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HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

E-Mail: _____ Marital Status: _____

Date of Birth: _____ Age: _____ Physician: _____

Physician Phone: _____ Address: _____

In Emergency Notify: _____ Phone: _____

Main Complaint (symptoms, diagnosis, duration, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Significant Trauma (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks Caffeinated Drinks Alcohol per week

What makes your condition better? (Rest, movement, heat/cold, fresh air, eating, crying, etc)

What makes your condition worse?(stress, fatigue, hunger, heat, certain foods, damp days etc)

Personal History Please check any conditions or symptoms you have now.

□ Alcoholism	□ Anemia	□ Arthritis	□ Asthma
□ Cancer	□ Chronic Fatigue	□ Chronic Pain	□ Diabetes
□ Diverticulitis/IBS	□ Elev.Blood Chol.	□ Emphysema	□ Food Allergies
□ Gastritis/Pancreatisits	□ Hepatitis	□ Hypo/Hyperglycemia	□ Heart Disease
□ High/Low Blood Pressure	□ Impotence	□ Infertility	□ Kidney Disease
□ Liver/Gall Bladder Disease	□ Lyme Disease	□ Raynaud's Disease	□ Respiratory Allergy
□ Stroke	□ Seizures	□ Thyroid Imbalance	□ Ulcer

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM(grandmother), GF (grandfather) next to choice.

□ Allergies__	□ Asthma __	□ Cancer__	□ Diabetes__
□ Heart Disease __	□ High Blood Pressure_	□ Seizures __	□ Stroke __

□ Other _____

Please check if you have had any of these items listed below in the last year.
Put a star on the box if you had this in the past but do not any longer.

General

□ Poor Appetite	□ Poor Sleeping	□ Fatigue	□ Fevers
□ Chills	□ Night sweats	□ Sweats Easily	□ Tremors
□ Cravings	□ Localized Weakness	□ Poor Balance	□ Change in appetite
□ Bleed/Bruise easily	□ Weight loss/gain	□ Dental/gum problems	□ Peculiar taste/smell
□ Muscle weakness/fatigue	□ Sudden energy drop	□ Strong thirst (hot or cold drinks)	

Skin and Hair

□ Hives/Allergic Dermatitis	□ Ulcerations	□ Itching	□ Rashes
□ Eczema/Psoriasis	□ Dandruff	□ Loss of hair	□ Recent moles
□ Change in hair/skin texture	□ Acne	□ Face flushing	□ Skin discoloration
□ Dermatitis	□ Warts	□ Fungal Infection	□ Weak or ridged nails
		□ Scars Location:_____	

Head, Eyes, Ears, Nose and Throat

□ Dizziness	□ Difficulty swallowing	□ Migraines	□ Glasses
□ Eye Strain	□ Eye pain	□ Poor vision	□ Night blindness
□ Color Blindness	□ Cataracts	□ Blurred vision	□ Earaches
□ Ringing in ears	□ Poor hearing	□ Spots in front of eyes	□ Sinus problems
□ Recurrent sore throats/colds	□ Nose bleeds	□ Grinding teeth	□ Facial pain
□ Sores on lips/tongue	□ Dental problems	□ Jaw clicks/locks	□ Headaches

Cardiovascular

□ Chest pain or pressure	□ Irregular heartbeat	□ Palpitations at rest	□ Fainting
□ Swelling of hands/feet	□ Cold hands/feet	□ Blood clots	□ Phlebitis
□ Shortness of breath	□ Varicose/spider veins	□ Pressure in chest	□ High blood pressure
□ Spontaneous sweating	□ Low blood pressure	□ Dizziness	

Respiratory

□ Asthma	□ Bronchitis	□ Cough/Wheezing	□ Difficult inhale/exhale
□ Tight sensation in chest	□Pain with deep breath	□ Pneumonia	□ Coughing blood
□ Difficulty breathing when lying down		□ Production of phlegm… what color?_____	

