

## HEALTH HISTORY QUESTIONNAIRE

**TODAY'S DATE:** \_\_\_\_\_

\_\_\_\_\_
   
 Primary Phone #                      (home/work/cell)      Alternate Phone #                      (home/work/cell)

Email: \_\_\_\_\_

**Would you like to join our e-mail list to receive our newsletter with clinic updates and special offers?**    \_\_\_YES    \_\_\_NO

*(Our newsletter is a good way to stay informed and special discounts and promotions. We send it infrequently, and we will not share your information with any third parties. You can unsubscribe easily at any time.)*

First Name	Last Name	Nickname
Street Address	Birth Date	Age      Gender
City, State, Zip Code	Height	Weight
Email Address	Occupation	
Emergency Contact	Relationship to Client	Emergency Contact Phone #
Primary Physician	Physician's Phone #	
Referred By	How did you find out about us?	

How did you hear about us?

☆ Print Ad   ☆ Web   ☆ Friend   ☆ Other \_\_\_\_\_

Have you been treated by acupuncture or oriental medicine before?    YES    NO

Have you had massage therapy or chiropractic treatment before?    YES    NO

Main problem(s) you would like to be treated for:
How long ago did this problem begin (please be specific)?
To what extent does this problem interfere with your daily activities?
Have you been given a diagnosis for this problem? If so, describe:
What kinds of treatment have you tried?

Please note the severity of your problem now (circle one):

1 2 3 4 5 6 7 8 9 10

No Problem Worst Imaginable

Please note the severity of your problem within the last week (circle one):

1 2 3 4 5 6 7 8 9 10

No Problem Worst Imaginable

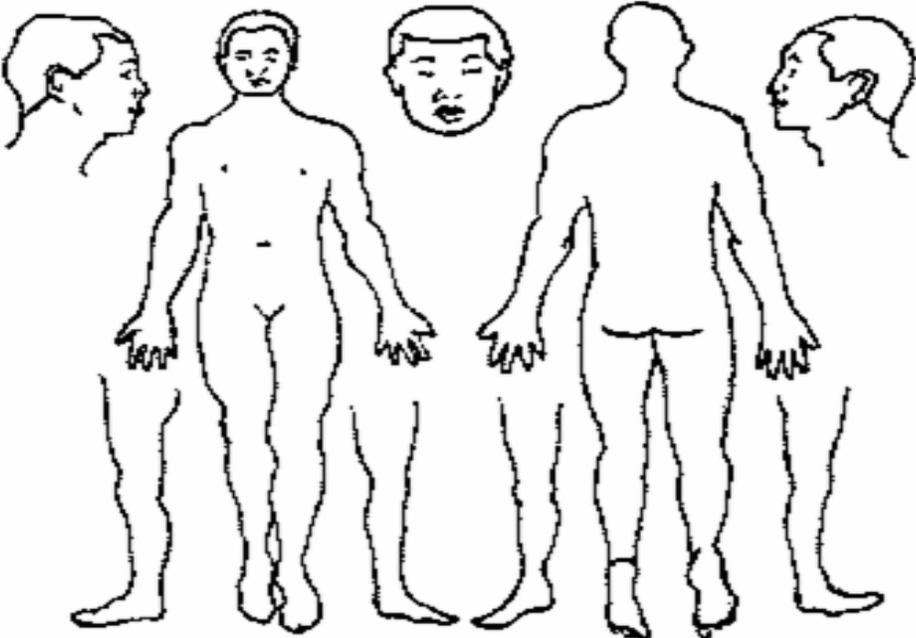
Comments (please mention any other problems you would like to discuss):

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Indicate painful or distressed areas:



**Medications:** (Please include any taken within the last two months, including vitamins, herbs, etc.)

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**PAST MEDICAL HISTORY** (please include dates)

<input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STDs
<input type="checkbox"/> Other	
<input type="checkbox"/> Surgeries (type & date)	
<input type="checkbox"/> Significant Trauma (auto accidents, falls, etc.)	
<input type="checkbox"/> Significant Dental Work	
<input type="checkbox"/> Birth History	(Prolonged labor, c-section, etc.)
<input type="checkbox"/> Allergies	

