PATIENT MEDICAL HISTORY INTAKE FORM

Acupuncture Arts East

Patient Name: _____ **Date:** _____

Date of Birth: _____

Primary Health Concerns: _____

_____

_____

_____

_____

Secondary Health Concerns: _____

_____

_____

Date of onset of symptoms: _____

Pain from this condition is: ☐ minimal ☐ moderate ☐ slight ☐ severe

Have you had this condition in the past? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ☐ getting worse ☐ comes and goes ☐ constant ☐ don't know

Medications you are currently taking: _____

_____

_____

List surgeries/procedures: _____

_____

_____

Have you been injured in an accident? Yes No

If yes, please describe: _____

_____

Date of last physical exam: _____

Medical History: (Please check box if you have ever had the following)

- ☐ arthritis
- ☐ asthma
- ☐ bronchitis
- ☐ pneumonia
- ☐ allergies
- ☐ anemia
- ☐ heart problems
- ☐ chronic pain
- ☐ migraine headache
- ☐ eye disorder
- ☐ cancer
- ☐ diabetes
- ☐ epilepsy
- ☐ stroke
- ☐ kidney or bladder problems
- ☐ gallstones
- ☐ ulcers
- ☐ gastric reflex
- ☐ eating disorder
- ☐ high blood pressure
- ☐ chronic fatigue
- ☐ hepatitis
- ☐ alcoholism
- ☐ substance abuse
- ☐ jaundice
- ☐ female reproductive disorders
- ☐ sudden weight loss
- ☐ sudden weight gain

Family History: (Please list any major medical conditions that your parents have or had that you know of)

_____

_____

_____

Are your currently receiving care from:

- ☐ chiropractor
- ☐ medical specialist
- ☐ physical therapist
- ☐ massage therapist
- ☐ nutritionist
- ☐ therapist

Have you had acupuncture before? Yes No

If yes, for what condition? _____

Do you use any of the following?

- ☐ Alcohol Amount/Wk _____
- ☐ Tobacco Amount/Wk _____
- ☐ Coffee Cups/Day _____
- ☐ Carbonated sugar drinks (Pepsi, Coke, etc.) Servings/Day _____
- ☐ Foods labeled "Diet"
- ☐ Processed Foods

How many glasses of water do you drink per day? _____

What exercise do you do on a regular basis?

- ☐ walking
- ☐ jogging
- ☐ bicycle
- ☐ hiking
- ☐ rowing/kayaking
- ☐ sports
- ☐ gym workout/training
- ☐ exercise classes
- ☐ yoga
- ☐ Pilates/Core/Barre
- ☐ dance
- ☐ other _____

Please complete reverse ▶

PATIENT SYMPTOM SURVEY

Acupuncture Arts East

Patient Name: _____ Date: _____

GENERAL
PAST NOW
- ☐ ☐ fatigue
- ☐ ☐ sleep problems
- ☐ ☐ swollen glands
- ☐ ☐ hot/cold intolerance
- ☐ ☐ frequent headaches
- ☐ ☐ weight loss
- ☐ ☐ weight gain
- ☐ ☐ fever or chills
- ☐ ☐ allergies

EMOTIONAL
- ☐ ☐ nervousness
- ☐ ☐ anxiety or worry
- ☐ ☐ frequent crying
- ☐ ☐ irritability
- ☐ ☐ anger
- ☐ ☐ tension
- ☐ ☐ mood swings
- ☐ ☐ fear
- ☐ ☐ restlessness
- ☐ ☐ confusion
- ☐ ☐ depression
- ☐ ☐ suicidal thoughts

NERVOUS SYSTEM
- ☐ ☐ dizziness
- ☐ ☐ fainting
- ☐ ☐ paralysis
- ☐ ☐ tremors
- ☐ ☐ numbness/tingling
- ☐ ☐ convulsions
- ☐ ☐ memory loss
- ☐ ☐ muscle weakness

