Lips or Tongue
__ Teeth Problems
__ Jaw clicks
__Headaches (Where and when?)
Any other head or neck problems?

Cardiovascular

__ High Blood Pressure
__ Low Blood Pressure
__ Chest Pain
__ Irregular Heartbeat
__ Dizziness
__ Fainting
__ Cold Hands or Feet
__ Swelling of Hands
__ Swelling of Feet
__ Blood Clots
__ Phlebitis
__ Difficulty in Breathing
Any other heart or blood vessel problems?

Respiratory

__ Cough
__ Coughing Blood
__ Asthma
__ Bronchitis
__ Pneumonia
__ Pain With a Deep Breath
__ Difficulty in Breathing when Lying Down
__ Production of Phlegm (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 or Cramps
__ Chronic Laxative Use
Any other problems with your stomach or intestines?

Genito-Urinary

__ Pain When Urinating
__ 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 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
__ Unusual Character (Heavy or Light)
__ Irregular periods
__ Painful Periods
__ Clots
__ Last PAP
__ Vaginal Discharge
__ Vaginal Sores
__ Breast Lumps
__Changes in Body/Psyche Prior to Menstruation
Do you use birth control?
Yes No
What type and for how long?

Musculoskeletal

__ Neck Pain
__ Muscle Pains
__ Knee Pain
__ Back Pain
__ Muscle Weakness
__ Foot/Ankle Pains
__ Hand/Wrist Pains
__ Shoulder Pain
__ Hip Pain
Any other joint or bone problems?