**FAMILY MEDICAL HISTORY**

<input type="checkbox"/> Cancer <hr/> <input type="checkbox"/> Diabetes <hr/> <input type="checkbox"/> Asthma <hr/> <input type="checkbox"/> High Blood Pressure <hr/>	<input type="checkbox"/> Heart Disease <hr/> <input type="checkbox"/> Thyroid Disease <hr/> <input type="checkbox"/> Seizures <hr/> <input type="checkbox"/> Stroke <hr/>
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<input type="checkbox"/> Occupational Stress	
<input type="checkbox"/> Regular exercise program	
<input type="checkbox"/> Restricted diet	
<input type="checkbox"/> Smoke	Number of cigarettes per day:
<input type="checkbox"/> Coffee/tea/soda	Number of servings per week:
<input type="checkbox"/> Alcohol	Number of servings per week:
<input type="checkbox"/> Non-medicinal drug use	

**PLEASE CHECK ANY SYMPTOMS YOU HAVE HAD IN THE PAST THREE MONTHS**

CARDIOVASCULAR	GENITO-URINARY	NEUROPSYCHOLOGICAL
<input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Blood clots <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Dizziness <input type="checkbox"/> Swelling of hands or feet <input type="checkbox"/> Phlebitis <input type="checkbox"/> Chest pain <input type="checkbox"/> Fainting <input type="checkbox"/> Difficulty in breathing <input type="checkbox"/> Other heart or blood vessel problems	<input type="checkbox"/> Pain during urination <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"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impotency <input type="checkbox"/> Genital sores <input type="checkbox"/> Other genital or urinary problems: <hr/> <input type="checkbox"/> Do you wake up to urinate? If so, how often? <hr/>	<input type="checkbox"/> Seizures <input type="checkbox"/> Areas of numbness <input type="checkbox"/> Concussion <input type="checkbox"/> Bad temper <input type="checkbox"/> Dizziness <input type="checkbox"/> Lack of coordination <input type="checkbox"/> Depression <input type="checkbox"/> Easily susceptible to stress <input type="checkbox"/> Loss of balance <input type="checkbox"/> Poor memory <input type="checkbox"/> Anxiety <input type="checkbox"/> Other neurological or psychological problems

<p><b>RESPIRATORY</b></p>	<p><input type="checkbox"/> Any particular color to your urine: _____</p>	
<p><input type="checkbox"/> Cough  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> Difficulty in breathing when lying down  <input type="checkbox"/> Production of phlegm              What color? _____  <input type="checkbox"/> Coughing blood  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Asthma  <input type="checkbox"/> Pain while breathing deeply  <input type="checkbox"/> Other lung problems: _____</p>	<p><b>PREGNANCY &amp; GYNECOLOGY</b></p> <p><input type="checkbox"/> Number of pregnancies _____</p> <p><input type="checkbox"/> Number of births _____</p> <p><input type="checkbox"/> Premature births _____</p> <p><input type="checkbox"/> Miscarriages _____</p> <p><input type="checkbox"/> Abortions _____</p> <p><input type="checkbox"/> Age at first menses _____</p> <p><input type="checkbox"/> # days between periods _____</p> <p><input type="checkbox"/> Duration _____</p> <p><input type="checkbox"/> First date of last period _____</p> <p><input type="checkbox"/> Unusual character _____</p>	
<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Nausea  <input type="checkbox"/> Constipation  <input type="checkbox"/> Black stools  <input type="checkbox"/> Bad breath  <input type="checkbox"/> Abdominal pain or cramps  <input type="checkbox"/> Chronic laxative use  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Gas  <input type="checkbox"/> Blood in stools  <input type="checkbox"/> Rectal pain  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Belching  <input type="checkbox"/> Indigestion  <input type="checkbox"/> Hemorrhoids  <input type="checkbox"/> Other stomach or intestinal problems: _____</p>	<p><input type="checkbox"/> Painful periods  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> PMS  <input type="checkbox"/> Clots  <input type="checkbox"/> Vaginal sores  <input type="checkbox"/> Irregular periods  <input type="checkbox"/> Last Pap _____  <input type="checkbox"/> Breast lumps  <input type="checkbox"/> Birth control: _____</p> <p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Neck pain  <input type="checkbox"/> Back pain  <input type="checkbox"/> Hand/wrist pain  <input type="checkbox"/> Muscle pain  <input type="checkbox"/> Muscle weakness  <input type="checkbox"/> Shoulder pain  <input type="checkbox"/> Knee pain  <input type="checkbox"/> Foot/ankle pain  <input type="checkbox"/> Hip pain</p>	

