HEALTH ON POINT acupuncture

Rachel S. Weissman BAS, MS, LAc
Board Certified Acupuncturist

Mercer Island, WA

Medical Profile Questionnaire

Please fill out the following questionnaire as completely as possible. This enables your Acupuncturist to establish a clinical profile upon which a safe and appropriate therapy program is planned.

Please print legibly. Today's Date: _____

Patient Name: _____ Age: _____ Gender: M F

Date of Birth (mm/dd/yyyy) : _____ How did you learn about HOP? doctor online friend other:

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____ E-Mail Address: _____

Occupation: _____ Referred by: _____

Emergency contact: _____ Phone No.: (_____)_____-_____

Primary care physician: _____ Phone No.: (_____)_____-_____

Have you ever been treated with Acupuncture, Chinese Herbs, Bodywork? Y N

If yes, what condition and by whom (include phone number): _____

_____

What is the purpose of your visit?: _____

How long have had this condition?: _____ Was the onset sudden or gradual?: _____

Symptoms are relieved by: _____

Symptoms are made worse by: _____

What medical diagnosis have you received?: _____

What other treatments have you received recently for this and/or other conditions?: _____

_____

List all medications taken within the last two (2) months (include vitamins, over the counter drugs, herbs) and reason for taking:

Medication name	Purpose for taking

PAST MEDICAL HISTORY

Family Physician/Internist name: _____ Phone No.: (_____)_____-_____

Date of last doctor's visit/exam (mm/dd/yyyy) : _____ Date of next visit/exam (mm/dd/yyyy) : _____

I have a history of (circle those that apply):

HIV/AIDS	Cancer	Multiple Sclerosis	Tuberculosis
Alcoholism	Diabetes	Pacemaker	Asthma
Allergies	Emphysema	Lymph Nodes removed	Birth Trauma
Cancer/tumors	Polio	Herpes I/II	Scarlet Fever
Heart disease	Rheumatic Fever	Cyclo-megalo Virus	Prosthetics
Hepatitis A/B/C	Mononucliosis	Implants	Other: _____
Epstein Bar Virus	Lyme Disease	Seizures	_____

For WOMEN (check if yes):

- ❑ I have had a recent pelvic exam (PAP)
- ❑ I am or may be PREGNANT
- ❑ I have had a recent mammogram or breast exam

For MEN (check if yes):

- ❑ I have had a recent prostate exam

Allergies: Medications, food other (i.e. tape, beeswax, etc).

List reactions (such as hives, rash, shock, tongue swelling, breathing difficulty, etc.)

_____

_____

Describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not, and the dates:

_____

_____

Imaging: X-Rays, MRI, CT (specify by name and dates of studies & results if known):

_____

_____

Please bring copies of your studies to your appointment!

Gastrointestinal (GI) Profile

(Circle those that apply)

Bloating	Blood in feces	Irregular Bowel movements	Undigested food in stool
Acid regurgitation	Stomach Ulcers	Constipation	Loose stool
Heartburn	Hernia	Diarrhea	Hard stools
Belching	Indigestion	Gas	Itchiness
Vomiting	Stomach pains	Use laxatives	Other
Blood in urine	Hemorrhoids		

Bowel movements: How often? _____day/wk Do you frequently have painful bowel movements?: Y N

Exercise and Energy

How is your energy level? _____

What time of the day is your energy?: Highest: _____ Lowest: _____

Do you fatigue easily?: _____

What type of exercise do you participate in and how often?: _____

_____

Emotions and Sleep

How do you feel emotionally?: _____

_____

How many hours of sleep do you get per night? _____ Do you have difficulty falling asleep? Y N

Do you have difficulty staying asleep? Y N

Do you have (circle those that apply)

Panic attacks	Anxiety	Nervousness	Fear/Fright
Depression	Bad Temper	Poor memory	Difficulty concentrating
			Other

Where do you hold stress?: _____

How do you relax or reduce stress?: _____

How do you feel about your work or profession?: _____

How do you feel about your relationship with your spouse or significant other?: _____

_____

_____

Do you use recreational drugs?: Y N If yes, which substance(s)?: _____

Do you drink alcohol?: Y N If yes, how many glasses per week?: _____

Urogenital

How many times per day do you urinate?: _____

Color (circle) : Pale yellow Dark yellow/orange Do you have trouble starting a stream: Y N

(Circle those that apply)

Frequent urination	Pain on urination	Dribbling when sneezing
Incontinence	Urinary tract infection	Other