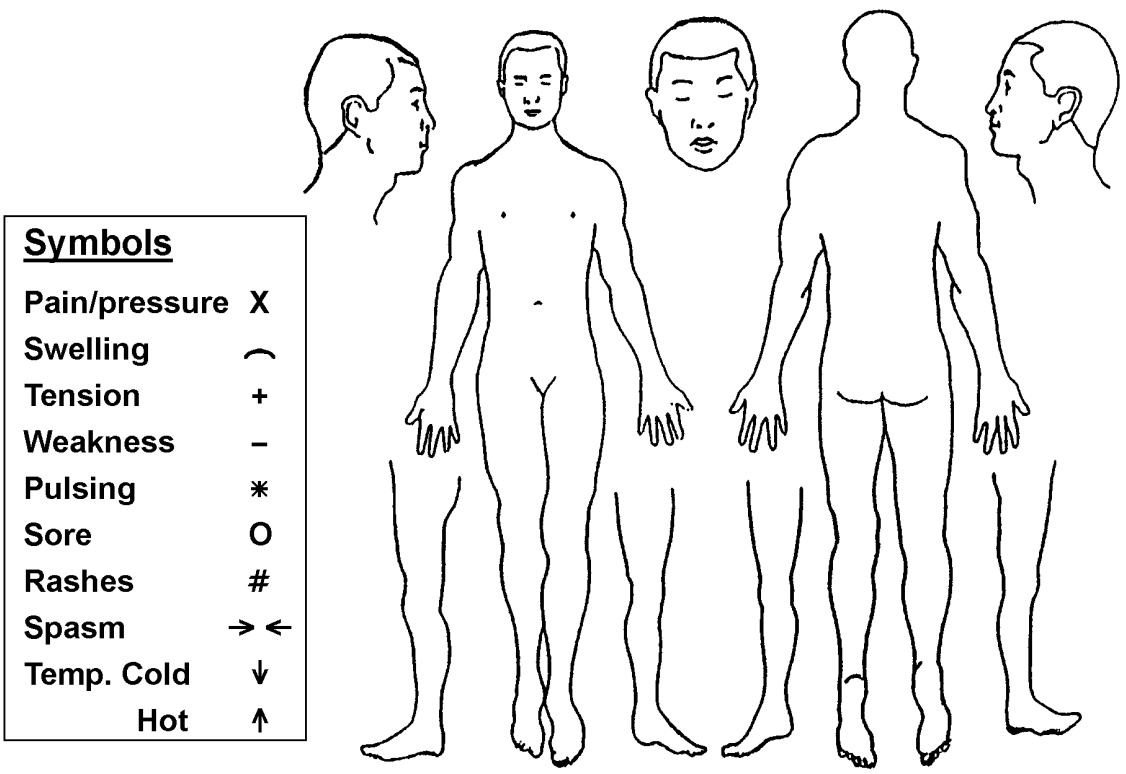
Neuropsychological

__ Seizures
__ Dizziness
__ Loss of Balance
__ Areas of Numbness
__ Lack of Coordination
__ Poor Memory
__ Concussion
__ Depression
__ Anxiety
__ Bad Temper
__ Easily Susceptible to Stress
Have you ever been treated for emotional problems?
Yes No
Have you ever considered or attempted suicide?
Yes __ No
Any other neurological or psychological problems?

_____

_____

Indicate painful or distressed areas:



Comments

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

_____
_____
_____
_____

PATIENT POLICIES

CLINIC – PATIENT AGREEMENTS

Welcome to the office of the Integrated Oriental Medicine, Inc.

The purpose of these pages are to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that those patients who adhere to the following policies get the best results:

1. PATIENT POLICY: CLOTHING

The acupuncture points used for your condition will determine the areas of your body that need to be exposed.

Please wear clothing that is loose fitting (e.g.: pants that can be moved above the knee) or bring shorts. If you are receiving Massage Therapy, your therapist will instruct you.

2. PATIENT POLICY: CLINIC PROCEDURES

1. Please arrive 5 minutes before your designated time (for example, if you have an appointment at 9:00, arrive at 8:55). This will help to insure that patients are treated in a timely manner.
2. If you are receiving acupuncture, take off your shoes and socks. Move clothing as appropriate (e.g.: pull your pant legs above the knee and roll up your sleeves if appropriate).
3. Lay down on the table. The reason we ask you to lay down is so that you can relax for a moment, which will allow you to get a better treatment.
4. To hold your preferred treatment time, we request that all appointments be made in advance. This will save you and the office time, and help eliminate waiting.

3. PATIENT POLICY: PAYMENT OF BILLS

We will expect you to honor the financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, advise our staff immediately so new arrangements can be made.

4. PATIENT POLICY: MISSING OR CHANGING APPOINTMENTS

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

1. If you need to change the time of your appointment, plan to come at another time on the same day.
2. If the same day is not possible, be sure to make up the missed appointment within 7 days.
3. If you miss/cancel/re-schedule your appointments without at least a 24 hour notice, and this happens more than three times, you will be charged the full rate for each appointment every time it happens thereafter.

5. PATIENT POLICY: RE-EXAMINATIONS

During your treatment series, Re-Examinations may take place approximately once a month. The purpose of these visits will be to review your progress and make any adjustments necessary. It will also give us time to determine if any new condition needs to be treated and how you are progressing so far.

6. PATIENT POLICY: DIETARY SUGGESTIONS, LINIMENTS, FOOD SUPPLEMENTS AND HERBS

If applicable, your practitioners may suggest dietary supplements such as herbs, food supplements, and liniments. Any problems you may have with these recommendations should be communicated to your Acupuncturists.

7. PATIENT POLICY: NOTIFY THE OFFICE IF YOU BECOME SICK

Infections and illnesses such as colds, flu's, ear infections, and allergies (known as wind invasions in Oriental
Medicine), are often times easily treated if addressed within the first 24 hours of onset. If not immediately addressed, these conditions can cause two possible outcomes: first, it may prolong your movement to stabilization, and second, it could be complicated by your current herbal formula. It is essential to let your acupuncturists know of such illnesses.

8. PHARMACEUTICAL DRUGS: ALWAYS CONSULT YOUR DOCTOR

An Acupuncturist in the State of Washington is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that is currently medicated we will be happy to do so, so long as the condition has been diagnosed by your doctor and is not an emergency condition. **If the patient decides they want to alter their pharmaceutical regime in any way the patient must consult their doctor before doing so.**

9. PATIENT POLICY: UPSETS

We are here to serve you. Please speak with your acupuncturists about any upsetting matter. We see your comments as allowing us to help you and others.

I have read the above and I understand and accept these policies.

