Seattle Acupuncture Wellness Center
10564 5th Avenue N.E., Suite 404
Seattle, WA 98125
Phone: 206-522-1509

PATIENT AND INSURANCE INFORMATION

The following information is important to the maintenance of your account and or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed. We will be happy to help you.

PATIENT INFORMATION:

Name ____Social Security ________-_____-_______

Age_________Date of Birth___________________________Male_________Female ______

Married_______Divorced_______Single_______Separated_______Widowed_______

Address______________________________________City_______________State________Zip_________

Home phone_____________________Work phone______________________Cell Phone________________

Email__________________________

Occupation__________________________________Employer___________________________________

RESPONSIBLE PARTY:

Name of responsible party___________________________________Relationship_____________________

Address______________________________________City_______________State________Zip_________

Home phone_____________________Work phone______________________Cell Phone________________

Email__________________________

INSURANCE INFORMATION:

Subscriber name____ID #____________________________

Address______________________________________City_______________State________Zip_________

Customer service phone number____

Subscriber date of birth_________________________Relationship to subscriber_____________________

Secondary Insurance_______________________________________ID #____________________________

Address______________________________________City_______________State________Zip_________

Customer service phone number____

Subscriber date of birth_________________________Relationship to subscriber_____________________

EMERGENCY CONTACT / NEXT OF KIN:

Name_________________________________Phone____________________Relationship_______________

Name_________________________________Phone____________________Relationship_______________

Whom may we thank for referring you?____

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HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist
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.

Name of your primary physician:____

Is there anything limiting you from care ❑Yes ❑No______________________________

Other physicians/therapists seen for the condition:__________________________________

How did you hear about our office:____

Medications you are current taking:

1)______________ 2)______________ 3)______________ 4)______________

5)______________ 6)______________ 7)______________ 8)______________

Prescribed by:____

For Treatment of:____

____

Results:____

Supplements (if any, vitamins, herbs, minerals, etc.)______________________________

____

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

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ Additional:__________________________

How do these conditions impair your daily activities?_____________________________

____

II. **Patient Medical History**

How was your childhood health?____

Hospital Visits/Stays: ____
Recent tests: (please indicate test results and date below)

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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.

The Seattle Acupuncture Wellness Center respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact your to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
  - medical quality review by your health plan;
  - accounting, legal, risk management, and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

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Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you.

You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant this request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request;
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosure to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months;
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel and authorization if its purpose was to obtain insurance.

For help with these rights during normal business hour, please contact:
Office manager/HIPAA Officer at (206) 522-1509.

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of the Notice by calling and asking for it or to pick one up.

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To ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Office Manager/HIPAA Officer at (206) 522-1509.

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Office Manager/HIPAA Officer at our practice/health care facility. You may also file a complaint with the U.S. Secretary of Health and Human Services.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.
- [Hospitals] Information may be provided to people who ask for you by name. we may use and disclose the following information in a hospital directory:
  - Your name,
  - Location,
  - General condition, and
  - Religion (only to clergy)

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers-**if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researcher preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating problems with food, supplements, and products.
- **To Comply with Workers' Compensation Laws—**if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
  - To prevent or reduce a serious, immediate threat to the health or safety of a person
  - Or public.

- To public health or legal authorities
  - To protect public health and safety
  - To prevent or control disease, injury, or disability
  - To report vital statistics such as births or deaths.

- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For examples, we may share information for national security purposes.

Other Uses of Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- We have a Web site that provides information about us.

Effective Date:

January 1, 2012

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

- We keep a record of the health care services we provide you.
- You may ask to see and copy that record.
- You may also ask to correct that record.
- We will not disclose your record to other unless you direct us to do so or unless the law authorizes or compels us to do so.
- You may see your record or get more information about it by contacting the Office Manager / HIPAA Offices.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

________________________________ ________________
Patient or legally authorized individual signature Date Time

________________________________ ________________
Printed name and signed on behalf of the patient Relationship
Parent, legal guardian or representative

____
Witness/Staff Member

(Notation, if any, by staff)
This form will be retained in your Seattle Acupuncture Wellness Center medical record.