How is your sexual energy?: _____

What type of birth control do you use?: _____

Do you have infertility: Y N

What was determined to be the cause of your infertility: _____

_____

Women Please indicate current or previous menstrual conditions even if now menopausal:

At what age did you start menstruating?: _____ Number of days between cycles: _____

Number of days of menstrual flow: _____ Color of flow: _____

(Circle those that apply)

Irregular menstruation	Light flow	Clots
Heavy flow	No flow	Vaginal itching/burning
Spotting between periods	Pain/discomfort before period	Other: _____

Do you have any vaginal discharge?: Y N Amount: _____ Color: _____

Frequency: _____

Do you have any blood or mucous breast discharge?: Y N Amount: _____ Frequency: _____

PMS symptoms:

_____

Menopausal symptoms: _____

Number of pregnancies: _____ Number of deliveries: _____ Abortion (s)/Miscarriage: _____

Men: (circle those that apply)

Impotence	Penile blood/mucous discharge	Other:
Premature ejaculation	Prostatitis	

Eyes, Ears, Nose, Throat, and Head

Have you ever smoked? Y N Do you smoke? Y N How many cigarettes per day? _____

How long have you been smoking? _____ Have you ever tried to quit? Y N

If yes, how many times? _____ What method of quitting have you used: _____

(Circle those that apply)

Frequent colds	Asthma	Painful/red eyes	Coughing up mucous
Coughing up blood	Chronic cough	Poor vision	
Chronic runny nose	Nose bleeds	Seeing spots	Color of mucous:
Pain on inhalation	Cold sores	Ear pain	
Difficulty inhaling	Bleeding gums	Clogged/Popping ears	How much?
Post nasal drip	Dry mouth	Ringing in the ears	
Difficulty exhaling	Frequent sore throat	Dizziness	Other:

Headaches/migraines: Y N

If yes, please where on your head the Headaches/migraines manifests: _____

Describe further:_____

Are you aware of any triggers? _____

Cardiovascular

Blood Pressure: _____/_____ Do you have a history of high blood pressure?: Y N

Have ever been diagnosed with heart trouble?: Y N

(Circle those that apply)

Irregular heart beat	Chest pain	Palpitations
Varicose veins	Phlebitis	Lymphedema
Cold hands and feet	Poor circulation	Other:

Skin and Hair

(Circle those that apply)

Dry skin	Rashes	Itching
Acne	Eczema	Hives
Hair loss	Premature graying	Other:

Muscles, Joints, and Bones

Do you have pain, tenderness, or tightness?: Y N

If yes, where?: _____

Is your pain worse or better with heat or cold?: _____ Is your pain worse in the AM/PM: _____

What makes your pain symptoms BETTER? _____

What makes your pain symptoms WORSE? _____

Have you had this problem before? Y N

Circle all that apply:

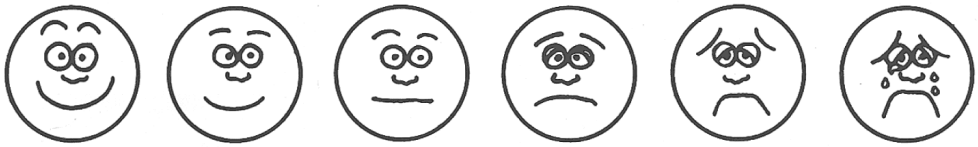
Swollen joints	Arthritis/joint pain	Bone pain	Repetitive strain injury
Tendonitis	Rheumatism	Muscle pain	Other:

Visual analog scale

What is your primary reason for seeking acupuncture treatment? _____

Place an "X" on the line below that best rates the severity/intensity of this **complaint** on a scale of 1-10:

0_____10



Place an "X" on the line below that best rates your **distress** level on a scale of 1-10:

0_____10

Family Medical History (please list any significant family illness):

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

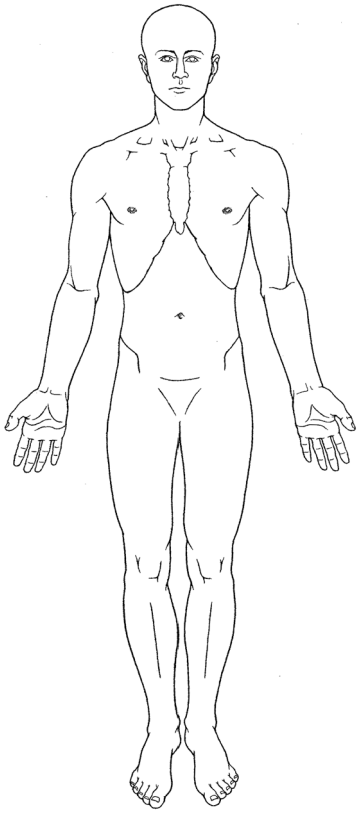
I, _____, certify that the information provided on this intake is accurate, and I will inform Rachel S. Weissman, BAS, MS, L.Ac. if there are any changes to this information. Date: _____

