



**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.*

**I. General Patient Information**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Age: \_\_\_\_\_  
Phone: \_\_\_\_\_ SS#: \_\_\_\_\_  
E-Mail: \_\_\_\_\_  
Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

Health condition(s), in order of significance to you:

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

How do these conditions impair your daily activities? \_\_\_\_\_  
\_\_\_\_\_

**II. Patient Medical History**

How was your childhood health? \_\_\_\_\_

Hospital visits/stays/surgeries: \_\_\_\_\_  
\_\_\_\_\_

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

- Physical       Cholesterol       Prostate       Blood
- HIV/STD       Pap Smear       Mammography       Other: \_\_\_\_\_

Test Results and Date: \_\_\_\_\_

Immunizations: \_\_\_\_\_

Check any you have had in the past:

- AIDS/HIV       Diabetes       Measles       Rheumatic Fever       Other: \_\_\_\_\_
- Acoholism       Emphysema       Meningitis       Scarlet Fever      \_\_\_\_\_
- Allergies       Epilepsy       Migraines       Seizures      \_\_\_\_\_
- Appendicitis       Glaucoma       Mononucleosis       STD's      \_\_\_\_\_
- Arteriosclerosis       Goiter       Mumps       Stroke      \_\_\_\_\_

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Birth Trauma      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Pleurisy         | <input type="checkbox"/> Typhoid Fever    |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Polio            | <input type="checkbox"/> Vein condition   |

### III. 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 function):

#### Temperature: (Kidney Function)

- |  |                                       |  |   |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Cold hands        | <input type="checkbox"/> Cold fingers | <input type="checkbox"/> Cold feet       | <input type="checkbox"/> Cold toes              |
| <input type="checkbox"/> Sweaty hands      | <input type="checkbox"/> Sweaty Feet  | <input type="checkbox"/> Hot body temp.  | <input type="checkbox"/> Heat in the hands/feet |
| <input type="checkbox"/> Afternoon flushes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Cold body temp. | <input type="checkbox"/> Heat in the chest      |
| <input type="checkbox"/> Hot flashes       | <input type="checkbox"/> Thirst       | <input type="checkbox"/> Perspire easily | <input type="checkbox"/> Lack of perspiration   |
| <input type="checkbox"/> Take water to bed |                                       |  |   |

#### Energy: (Lung, Spleen, Kidney Function)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> General weakness   | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty keeping eyes open in daytime |
| <input type="checkbox"/> Easily catch colds | <input type="checkbox"/> Low energy          | <input type="checkbox"/> Feel worse after exercise               |

#### Blood: (Liver, Spleen, Heart)

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> See floating black/gray spots in vision |
|------------------------------------|--|

#### Heart Function:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Palpitations                             | <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Sores on the tip of the tongue   |
| <input type="checkbox"/> Restlessness                             | <input type="checkbox"/> Mental confusion | <input type="checkbox"/> Chest pain traveling to shoulder |
| <input type="checkbox"/> Frequent dreams                          | <input type="checkbox"/> Vivid Dreams     | <input type="checkbox"/> Wake un-refreshed                |
| <input type="checkbox"/> Drink coffee (# of cups per week: _____) |   |   |

#### Lung Function:

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Cough       | <input type="checkbox"/> Nose bleeds  | <input type="checkbox"/> Nasal Discharge (Color: _____) |
| <input type="checkbox"/> Dry mouth   | <input type="checkbox"/> Dry throat   | <input type="checkbox"/> Sinus congestion               |
| <input type="checkbox"/> Dry nose    | <input type="checkbox"/> Dry skin   | <input type="checkbox"/> Allergies (to what: _____)     |
| <input type="checkbox"/> Sneezing    | <input type="checkbox"/> Headache   | <input type="checkbox"/> Alternating fever and chills   |
| <input type="checkbox"/> Stiff neck  | <input type="checkbox"/> Stiff shoulders                                    | <input type="checkbox"/> Generalized achy feeling       |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Melancholy   | <input type="checkbox"/> Difficulty breathing           |
| <input type="checkbox"/> Sadness     | <input type="checkbox"/> Smoke cigarettes: (# of cigarettes per day: _____) |   |