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Consent Form for Traditional Methods

I, the undersigned hereby authorize Hyejung Hayes, E.A.M.P., who received her Master of Acupuncture in June 2002 from the Northwest Institute of Acupuncture and Oriental Medicine and who is currently licensed in the State of Washington (Lic # 00002067) to perform the following acupuncture procedures:

- **Acupuncture**: the insertion of special sterilized. Disposable needles through the skin into the underlying tissues at specific points on the surface of the body
- **Cupping**: a technique used to relieve symptoms by applying cups made of glass, bamboo, or other materials to the skin with a vacuum created by heat or other devices.
- **Plum Blossom or Seven Star hammer**: multi-needle devices applied to areas of the body with a light to-moderate tapping technique.
- **Moxabustion (moxa)**: the burning of herbs on or near the body to warm it, strengthen it, and relive symptoms. Moxa comes in several forms such as a stick, string, ball, cone, or rice grain.
- **Dietary Advice**: food and herbal advice based on traditional Chinese medical theory.
- **Electro –Acupuncture**: the running of very low electrical current through one or more needles to help heal the body.
- **Sonopuncture**: the use of tuning forks to help heal the body with sound waves and vibration. The forks are placed near and on the body, often on acupuncture points and energy meridians.

I recognize the potential risk and benefit of these procedures as described below

Potential risks: Although uncommon, there is a potential for acupuncture to produce some discomfort or pain at needled sites, **minor bruising**, or infection. It may also cause needle sickness, a broken needle, temporary discoloration of the skin, and potentially… an aggravation of symptoms existing prior to the acupuncture treatment. Clients with severe bleeding disorders or pace-makers should inform their practitioners prior to treatment.

Potential benefits: drugless or drug-reduced relief of presenting symptoms and the improved balance of bodily energies which may lead to prevention or elimination of the Client's main complaints.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Hyejung Hayes, E.A.M.P., regarding the cure or improvement of my conditions.

I hereby release Hyejung Hayes, E.A.M.P., 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 my consent and to discontinue participating in these procedures at any time.

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Written Waiver to Continue East Asian Medical Treatment

Washington State law requires acupuncturists to receive a written diagnosis or to consult with a primary car provider (MD, DO, ND, PA, ARNP) before treating patients with any of the following potentially serious disorders. This consultation requires your authorization; if you refuse the authorization or do not provide a recent diagnosis from the physician, you will have to sign this waiver so that treatments may continue.

I, the undersigned patient, acknowledge I may have a potentially serious disorder. The nature of the disorder is:

(Initial each applicable disorder)

____ Cardiac conditions including uncontrolled hypertension
____ Acute abdominal symptoms
____ Acute diagnosed neurological changes
____ Unexplained weight loss or gain in excess of fifteen percent body weight within a three month period
____ Suspected fracture or dislocation
____ Suspected systemic disorders and infections
____ Any serious diagnosed hemorrhagic disorder
____ Acute respiratory distress without previous history or diagnosis

Initial ______

Because of the above disorder, Seattle Acupuncture Wellness Center and the undersigned practitioner requested a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder.

I acknowledge that failure to pursue treatment from my primary health care provider may involve risks not limited to as death, additional distress, aggravation of underlying condition, disability, pain, and impairment.

I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary health care provider and wish to continue with treatment. I further understand the services and techniques the East Asian medicine practitioner is authorized to provide will not resolve my underlying potentially serious disorder(s).

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SIGN ONLY AFTER YOU UNDERSTAND AND AGREE TO THE ABOVE TERMS

____
(Please Print) Name of Patient

________________________________ ______________
Signature of Patient or Representative (if patient is a minor or handicapped) Date

________________________________ ______________
Witness to Patient's Signature Date

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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 by the Seattle Acupuncture Wellness Center (SAWC) 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 a 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

If a patient fails to give the wellness center 24 hours notice of a change of appointment, or in the case of a "no show" (i.e. not showing up at a prearranged date and time for an appointment at SAWC), the PATIENT AUTHORIZES SAWC TO AUTOMATICALLY CHARGE A $45 FEE TO THE PATIENT'S CREDIT CARD ON FILE. FURTHERMORE, THE PATIENT AUTHORIZES SAWC TO AUTOMATICALLY CHARGE THE PATIENT'S CREDIT CARD ON FILE, FOR ALL ADDITIONAL "NO SHOWS" AS THEY HAPPEN. SHOULD A PATIENT NOT HAVE A CREDIT CARD ON FILE, AFTER THE FIRST "NO SHOW," THE PATIENT AGREES TO PROVIDE CREDIT CARD INFORMATION OVER THE TELEPHONE TO SAWC, AND TO AUTHORIZE SAWC TO CHARGE THE $45 FEE, FOR EACH AND EVERY "NO SHOW."