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Poor appetite  <input type="checkbox"/> Fever  <input type="checkbox"/> Sweat easily  <input type="checkbox"/> Localized weakness  <input type="checkbox"/> Bleed or bruise easily  <input type="checkbox"/> Peculiar taste or smells  <input type="checkbox"/> Strong thirst (cold or hot)  <input type="checkbox"/> Low thirst  <input type="checkbox"/> Sudden energy drop              What time of day? _____  <input type="checkbox"/> Poor sleeping  <input type="checkbox"/> Chills or tremors</p>	<p><b>SKIN AND HAIR</b></p> <p><input type="checkbox"/> Rashes  <input type="checkbox"/> Itching  <input type="checkbox"/> Dandruff  <input type="checkbox"/> Change in hair or skin  <input type="checkbox"/> Ulcerations  <input type="checkbox"/> Eczema  <input type="checkbox"/> Hair loss  <input type="checkbox"/> Hives  <input type="checkbox"/> Acne  <input type="checkbox"/> Recent moles  <input type="checkbox"/> Other hair or skin problems</p>	<p><b>HEAD, EYES, EARS, NOSE, THROAT</b></p> <p><input type="checkbox"/> Grinding teeth  <input type="checkbox"/> Dental problems  <input type="checkbox"/> Concussion  <input type="checkbox"/> Eye strain  <input type="checkbox"/> Night blindness  <input type="checkbox"/> Blurry vision  <input type="checkbox"/> Poor hearing  <input type="checkbox"/> Nose bleeds  <input type="checkbox"/> Facial pain  <input type="checkbox"/> Jaw clicks  <input type="checkbox"/> Migraines  <input type="checkbox"/> Eye pain</p>
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<input type="checkbox"/> Poor balance <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Cravings <input type="checkbox"/> Weight gain/loss	<b>HEAD, EYES, EARS, NOSE, THROAT</b>	<input type="checkbox"/> Color blindness <input type="checkbox"/> Earaches <input type="checkbox"/> Spots in eyes <input type="checkbox"/> Recurrent sore throat <input type="checkbox"/> Lip or tongue sores <input type="checkbox"/> Headaches <input type="checkbox"/> Other head or neck problems
	<input type="checkbox"/> Dizziness <input type="checkbox"/> Glasses <input type="checkbox"/> Poor vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems	

**Describe your average daily diet.**

Morning	
Afternoon	
Evening	

## CLINIC & FINANCIAL POLICIES

The following financial policy has been established to support the administration of the clinic and its mission.

**Fees are due at the time of treatment.** Current fees are available online at NATUREWORKSACUPUNCTURE.COM. They are also posted at the clinic front desk. Herbs vary in price and are not included in clinic treatment fees unless otherwise stated. Custom herbal formulas are non-refundable. Only un-opened patent herbs can be returned within 30 days of purchase.

Our goal is to make acupuncture available to those who might not be able to afford it otherwise. Please inquire about discounts. NatureWorks Acupuncture accepts major insurances. However insurance coverage varies and eligibility has to be determined. Ultimately the financial responsibility lies by the patient. NatureWorks Acupuncture can provide a “SUPER-BILL”, which the patient submits to his insurance provider. This bill contains all necessary information and insurance codes for REIMBURSEMENT of the treatment costs excluding herbs and other merchandise. Reimbursement depends on the individual patient policy. We ask for payment in full at the time of service. Payments can be made by credit card, cash or check; We accept VISA and MC only. We will make an effort to respond to requests for records for insurance claims in a timely manner.

We currently do offer a limited reduced fee for those who are low-income, or are on Disability or Medicaid. Please ask at the front desk about these reduced fees.