GASTROINTESTINAL
- ☐ ☐ change in appetite
- ☐ ☐ thirst
- ☐ ☐ nausea
- ☐ ☐ vomiting
- ☐ ☐ diarrhea
- ☐ ☐ constipation
- ☐ ☐ gas
- ☐ ☐ hemorrhoids
- ☐ ☐ belching
- ☐ ☐ heartburn
- ☐ ☐ abdominal pain
- ☐ ☐ bloody/black stools
- ☐ ☐ indigestion

URINARY
- ☐ ☐ painful urination
- ☐ ☐ frequent urination
- ☐ ☐ difficult urination
- ☐ ☐ incontinence
- ☐ ☐ bed wetting
- ☐ ☐ dark urine
- ☐ ☐ frequent infections
- ☐ ☐ prostate problems

REPRODUCTIVE SYSTEM
PAST NOW
- ☐ ☐ painful intercourse
- ☐ ☐ prostate problems
- ☐ ☐ sexual problems
- ☐ ☐ loss of sex drive
- ☐ ☐ genital infections

birth control method: _____

WOMEN ONLY
- ☐ ☐ cramps
- ☐ ☐ PMS
- ☐ ☐ irregular periods

  Are you pregnant?
  ☐ Yes ☐ No
  date of last period ____
  # pregnancies _____
  # of miscarriages _____
- ☐ ☐ difficult labor
- ☐ ☐ breast problems

HEAD
- ☐ ☐ headache
  - ☐ ☐ entire head
  - ☐ ☐ back of head
  - ☐ ☐ forehead
  - ☐ ☐ temples
  - ☐ ☐ migraine
- ☐ ☐ head feels heavy
- ☐ ☐ loss of memory
- ☐ ☐ light-headedness
- ☐ ☐ fainting
- ☐ ☐ light bothers eyes
- ☐ ☐ loss of smell
- ☐ ☐ loss of taste
- ☐ ☐ loss of balance
- ☐ ☐ dizziness

EYES, EARS, NOSE, THROAT
- ☐ ☐ eye pain
- ☐ ☐ dry eyes
- ☐ ☐ blurred vision
- ☐ ☐ earache
- ☐ ☐ ear discharge
- ☐ ☐ ringing in ears
- ☐ ☐ hearing loss
- ☐ ☐ nosebleeds
- ☐ ☐ hoarseness
- ☐ ☐ problems swallowing
- ☐ ☐ sore throat
- ☐ ☐ jaw tight or sore
- ☐ ☐ dental problems

NECK
- ☐ ☐ pain in neck
- ☐ ☐ pain with movement
- ☐ ☐ pinched nerve in neck
- ☐ ☐ stiff neck
- ☐ ☐ muscle spasms in neck
- ☐ ☐ arthritis in neck

CHEST
PAST NOW
- ☐ ☐ chest pain
- ☐ ☐ shortness of breath
- ☐ ☐ pain around ribs

MUSCULOSKELETAL
- ☐ ☐ joint swelling
- ☐ ☐ muscle cramps
- ☐ ☐ neck pain
- ☐ ☐ shoulder pain
- ☐ ☐ tennis elbow
- ☐ ☐ arm pain
- ☐ ☐ hand sensations
- ☐ ☐ loss of grip
- ☐ ☐ mid-back pain
- ☐ ☐ rib pain
- ☐ ☐ low back problems
- ☐ ☐ hip pain
- ☐ ☐ foot problems
- ☐ ☐ leg cramps
- ☐ ☐ knee pain
- ☐ ☐ ankle weakness
- ☐ ☐ tingling foot

LOW BACK
- ☐ ☐ low back pain
- ☐ ☐ low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
- ☐ ☐ pinched nerve
- ☐ ☐ slipped disk
- ☐ ☐ muscle spasms
- ☐ ☐ arthritis

MID BACK
- ☐ ☐ mid back pain
- ☐ ☐ pain between shoulder blades
- ☐ ☐ sharp stabbing pain
- ☐ ☐ muscle spasms

SHOULDERS
- ☐ ☐ pain in shoulder joint
- ☐ ☐ pain across shoulders
- ☐ ☐ bursitis (R/L)
- ☐ ☐ arthritis (R/L)
- ☐ ☐ tension in shoulders
- ☐ ☐ pinched nerve
- ☐ ☐ limited range of motion