If the patient were to reschedule, on the same day of their original appointment, then no $45 fee will be charged.

If the patient has an appointment scheduled to take place on a Monday, or on a Tuesday after a holiday taking place on a Monday (e.g. Labor Day, Memorial Day, etc.), notice to cancel an appointment is required, on the previous Thursday (the clinic is not open on Fridays).

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 SAWC for those medical services.

Patient Signature:____Date_______________________

Clinic Verification of Signatures:
____Date__________________________________

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Dear New Patient:

a. Please **read** and **fill in** all of the information that pertains to you.
b. On pages 2 through 11, under each category, **check all** symptoms that you experience either *acutely or chronically* .
c. **Add** and **total** all of the boxes you checked.
d. **Date** today's day.

	TEST	DATE	TEST RESULTS
☐	Physical	______	______________________________
☐	Cholesterol	______	______________________________
☐	Prostate	______	______________________________
☐	Mammography	______	______________________________
☐	Pap Smear	______	______________________________
☐	Blood (which test?)	______	______________________________
☐	HIV/STD	______	______________________________
☐	Other	______	______________________________

Please indicate if you have (or have been tested for) any of the following:			
☐ Diabetes	☐ Allergies	☐ Rheumatic Fever	☐ Vein Condition
☐ Heart Disease	☐ CVA (stroke)	☐ Thyroid Disorder	☐ Tuberculosis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Chicken Pox
☐ High Blood Pressure	☐ Gonnorhea	☐ Bleeding Tendency	☐ Polio
☐ Syphilis	☐ Measles	☐ Nervous Disorder	☐ Migraines
☐ Meningitis	☐ HIV	☐ Monoucleosis	☐ Other Liver Illnesses
☐ Epilepsy	☐ High Fever	☐ Multiple Sclerosis	☐ Other Heart Illnesses
☐ Paralysis	☐ Cancer	☐ Jaundice	☐ Other Kidney Illnesses
☐ Glaucoma	☐ Mumps	☐ Hepatitis	☐ Other Lung Illnesses

IMMUNIZATIONS?

____
____
____
____
____

SURGERIES?

____
____
____
____
____

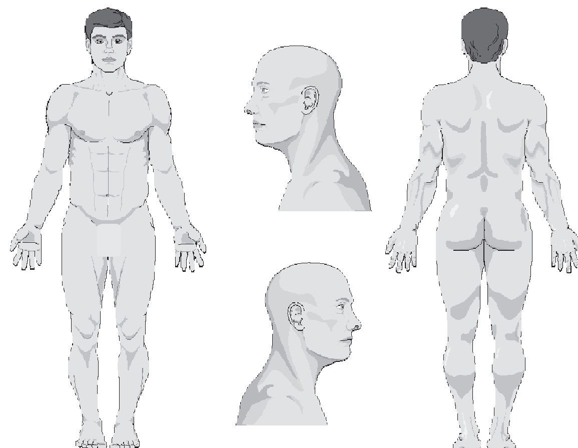
NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

1. Pain:

☐	What makes the pain better?
☐	Soft Preassure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Rest
☐	Other

☐	What makes the pain worse?
☐	Soft Pressure
☐	Hard Pressure
☐	Cold
☐	Heat
☐	Exercise
☐	Other

On the figures below, please mark clearly any areas of pain and indicate any scars.