- SEE NEXT PAGE -

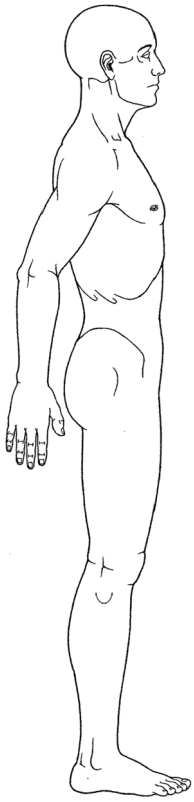
If you have pain, what does it feel like? (circle those that apply):

Sharp	Aching	Numb	Deep
Burning	Dull	Superficial	Tingling

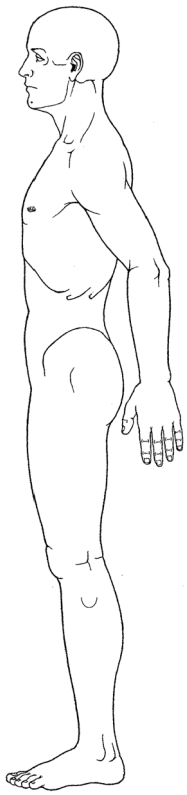
On the following drawings, please shade in areas you feel should be addressed.



(front)



(right)



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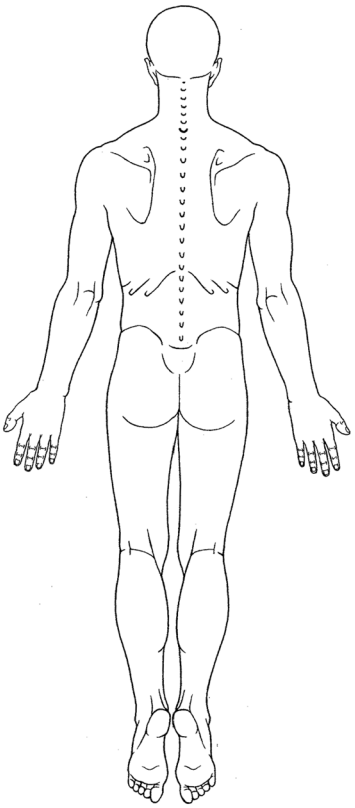

(back)

HEALTH ON POINT
acupuncture

Notice of Privacy Policies

This office is dedicated to providing service with respect for human dignity. Protecting your privacy and Patient Health Information (PHI) is fundamental in the course of our relationship. To this effect, we want you to know how your PHI is going to be used in this office, and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. This notice will remain in effect until it is replaced or amended by changes in law.

1. We gather PHI in several ways:
   - We receive information from you at intake and in the course of office visits.
   - We receive information from other healthcare providers.
   - We receive information from third party payers such as insurance companies.
2. Your PHI is used for the purpose of treatment, payment, healthcare operations of this office and for coordination of care.
3. You may specifically authorize this office to use your PHI for any purpose or to disclose your PHI to any party of your choosing by submitting the authorization in writing.
4. This office will not use your PHI for marketing communications without your written authorization. This office may send postcards, greeting cards and/or newsletters or email. This office may send appointment reminders by postcards, letters, telephone, or answering machine unless you specify that we may not.
5. This office may use or disclose your PHI when required by law.
6. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
7. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
8. The patient has the right to receive all notices from this office in written form.
9. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the Licensed Acupuncturist has the right to refuse to give care.

If you have questions, complaint or want more information please contact this office:

Health On Point PLLC
9249 SE 59th St
Mercer Island, WA 98040

If desired, you may send a written complaint about these procedures to the U.S. Department of Health and Human Services at:

DHHS (Office of Civil Rights)
200 Independence Ave. S.W., Room 509 F HHH Building
Washington DC, 20201

I have read and understand how my Patient Health Information will be used and I agree to the above policies and procedures.

Patient Name _____

Patient Signature _____ Date _____