ARMS & HANDS
PAST NOW
- ☐ ☐ pain in upper arm
- ☐ ☐ pain in forearm
- ☐ ☐ pain in hands
- ☐ ☐ pain in fingers
- ☐ ☐ pinched nerve in arm
- ☐ ☐ pinched nerve in hand
- ☐ ☐ pins & needles in arm
- ☐ ☐ pins & needles in hand
- ☐ ☐ fingers go to sleep
- ☐ ☐ hands cold
- ☐ ☐ swollen joints in fingers
- ☐ ☐ arthritis in fingers
- ☐ ☐ loss of grip strength

HIPS, LEGS & FEET
- ☐ ☐ pain in buttocks (R/L)
- ☐ ☐ pain in hip joint (R/L)
- ☐ ☐ pain down leg (R/L)
- ☐ ☐ pain down both legs
- ☐ ☐ leg cramps
- ☐ ☐ pins & needles in legs
- ☐ ☐ numbness of leg (R/L)
- ☐ ☐ numbness of feet (R/L)
- ☐ ☐ numbness of toes
- ☐ ☐ feet feel cold
- ☐ ☐ cramps in feet (R/L)
- ☐ ☐ swollen ankles (R/L)
- ☐ ☐ swollen feet (R/L)
- ☐ ☐ painful joints in toes
- ☐ ☐ pain in foot (R/L)
- ☐ ☐ pain in knee (R/L)

HEART/LUNG
- ☐ ☐ chest pain
- ☐ ☐ high blood pressure
- ☐ ☐ low blood pressure
- ☐ ☐ persistent cough
- ☐ ☐ hard to breathe
- ☐ ☐ coughing blood
- ☐ ☐ coughing phlegm
- ☐ ☐ irregular heartbeat
- ☐ ☐ varicose veins
- ☐ ☐ ankle swelling

SKIN
- ☐ ☐ easy bruising
- ☐ ☐ dry skin
- ☐ ☐ itching
- ☐ ☐ boils
- ☐ ☐ rashes
- ☐ ☐ excessive sweat
- ☐ ☐ hair changes

_____
PATIENT SIGNATURE

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PATIENT INFORMATION AND CONSENT TO TREATMENT

Name_____

Address_____

City_____

State_____

Zip_____

Tel # Cell_____

Tel #Home_____

Tel # Work_____

Your Doctor's Name_____

Specialty_____

Tel # _____

Birth Date_____Age_____

Email_____

Occupation_____

Employer_____

In Case of Emergency:
Contact Name_____

Relationship_____

Contact Tel # Cell_____

Contact Tel # Home_____

Contact Tel # Work_____

Referred by: Physician Friend

Website Ad

Present Health Concerns

_____

Consent for Acupuncture Treatment and Care

I, the undersigned, do hereby request and consent to the performance of acupuncture treatments and other Eastern medical procedures. The methods of treatment may include, but are not limited to, acupuncture, far-infrared heat therapy, cupping, electrical stimulation and acupressure.

I have been informed that acupuncture is a safe method of treatment but, occasionally, there may be light bruising or tingling near the needling sites which lasts a few days. There may be some bruising after cupping.

I wish to rely on the acupuncturist to make recommendations during the course of treatment as to what is in my best interest. I understand that I will be informed of any procedures that are recommended before they are performed.

By signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition(s).

Patient's Signature_____ Date_____

HIPPA Information and Consent Form
Acupuncture Arts East

Welcome to our office. We are required to inform all patients about our privacy policies. We comply with HIPPA rules and regulations.

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" reminder. A more complete text is posted in the office.

What this is all about: specifically, there are rules and restriction on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U. S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documentation or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail or text message. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the provider of services.

5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

7. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

8. You have the right to request restrictions in the use of your protected health information and to request changes to certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

9. Should you have additional questions or would like additional information, please contact our office at 978-372-4771.

I, _____, DOB _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward
Date: _____.