PATIENT HEALTH HISTORY

Name: _____ _____ _____
FIRST MI LAST

DOB: _____/_____/_____ Age:_____ Gender: ❒Male ❒ Female Today's date: _____/_____/_____

Address: _____ City: _____

State: _____ ZIP: _____ Email: _____

Phone: _____DAYTIME _____EVENING _____MOBILE

1. What conditions are you seeking help with today? [list in order of importance]

CONDITION	EFFECT ON YOUR LIFE
A. _____	A. _____
B. _____	B. _____
C. _____	C. _____

2. Have you received acupuncture or taken Chinese herbal medicine before? ❒Yes ❒ No

If yes, approximate date of last treatment: _____

What was the purpose of the visit/herb formula? _____

3. Medications/Supplements/Vitamins [list prescriptions, OTC medicines & natural substances you are currently taking]

4.

Drug/Substance	Dose/Frequency	Reason	Drug/Substance	Dose/Frequency	Reason
1.			4.		
2.			5.		
3.			6.		

Allergies [list allergies or sensitivities to any drug or natural substance, including when the allergy started]

Drug/Substance	Reaction	How long?	Drug/Substance	Reaction	How long?
1.			4.		
2.			5.		
3.			6.		

5. Hospitalizations/Operations

6.

Date	Reason for Hospitalization/Procedure	Outcome
1.		
2.		
3.		

Which childhood illnesses have you had? [check all that apply]

❒ chicken pox ❒ diphtheria ❒ measles ❒ mumps ❒ recurrent ear infections

7. What was your most recent blood pressure reading? _____/_____ When was this taken? _____/_____/_____

8. What was the date of your last physical exam? _____/_____/_____ Any significant findings?_____

9. What are the names of your current medical doctors and/or healthcare providers?

10.

PHYSICIAN/OTHER PROVIDER	ADDRESS	PHONE NUMBER

Family History [check those that apply]

11.

	Age [or age at death]	Health [G-good] [P-poor]	Cancer	Diabetes	Heart Disease	Mental Illness	Stroke	Other
Grandparent								
Father								
Mother								
Siblings								
Spouse								
Children								

Your Diet Do you eat regular meals? ❒Yes ❒ No Do you skip meals? ❒Yes ❒ No # of meals/day? _____

What do you typically eat?

Breakfast	Dinner
Lunch	Snacks

Foods you don't eat/avoid: _____ Flavors/foods you crave: _____

How do you feel after you eat? ❒ satisfied ❒ hungry ❒ gas/bloating ❒ overly full ❒ tired

Appetite: ❒ good ❒ poor ❒ increased ❒ decreased ❒ constant or frequent hunger

Thirst: ❒ thirst w/desire to drink ❒ thirst, no desire to drink ❒ no thirst Fluid Intake: _____oz /day

12. Your Sleep Hours per night: _____ Time to bed: _____ Time to wake: _____

Quality: ❒ rested upon waking ❒ diff. falling asleep ❒ diff. staying asleep ❒ diff. falling back to sleep

❒ vivid dreams ❒ palpitations ❒ night sweats ❒ restless legs ❒ tossing/turning ❒ snoring

13. Your energy Level of energy: _____ Best time of day: _____ Worst time of day: _____

What makes you feel more/less tired? _____

Type of exercise:_____ How often? _____

14. Do you currently, or have you in the past, consumed any of the following?

Substance	Y/N/Past	Amount	How Often?	How Long?
Alcohol				
Caffeine				
Cigarettes				
Drugs				

15. Level of education completed: ❒ High School ❒ Bachelors ❒ Masters ❒ Ph.D. ❒ Other _____

16. Occupation: _____ Employer: _____

Hours per week: _____ Do you enjoy work? ❒Yes ❒ No

17. Describe any pain you are currently experiencing:

Location	Better/worse w/pressure	Better/worse w/ heat or cold	Better/worse w/movement or rest	Sharp/stabbing or dull/achy
1.				
2.				
3.				
4.				

