ALBERTA STREET ACUPUNCTURE CLINIC
Patient Health History

Legal Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Preferred Name: _____ Date of Birth: _____/_____/_____ Age: _____ Gender: _____

Primary Phone: _____ Alternate Phone: _____ Email: _____

Address: _____

Emergency Contact: _____ Phone: _____

What are you hoping to address in your visits with us? _____

How did you hear about our clinic? _____

Do you have a Primary Care Provider? Y N Name: _____ Phone: _____

Please list any medications, vitamins, and supplements you are currently taking: _____

_____

_____

Do you have any reason to believe you may be pregnant? Y N If so, how far along? _____

Do you have any infectious diseases? Y N If yes, please identify: _____

Please list all foods, drugs, or medications to which you are hypersensitive / allergic, include the reaction: _____

_____

Family History (please list any medical issues experienced by your parents and/or siblings including heart disease, diabetes, autoimmune disease, cancer, etc.): _____

_____

Personal History:

Major Injuries, Illnesses, Hospitalizations and/or Surgeries (Reason & When?): _____

_____

X-Rays / CAT Scans / MRIs / NMRs / Special Studies (Reason & When?): _____

_____

Head / Eyes / Ears / Nose / Throat (circle any that you experience now and underline any that you experienced in the past):

Impaired Vision	Eye Pain / Strain	Glasses / Contacts	Tearing / Dryness	Glaucoma
Headaches	Head Injury	Neck Lumps	Impaired Hearing	Ear Ringing
Earaches	Sinus Problems	Hayfever	Nose Bleeds	Loss of Smell
Frequent Sore Throats	Teeth Grinding	TMD / Jaw Problems	Gum Problems	Cavities

Respiratory (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia | Frequent Common Colds | Difficulty Breathing | Shortness of Breath

Persistent Cough | Asthma | Emphysema | Pleurisy | Tuberculosis

Cardiovascular (please circle any that you experience now and underline any that you have experienced in the past):

High Blood Pressure | Chest Pain | Swelling of Ankles | Palpitations/Fluttering

Heart Attack | Stroke | Heart Murmurs | Irregular Heartbeat

High Cholesterol | Varicose Veins | Deep Vein Thrombosis / Blood Clots

Gastrointestinal (please circle any that you experience now and underline any that you have experienced in the past):

Changes in Appetite | Nausea/Vomiting | Epigastric Pain | Heartburn | Ulcers | Belching

Passing Gas | Abdominal Pain | Gall Bladder Disease / Stones | Liver Disease | Hepatitis

Hemorrhoids | Constipation | Diarrhea | Black / Clay Colored / Bloody Stools

Genito-Urinary Tract (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease | Painful Urination | Frequent UTI | Frequent Urination

Kidney Stones | Impaired Urination | Blood in Urine | Frequent Urination at Night

Female Reproductive (circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles | Heavy Flow | Painful Periods | Clotting

Vaginal Discharge | Premenstrual Problems | Bleeding Between Cycles | Menopausal Symptoms

Difficulty Conceiving | Breast Lumps / Tenderness | Nipple Discharge

Menstrual & Birthing History:

Age of First Menses: _____ Period Length: _____ # Days Between Periods: _____

First Date of Last Period: _____ # of Pregnancies: _____ # of Live Births: _____

Birth Control Type: _____ # of Miscarriages: _____ # of Abortions: _____

Male Reproductive (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties | Prostate Problems | Testicular Pain / Swelling | Penile Discharge

Endocrine (please circle any that you experience now and underline any that you have experienced in the past):

Diabetes (Type ____) | Hypoglycemia | Hypothyroid | Hyperthyroid | Night Sweats | Feeling Hot / Cold

Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue | Slow Wound Healing | Chronic Infections | Chronic Fatigue Syndrome

Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings | Nervousness | Anxiety | Depression | Other: _____

Neurologic (please circle any that you experience now and underline any that you have experienced in the past):