2. Describe your pain:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

☐		#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Sharp	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Fixed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Moving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Cramping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Aching	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Dull	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Other:______________________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:___________	RE Date:												

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

3. *Kidney Function:*
(Overall Temperature)

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

☐	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Cold Hands												
☐	Cold Fingers												
☐	Cold Toes												
☐	Cold Feet												
☐	Sweaty Hands												
☐	Sweaty Feet												
☐	Hot Body Temperature Sensation												
☐	Cold Body Temperature Sensation												
☐	Afternoon Flushes												
☐	Night Sweats												
☐	Heat in the hands, feet & chest												
☐	Hot flashes any time of the day												
☐	Thirsty												
☐	Perspire easily												
☐	Lack of perspiration												
☐	Do you take water to bed												
☐	***Total Boxes Checked***												

Date:____________ RE Date:

4. *Lung, Kidney Function:*
(Overall Energy)

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

☐	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Shortness of Breath												
☐	Difficulty keeping eyes open (daytime)												
☐	General Weakness												
☐	Easily catch colds												
☐	Low Energy												
☐	Feel worse after exercise												
☐	Chronic (daily) fatigue & malaise												
☐	***Total Boxes Checked***												

Date:____________ RE Date:

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

5. Liver, Spleen, Heart Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Dizziness												
☐ See floating black spots												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

6. Heart Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Anxiety												
☐ Sores on tip of tongue												
☐ Restlessness												
☐ Mental confusion												
☐ Chest pain traveling to shoulder												
☐ Frequent dreams												
☐ Wake unrefreshed												
☐ Coffee? How much per week?_______												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

7. Spleen Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Low Appetite												
☐ Abrupt Weight Gain												
☐ Abrupt Weight Loss												
☐ Abdominal Bloating												
☐ Abdominal Gas												

spleen function continued next page...

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

7. Spleen Function, continued…

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Gurgling noise in Stomach												
☐ Fatigue after eating												
☐ Prolapsed Organs? Which?_________												
☐ Bruise easily?												
☐ Over-Thinking												
☐ Worry												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

8. Lung Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Nasal Discharge (color___________)												
☐ Cough												
☐ Nose Bleeds												
☐ Sinus Congestion												
☐ Dry Mouth												
☐ Dry Throat												
☐ Dry Nose												
☐ Dry Skin												
☐ Allergies (what?_________________)												
☐ Alternating Chills/Fever												
☐ Sneezing												
☐ Headache (location______________)												
☐ Overall achy feeling in body												
☐ Stiff Neck												
☐ Stiff Shoulders												
☐ Sore Throat												
☐ Difficulty breathing												
☐ Smoke cigarettes (# per day_______)												
☐ Sadness												
☐ Melancholy												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

9. Spleen, Stomach, Small/Large Intestine Function

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Loose Stools												
☐	Constipated												
☐	Incomplete Stools												
☐	Diarrhea												
☐	Blood in Stools												
☐	Mucous in Stools												
☐	Undigested food in the Stools												
☐	***Total Boxes Checked***												
	Date:____________ RE Date:												

10. Stomach Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Burning sensation after eating												
☐	Large appetite												
☐	Bad Breath												
☐	Canker Sores (mouth)												
☐	Bleeding, swollen or painful gums												
☐	Heartburn												
☐	Acid Regurgitation												
☐	Ulcer (diagnosed?)												
☐	Belching												
☐	Hiccups												
☐	Stomach Pain												
☐	Vomiting												
☐	***Total Boxes Checked***												
	Date:____________ RE Date:												

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

11. Dampness trapped in the Body:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Bodily sensation of heaviness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Mental heaviness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Mental sluggishness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Mental fogginess	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Swollen hands	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Swollen feet	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Swollen joints	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Chest congestion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Snoring	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Date:____________ RE Date:												

12. Liver Function (eyes):

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐	Itchy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Bloodshot	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Hot	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Dry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Watery	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Gritty	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Blurry Vision	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Decreased Night Vision	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Near-sighted	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	Far-sighted	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐	***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Date:____________ RE Date:												

13. Liver, Gall Bladder Function:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Alternating Diarrhea & Constipation												
☐ Chest Pain												
☐ Tight sensation in the Chest												
☐ Bitter taste in the mouth												
☐ Anger easily												
☐ Depression												
☐ Frustration												
☐ Irritability												
☐ Skin Rashes												
☐ Headache at the top of the Head												
☐ Tingling Sensation												
☐ Numbness												
☐ Muscle twitching												
☐ Muscle cramping												
☐ Muscle Spasms												
☐ Seizures												
☐ Convulsions												
☐ Lump in the throat												
☐ Neck Tension												
☐ Shoulder Tension												
☐ Limited Range-of-Motion (Neck)												
☐ Limited Range-of-Motion (Shoulder)												
☐ How much Alcohol / day?_________												
☐ Recreational drugs (which?_________)												
☐ High-pitched Ringing in Ears												
☐ Gallstones (history or current)												
☐ STD's (which?_________________)												
☐ Unable to adapt to Stress												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