18. Please indicate which of the following conditions you have had: [check all that apply]

Cardiovascular
- ❒ chest pain
- ❒ cold hands/feet
- ❒ heart disease
- ❒ heart murmur
- ❒ high blood pressure
- ❒ high cholesterol
- ❒ pacemaker
- ❒ palpitations
- ❒ stroke
- ❒ varicose veins
- ❒ other: _____

Dermatologic
- ❒ acne
- ❒ age spots
- ❒ allergic dermatitis
- ❒ carcinoma
- ❒ eczema
- ❒ hives
- ❒ itching
- ❒ psoriasis
- ❒ rash
- ❒ rosacea
- ❒ sensitive skin
- ❒ shingles
- ❒ other: _____

Ear/Eye/Nose/Throat
- ❒ ear ringing
- ❒ frequent ear infection
- ❒ loss of hearing
- ❒ glasses/contacts
- ❒ glaucoma
- ❒ floaters in vision
- ❒ liver disease
- ❒ impaired vision
- ❒ dry eyes/tearing
- ❒ red/itchy/burning/watery eyes
- ❒ nosebleed
- ❒ sinus problems
- ❒ sneezing/runny nose
- ❒ dry mouth
- ❒ sore throat
- ❒ grinding teeth/TMJ
- ❒ other: _____

Endocrine
- ❒ adrenal fatigue
- ❒ diabetes
- ❒ hyperthyroid
- ❒ hypothyroid
- ❒ hypoglycemia
- ❒ hormonal imbalance
- ❒ other: _____

Energy/Immunity
- ❒ anemia/easy bruising
- ❒ auto-immune disorder
- ❒ cancer
- ❒ chronic fatigue
- ❒ easily tired
- ❒ exotic disease
- ❒ fibromyalgia
- ❒ high fever
- ❒ infectious disease
- ❒ slow wound healing
- ❒ other: _____

Gastro-Intestinal
- ❒ abdominal pain
- ❒ belching
- ❒ change in appetite
- ❒ constipation
- ❒ diarrhea
- ❒ undigested food in stools
- ❒ blood in stools
- ❒ gallstones
- ❒ gas/bloating
- ❒ heartburn/acid reflux
- ❒ hemorrhoids
- ❒ liver disease
- ❒ ulcer
- ❒ other: _____

Genito-Urinary
- ❒ bloody urine
- ❒ frequent urination
- ❒ incontinence
- ❒ dribbling
- ❒ urgency
- ❒ burning
- ❒ normal
- ❒ kidney infections
- ❒ kidney stones
- ❒ UTI
- ❒ STD
- ❒ other: _____

Muscular-Skeletal
- ❒ back pain
- ❒ broken bone
- ❒ injury/trauma
- ❒ joint pain
- ❒ muscle cramps
- ❒ neck/shoulder tension
- ❒ osteoporosis
- ❒ weakness
- ❒ other: _____

Neurologic
- ❒ dizziness
- ❒ headache/migraine
  - location: _____
  - type of pain:
    - ❒ sharp
    - ❒ dull
    - ❒ constant
    - ❒ intermittent
    - ❒ severe
    - ❒ moderate
- ❒ head injury
- ❒ numbness/tingling
- ❒ paralysis
- ❒ seizures
- ❒ other: _____

Respiratory
- ❒ asthma
- ❒ bronchitis
- ❒ emphysema/COPD
- ❒ frequent cold/flu
- ❒ persistent cough
- ❒ pneumonia
- ❒ shortness of breath
- ❒ other: _____

Male Reproductive
- ❒ hernia
- ❒ impotence
- ❒ erectile disorders
- ❒ ejaculatory disorders
- ❒ low libido
- ❒ low motility/sperm count
- ❒ penile discharge
- ❒ prostatitis
- ❒ testicle pain/swelling
- ❒ other: _____

Emotional
- ❒ abuse
- ❒ addiction
- ❒ anxiety
- ❒ depression
- ❒ frustration
- ❒ mental tension
- ❒ mood disorder
- ❒ overwhelmed
- ❒ stress
- ❒ other: _____