#### Spleen Function:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Low appetite       | <input type="checkbox"/> Fatigue after eating | <input type="checkbox"/> Abrupt weight gain                    |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Abdominal bloating   | <input type="checkbox"/> Abdominal gas                         |
| <input type="checkbox"/> Bruise easy        | <input type="checkbox"/> Hemorrhoids          | <input type="checkbox"/> Gurgling noise in stomach             |
| <input type="checkbox"/> Pensive            | <input type="checkbox"/> Over-thinking        | <input type="checkbox"/> Prolapsed organs (which organ? _____) |
| <input type="checkbox"/> Worry              |   |  |

#### Spleen, Stomach, Large Intestine, Small Intestine Function:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Loose stools             | <input type="checkbox"/> Constipated    | <input type="checkbox"/> Incomplete bowel movements |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Mucous in stool            |
| <input type="checkbox"/> Undigested food in stool |   |   |

Dampness trapped in the body:

- Heavy head
- Mental sluggishness
- General sensation of heaviness/weighted down
- Mental fogginess
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach Function:

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

Liver, Gall Bladder Function:

- Chest Pain
- Bitter taste in the mouth
- Alternating diarrhea and constipation
- Anger easily
- Frustration
- Tight sensation in chest
- Depression
- Irritable
- Frequently unable to adapt to stress
- Skin rashes
- Headache at top of head
- Tingling sensations
- Numbness
- Muscle spasms/twitching
- Muscle cramping
- Seizures
- convulsions
- Lump in throat
- Gall stones
- Neck tension
- Neck - limited range of motion
- Shoulder tension
- Shoulder – limited range of motion
- Drink alcohol
- Recreational drugs (Which? \_\_\_\_\_ Frequency: \_\_\_\_\_)
- High pitched ringing in ears
- STD (Which? \_\_\_\_\_)

Eyes: (Liver Function)

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

Kidney, Urinary Bladder Function:

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

Urination:

- Normal color
- Dark yellow
- Clear, no color
- Reddish
- cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful
- Discharge
- Difficult
- Urgent
- Frequent

Libido: (Kidney Function)

- Normal
- High
- Low





## Consent to Receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Healing Response Acupuncture & Integrative Medicine. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Cupping:** I understand that if I receive cupping as part of therapy, there is a risk of temporary bruising, reddening of the skin or blistering from its use. I understand that I may refuse this therapy.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Healing Response Acupuncture & Integrative Medicine as soon as possible.*

**Acupressure/Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Phone:** \_\_\_\_\_



## Financial Policy

### Payment

If my insurance covers acupuncture I can elect to have Healing Response Acupuncture & Integrative Medicine submit claims for me. I am responsible for my deductible, co-pay and co-insurance amounts. **If my insurance denies payment of a claim I am responsible for the billed charges.**

I understand the clinic provides a non-billable discount for full payment at the time of service and MasterCard and Visa are accepted as well as cash and checks.

A sliding scale is available upon request for annual income of less than \$25,000 for a single person, \$50,000 for a couple, or \$70,000 for a family with children. Qualifying for the sliding scale requires documentation of income – either pay stubs or previous year's tax return. The sliding scale is 30% off the usual and customary billed charges.

### Missed Appointments/Late Cancellations

My appointment time is reserved specifically for me. **If an appointment is cancelled with less than 24 hours notice I will be given a verbal warning on the first occurrence, and charged a \$30 fee for subsequent occurrences. In the event of a missed appointment with no prior notification I will be charged \$65.00.** I understand insurance will not pay for a missed appointment or late cancellation fee.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

## Privacy Policy

I understand I have the right to review Healing Response Acupuncture's Privacy Policy prior to signing this document. The Privacy Policy describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Healing Response Acupuncture. The Privacy Policy is also provided at the front desk. This Privacy Policy also describes my rights and the duties of Healing Response Acupuncture with respect to my identifiable health information.

Healing Response Acupuncture reserves the right to change information contained in the Privacy Policy at any time. I may obtain a revised Privacy Policy by requesting the most current notice during any office visit.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship

## **Privacy Policy**

### **Our Clinic Protects Your Health Information and Privacy**

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

***Safeguards in place at our office include:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

***Types of information that we gather and use:***

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

We value your relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call during regular business hours at 541-390-8184.