_____ _____

Patient's Signature Date

_____

Patient's Name (Print)

AGREEMENT BY THE PATIENT / GARANTOR TO BE FINANCIALLY RESPONSIBLE FOR FEES

I _____(patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that monthly interest rate of 1.5% will be applied to any unpaid patient balance over 30 days past due.

Patient Signature: _____Date_____

AGREEMENT BY THE PATIENT REGARDING CANCELLED/MISSED APPOINTMENTS

Patient understands that a missed appointment (No Show) will result in a $60 charge which will be donated to local charity organizations. If a patient fails to give the clinic 24 hours notice of a change of appointment, the patient may be charged for that appointment.

Patient Signature: _____Date_____

MEDICAL RELEASE TO INSURANCE COMPANY & NOTICE OF PRIVACY PRACTICES

I authorize the release of medical information to my insurance company / companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company / companies to pay directly to Integrated Oriental Medicine, Inc. for those medical services.

Patient
Signature:_____Date_____

Clinic Verification of Signatures:

_____Date_____

Informed Consent

This disclosure is to advise you of the credentials of the practitioner, the scope of practice for Acupuncture in the State of Washington, and to document your consent for services (WAC 246-802-120).

Scope of Practice: I hereby authorize Integrated Oriental Medicine, PS and all of their practitioners, to perform the following treatments, which include but are not limited to:

- **Acupuncture:** The use of pre-sterilized, disposable acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians.
- **Electrical, Mechanical or Magnetic Stimulation of Acupuncture Points:** Using very small amounts of electricity to stimulate acupuncture points and meridians or using mechanical or magnetic devises to stimulate acupuncture points or meridians.
- **Moxibustion:** A soft woolly mass prepared from ground young leaves, typically in the form of sticks or cones, which are ignited and placed on or close to the skin or used to heat acupuncture needles.
- **Acupressure:** Traditional Chinese medical massage and manual therapy.
- **Cupping:** Glass cups are placed on the skin with a vacuum created by heat or suction device.
- **Dermal-friction Technique (Gwa-sha):** Friction is applied topically to the skin using a smooth object to relieve symptoms.
- **Infrared Heat:** Applying heat generated by an infrared lamp over a specific area of the body.
- **Sonopuncture:** The use of sound to stimulate acupuncture points or meridians.
- **Laserpuncture:** Laser light beams are applied to the acupuncture points to help stimulate the flow of chi and promote healing.
- **Dietary Advice and Health Education Based on East Asian Medical Theory:** Suggestions for nutrition and herbal food products including herbs, vitamins, minerals, and dietary and nutritional supplements.
- **Breathing, Relaxation, and East Asian Exercise Techniques**
- **Qi Gong:** an internal Chinese meditative practice that often uses slow graceful movements and controlled breathing techniques to promote the circulation of qi within the human body, and enhance a practitioner's overall health.
- **East Asian Massage and Tui Na:** Bodywork characterized by kneading, pressing, rolling, shaking, and stretching of the body. This does not include spinal manipulation.

- **Superficial Heat and Cold Therapy**
- **Aquapuncture:** Point injection therapy.
- **Liniments, Oils, and Plasters:** herbal formulas applied topically to the skin.

I recognize the potential benefits and risks of these procedures, which include but are not limited to:

- **Potential Benefits:** Drugless relief of presenting symptoms and improved balance of body energies that may lead to the prevention, improvement or elimination of the presenting problem.
- **Potential Risks:** Some pain following treatment in insertion area, minor bruising, a burn, blistering, bleeding, infection, numbness or tingling at or near the site of the procedure, temporary discoloration of the skin, broken needle, needle sickness, possible aggravation of symptoms existing prior to the acupuncture treatment, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax).

Patients with bleeding disorders or pacemakers as well as pregnant patients should inform the practitioner prior to receiving treatment

I acknowledge that it is my responsibility to seek the advice of a medical doctor or other primary healthcare provider as I see fit to ensure that in the event of serious illness, I do not unknowingly delay necessary medical treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Integrated Oriental Medicine, PS regarding cure or improvement of my condition. I hereby release Integrated Oriental Medicine, PS from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

_____ _____

Signature of patient Date

_____

Name of patient