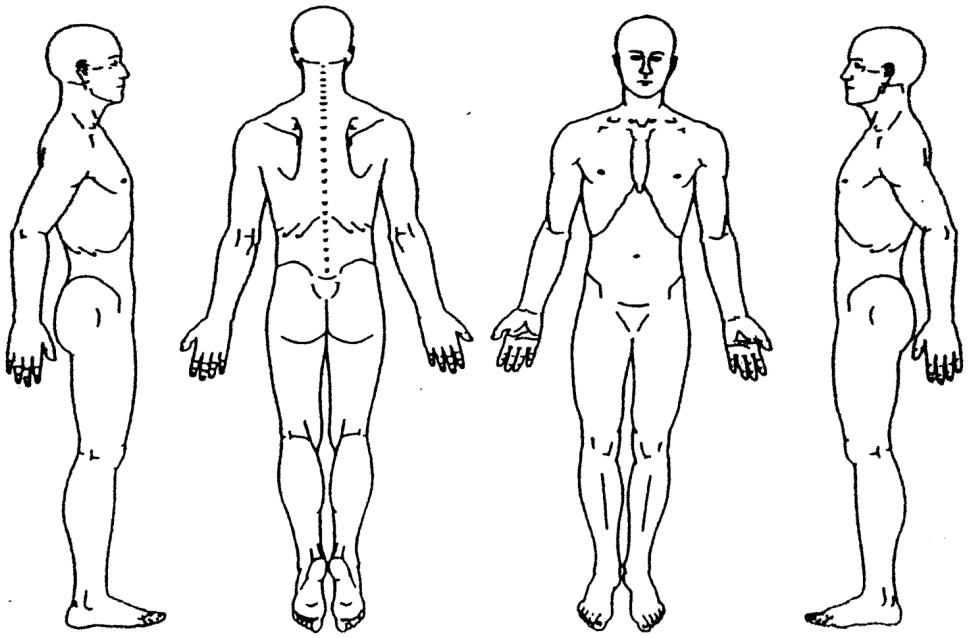
Numbness / Tingling Paralysis Loss of Balance Vertigo / Dizziness Seizures / Epilepsy

Musculoskeletal (please circle any that you experience now and underline any that you have experienced in the past):

Neck / Shoulder Pain Arm Pain Leg Pain Muscle Spasms / Cramps Fibromyalgia

Upper Back Pain Mid Back Pain Low Back Pain Joint Pain Arthritis

Please indicate on the diagram below any areas where you are *currently* experiencing pain (P), numbness (N), or tingling (T):



Skin (please circle any that you experience now and underline any that you have experienced in the past):

Acne Boils Itching Rashes Eczema / Hives Hair Loss

Other (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Bruising Easily Cancer (Type _____)

Cold Hands / Feet Autoimmune Disease (Type _____)

Lifestyle: Diet (please circle all that apply): Water # cups / day _____ Vegetarian Vegan Fish Only

Organic Loves Veggies Hates Veggies Sugar Caffeine (Type & Amount _____)

Habits (circle all that apply): Alcohol (# drinks / week ___) Tobacco (Type & Frequency _____)

Recreational Drug Use (Type & Frequency _____)

How many hours per night do you sleep? ____ Do you wake rested? Y N Difficulty Falling/Staying Asleep? Y N

Occupation: _____ Work Hours / Week: _____ Do you enjoy work? Y N

Exercise routine: _____

Interests and hobbies: _____

ALBERTA STREET ACUPUNCTURE CLINIC

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 Alberta Street Acupuncture Clinic. 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring 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 movements, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems that I associate with these substances, I should suspend taking them and call Alberta Street Acupuncture Clinic as soon as possible.*

Acupressure/Shiatsu/Tui-Na Massage: I understand that I may also be given acupressure/shiatsu/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:** _____

ALBERTA STREET ACUPUNCTURE CLINIC

Summary of Patient Privacy Policy Uses and Disclosure of Protected Health Information

This notice is to inform you that we are in compliance with the law concerning privacy of your health information, HIPAA. This is a short summary. The full-length explanation of HIPAA is available for you upon request. If you are concerned about how we may use your information, please read the long version called "Notice of Privacy Practices." By signing this, you acknowledge understanding of this Notice.

We, at this clinic, do not share your protected health information (PHI) with anyone other than entities with whom you agree to share information. By signing this form, you agree to allow us to use your information for pertinent reasons: products and services, healthcare operations, or billing you for payment of products and services. We will give out only the information necessary to accomplish this. These reasons are described in more detail in the "Notice of Privacy Practices." This type of information includes your name, social security number, birth date, address, insurance company, phone numbers, health history questionnaire, and all related medical charting in regards to products or services provided to you.

Patients can request to have anyone accompany them in the room during treatment. The patient then acknowledges that personal health information may be shared with this other person. We do not share your PHI with anyone else in the clinic other than pertinent staff or practitioners of the clinic for the purposes of clinic operation.

We have the right to contact you by phone, mail, or email if you list this information on your consent form regarding scheduling, promotions or other pertinent reasons for the clinic. We will not give PHI to anyone else as a result of these types of contact.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Financial Agreement and Cancellation Policy

By signing below, you acknowledge that all payments for products or services are due at the time of service, unless prior arrangements have been made directly with your practitioner.

For patients wishing to use their insurance benefits, our agreement is with you, the patient, and not your insurance carrier for services rendered. If you authorize your practitioner to bill insurance on your behalf, you are ultimately responsible for the services you receive and any/all amounts not covered by your insurance carrier including co-pays and deductibles. Please ensure this office has the most current copy of your insurance information on hand at all times, as well as any referrals and/or prior-authorizations if needed.

Alberta Street Acupuncture Clinic requires 24-hours notice for appointment cancellations or rescheduling. If you fail to notify us within 24-hours of your appointment, you will be charged for the full amount of the missed appointment. In case of emergency or inclement weather, please contact us as soon as possible.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____