Female Reproductive

Breasts:
- ❒ discharge
- ❒ lumps
- ❒ tenderness
- ❒ other: _____

Menses:
- age period started: _____
- date last period: _____
- # of days: _____
- ❒ bleeding b/t cycles
- ❒ clotting
- ❒ endometriosis
- ❒ heavy menses
- ❒ scanty menses
- ❒ irregular cycles
- ❒ ovarian cysts
- ❒ PMS
- ❒ other: _____

Other:
- # of pregnancies: _____
- # of children: _____
- complications w/childbirth: _____
- ❒ infertility/difficulty conceiving
- ❒ hot flashes
- ❒ mood swings
- ❒ low libido
- ❒ night sweats
- ❒ oral contraceptive use
- ❒ vaginal discharge
- ❒ vaginal dryness
- ❒ other: _____

19. Who may we contact in case of emergency?

Name: _____ Relationship: _____

Address: _____ Phone: _____

20. How did you hear about us?

❒ personal referral ❒ medical referral ❒ newspaper ❒ yellow pages ❒ other: _____

21. We regularly send promotional discounts and informational flyers via mail and email.

Would you like to be included on our mailing list? ❒Yes ❒ No

If yes, please indicate where you would like to receive mailings:

❒ home address ❒ email address ❒ other:_____

STATEMENT AND AGREEMENT

By signing below I indicate that I have read and agree to the following:

1. All information contained herein is, to the best of my knowledge, a complete and accurate statement of my health history. I do not hold New Freedom Acupuncture & Oriental Medicine, its staff or employees responsible for inaccurate or withheld information.
2. All information contained herein is confidential in nature and will be viewed only by staff and employees of New Freedom Acupuncture & Oriental Medicine or its third-party designees (including insurance companies and recycling companies) and will not be released without my written consent.
3. Should I require my records be release to another party, I must make my request in writing and sign a formal consent form. I will be charged a fee of $1.00 per page of copied material.

SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY:

Received: _____ Reviewed: _____ Filed: _____

SIGNATURE: _____ DATE: ____ /____ /____

(designated office staff or practitioner)

CONSENT TO TREATMENT

By signing below, I voluntarily consent to be treated with acupuncture and/or Chinese herbs by Colleen Ragan. I understand that acupuncturists practicing in the state of South Dakota 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 practitioner.

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 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scaring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Chinese materia medica may be recommended to me to treat bodily dysfunction or disease, 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 effects 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 contact New Freedom Acupuncture & Oriental 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 taking these substances. 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 acupuncture. I am aware that certain adverse side effects may result from taking these substances. These could 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 which would be beneficial to my health and may be recommended by this clinic.

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.

Patient Name: _____
[please print]

SIGNATURE: _____ **DATE:** ____ /____ /____

Relationship to patient if acting as patient representative: _____

FINANCIAL POLICY

Payment: Payment is due in full at the time of service, unless prior arrangements have been made. It is the sole responsibility of the patient to make payments for services rendered.

Payment Methods: Payments are to be made by either cash or check, payable to *New Freedom Acupuncture*. Credit cards are accepted with an additional 2% processing fee.

Returned Checks: A $25 fee will be charged for checks that are returned as non-payable. This fee, along with the full amount past due, must be paid within 15 days of notice from our office. Any account 30 days past due may be subject to collection.

Insurance: This office does not currently bill for insurance. However, we will provide you with an invoice so that you may request reimbursement from your insurance provider. Filing insurance claims is the sole responsibility of the patient.

Cancellation Policy: Appointments must be cancelled within 24 hours of the scheduled time to avoid incurring a cancellation fee. Patient will be charged 100% of the anticipated fee if appointment is cancelled less than 12 hours before the scheduled appointment. Any fees incurred for missed appointments will be billed to the patient and must be paid within 30 days.

By signing below, I acknowledge that I have read and agreed to the financial policies and conditions of this clinic as outlined in this form.

Patient Name: _____
[please print]

SIGNATURE: _____ **DATE:** ____ /____ /____

Relationship to patient if acting as patient representative: _____