Natureworks Acupuncture prohibits the possession and use of all weapons, including but not limited to: firearms, knives, and mace, as well as noxious chemicals, fireworks and explosives.

We have limited clinic hours and there is often a waiting list. Therefore, we require 24 hours notice for changes or cancellations. **Appointments cancelled with less than 24 hours notice and appointments missed with no notification will be charged in full for that appointment.** Patients who qualify for a reduced fee will also be charged in full at the regular fee – not the reduced fee. Please pay for the missed visit at or before the next appointment. If you cancel two appointments with minimal or no notice, you will not be rescheduled until you have paid the cancellation fee for both visits. If there is a continued pattern of missed appointments, we may choose not to schedule you for appointments in the future. If necessary please change your appointment online at Natureworksacupuncture.com or by phone.

**By signing this form, I am indicating that I understand and accept this policy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## TRADITIONAL CHINESE MEDICINE INFORMED CONSENT TO TREAT

Licensed in Washington State as Hans-Thomas Richter EAMP, WA License # ACUP.AC.60412812

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese/Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment within the scope of Chinese/Oriental medicine may include, but are not limited to, acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridian, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping; dermal friction technique; infra-red; sonopuncture; laserpuncture; point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and superficial heat and cold therapies.. I understand that the herbs may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting, and needle sickness. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify the acupuncturist named below if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify an acupuncturist member who is caring for me if I am or become pregnant. ***Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases, cancer or lymphedema must inform practitioners prior to any treatment. Patients with a serious illness such as cancer are required to sign a "serious illness waiver".***

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups.

I understand that the acupuncturist may review my patient records and lab reports.

***I agree to the release of any medical information my health insurance may need in order to process payment. I assign such benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred.***

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Printed Name \_\_\_\_\_

## Patient Privacy Disclosure

The information provided below is the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important.

**Legal Responsibilities of the acupuncturist:** As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, the acupuncturist is required to ensure that you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration during the course of practice and will be in effect until it is replaced. The acupuncturist reserves the right to modify privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. The acupuncturist reserves the right to make the modifications effective for all protected health information that the acupuncturist maintain, including protected health information the acupuncturist created or received before the changes were made. Changing the notice will precede all significant modifications. **Protected Health Information Use and Disclosure:** Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. **Treatment:** Use and disclosure of your protected health information may be provided to a healthcare provider providing treatment to you. However, this information will not be provided unless you have authorized it in writing. **Payment:** Your protected health information may be used and disclosed to obtain payment for services the acupuncturist provided to you. **Healthcare Processes:** The acupuncturist may use and disclose your protected healthcare information in relation to our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your Authorization:** At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation. Your protected healthcare information may be disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization. **Person Involved in Care:** In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, the acupuncturist will disclose protected health information using her professional judgment, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. The acupuncturist will use professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled herbal prescriptions. **Marketing Health-Related Services:** The use of your protected health information for the purpose of marketing is prohibited without your written authorization. **Required By Law:** Your protected health information may be used or disclosed if required by law. **Abuse or Neglect:** As required by law, if the acupuncturist has reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If the acupuncturist has reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others, the acupuncturist may have to provide the necessary protected health information. **National Security:** Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information. **Appointment Reminders:** Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, emails, or letters. The acupuncturist may also write a thank you card to whom ever referred you to her practice. **Patient Rights Access:** With limited exception, you have the right to review your protected health information. **Disclose Accounting:** You may choose to request a review of every time the acupuncturist discloses your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. **Restrictions:** You may request the acupuncturist apply additional restrictions to any disclosure of your healthcare information. The acupuncturist is not required to respond to the application of these additional restrictions. If the acupuncturist agrees to follow your request regarding additional restrictions, the acupuncturist will follow the agreed restrictions unless an emergency situation dictates otherwise. **Alternative Communication:** You may request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications. **Electronic Notice:** If you receive a notice electronically, you are entitled to receive the notice in writing as well.

I HAVE READ THE PATIENT PRIVACY DISCLOSURE AND WAS OFFERED A COPY

Signed \_\_\_\_\_

Dated \_\_\_\_\_