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black Stools
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Loose stools (>2per day)
- ☐ Chronic laxative use
- ☐ Bloating/Edema
- ☐ Abdominal pain
- ☐ Change in appetite
- ☐ Acid reflex/GERD
- ☐ Hernia
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Significant thirst
- ☐ IBS/Crohn's Disease

Genito-Urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgent urination
- ☐ unable to hold urine
- ☐ Kidney stones
- ☐ Scanty flow
- ☐ Copious flow
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Urinary tract infection
- ☐ Burning urination
- ☐ Premature ejaculation
- ☐ Decreased libido
- ☐ Prostatitis
- ☐ Nocturnal emission
- ☐ Dribbling after urination
- ☐ Pain in testicles
- ☐ Herpes
- ☐ Infections
- ☐ Excessive libido
- ☐ Night urination .. .

What time?_____ How often____

Gynecological/Reproductive

- ☐ Difficult/Painful intercourse
- ☐ Ovarian cysts
- ☐ Age of first menses?_____
- ☐ Vaginal dryness
- ☐ Endometriosis
- ☐ Date of last menses?_____
- ☐ Vaginal sores
- ☐ Uterine Fibroids
- ☐ Date of last PAP/Pelvic_____
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Number of pregnancies_____
- ☐ Fibrocystic breast tissue
- ☐ PMS
- ☐ Number of ectopic pregnancies_____
- ☐ Polycystic Ovarian Disease
- ☐ Irregular menstruation
- ☐ Number of live births_____
- ☐ Painful menstruation
- ☐ Number of miscarriages_____
- ☐ Number of abortions_____
- ☐ Do you practice birth control?_____
- ☐ What type?_____

How long?_____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Carpal tunnel
- ☐ Knee pain
- ☐ Sprains/Strains
- ☐ Sciatica
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Tendonitis
- ☐ Back pain Low__Middle__Upper__
- ☐ Bursitis
- ☐ Rotator Cuff
- ☐ Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

- ☐ Seizures
- ☐ Loss of balance
- ☐ Vertigo/Dizziness
- ☐ Areas of numbness
- ☐ Lack of coordination
- ☐ Poor memory
- ☐ Concussion
- ☐ Depression
- ☐ Seasonal Affective Disorder
- ☐ Bad temper/irritable
- ☐ Nervousness
- ☐ Anxiety/Panic attacks
- ☐ Easily susceptible to stress
- ☐ ADD/ADHD
- ☐ Manic Depression

Have you ever been treated for emotional problems? ☐ Yes ☐ No
Have you ever considered or attempted suicide? ☐ Yes ☐ No
Have you ever been treated for substance abuse? ☐ Yes ☐ No

Comments Please inform me of any other problems you would like to discuss.

_____

_____

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Acupuncture Financial Policy

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly.

INSURANCE

All payments for acupuncture services will be required at time of service **in full.** We do not obtain insurance coverage for acupuncture and do not routinely bill for this service, as most policies do not provide payment. If you do have coverage, please provide the benefit details and the claim will be submitted for you. A receipt will be provided for you to submit to your insurance if you wish to pay the self-pay discount.

MINOR PATIENTS

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment at time of service.

FAILED APPOINTMENTS

By scheduling, you have agreed to attend all scheduled appointments in a timely manner. We require a **24-Hour** notice for cancellation of acupuncture appointments. Failure to cancel your appointment will result in being assessed a **$65.00 fee**. This fee is due when billed or at your next appointment which ever comes first.

PATIENT'S STATEMENT

I have read and understand the Financial Policy of Dickinson Chiropractic, P.C. I understand that I am responsible for payment in full of acupuncture services at time of service.

_____ _____

Print Name of Patient Date

_____

Signature of Patient (or Representative)

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

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 at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

_____	Deana S. Rehmel, D.C., L. Ac.
Print Name of Patient	Print Name of Acupuncturist
_____	_____
Signature of Patient (or Representative)	Signature of Acupuncturist
_____	_____
(Print Name of Patient Representative)	(Print Name of Witness/Translator)
_____	_____
Date Consent Completed	(Signature of Witness/Translator)