14. *Kidney, Urinary Bladder Function:*

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Frequent cavities, teeth problems												
☐ Easily broken bones												
☐ Sore knees												
☐ Weak knees												
☐ Cold sensation in the knees												
☐ Low Back Pain												
☐ Memory problems												
☐ Excessive hair loss												
☐ Low-pitched ringing in the ears												
☐ Kidney Stones												
☐ Bladder Infections												
☐ Lack of bladder control												
☐ Wake during the night 2 (or more) times to urinate?												
☐ Fear												
☐ Easily startled												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

15. *Libido:*

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Symptom	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Normal												
☐ High												
☐ Low												
☐ ***Total Boxes Checked***												
Date:____________ RE Date:												

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

16. *Urination (Bladder Function):*

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

Color (please check):	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Pale____; Dk Yellow____; Clear____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Reddish	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Cloudy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Scanty	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Profuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Strong Oder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Burning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Painful	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Discharge	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Difficult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Urgent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ Frequent	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
☐ ***Total Boxes Checked***	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Date:____________ RE Date:												

WOMEN ONLY

☐ Yes	☐ No	Do you have a regular menstrual cycle?	_______ Age of first menstruation
☐ Yes	☐ No	Are you pregnant?	_______ Average number of days in flow
☐ Yes	☐ No	Do you have bleeding beetween periods?	_______ Average number of days in entire cycle
☐ Yes	☐ No	Do you have a vaginal discharge?	_______ Number of children
			_______ Number of pregnancies
			_______ Age of menopause (if applicable)

Please fill in the menstrual chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (choose one): normal, pale, bright red, brown rust, dark purple, other							
Amount of flow (choose one): normal, heavy, light							
Pain/Cramps (choose one): dull, sharp, other							
Vomiting (check if yes):							
Nausea (check if yes):							

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Women Only:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM**, only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Nausea												
☐ Vomiting												
☐ Food cravings												
☐ Water retention												
☐ Breast swelling												
☐ Breast tenderness												
☐ Headaches												
☐ Migraines												
☐ Dull pain (where?_________)												
☐ Sharp pain (where?__________)												
☐ Depression												
☐ Irritability												
☐ Anxiety												
☐ Other (explain____________)												
☐ ***Total Boxes Checked***												

Date:____________ RE Date:

Men Only:

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your **RE-EXAM** only check the boxes that **NO LONGER** pertain to you, or if you **HAVE NOT** experienced the symptoms for two weeks. **Add** up your boxes and **date**.

	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11	#12
☐ Swollen testes												
☐ Testicular pain												
☐ Impotence												
☐ Premature ejaculation												
☐ Feeling of coldness or												
Numbnesss in external genitalia												
☐ Other?												
☐ ***Total Boxes Checked***												

Date:____________ RE Date:

WOMEN ONLY

- ☐ Yes ☐ No Do you have a regular menstrual cycle?
- ☐ Yes ☐ No Are you pregnant?
- ☐ Yes ☐ No Do you have bleeding between periods?
- ☐ Yes ☐ No Do you have a vaginal discharge?

Age of menopause (if applicable):_______

Age of first menstruation:_______
Average number of days of flow:_______
Average number of days of entire cycle:_______
Number of children?_______
Number of pregnancies?_______

Which of the following pre-menstrual syndromes do you experience?

- ☐ nausea
- ☐ vomiting
- ☐ food cravings
- ☐ water retention
- ☐ breast swelling
- ☐ breast tenderness
- ☐ headaches
- ☐ migraines
- ☐ dull pain (where?):___________________
- ☐ sharp pain (where?):_________________
- ☐ depression
- ☐ irritability
- ☐ anxiety
- ☐ other (explain)_______________ __________________________

Please fill in the following 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)							
Vomiting: (check if yes)							
Nausea: (check if yes)							
Other:							

MEN ONLY

- ☐ swollen testes
- ☐ testicular pain
- ☐ impotence
- ☐ premature ejaculation
- ☐ feeling of coldness or numbness in external genitalia

Please fill out the following:

Other Comments: ____
____

Patient Signature: _____________________________________ dated this ______ day of ____________________, 201__.