

**Acupuncture Clinic of Richmond
Initial Health Status**

General Information:

Date: _____
Patient Full Name: _____ Date of Birth: _____
Address: _____
City: _____ State: __ Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____ Employer: _____
Occupation: _____ Emergency Contact: _____
Email address: _____ May we contact you via email? Yes/No
Primary Care Physician: _____ Phone: _____
Date of Last Physical Exam: _____ By Whom: _____

How did you hear about the clinic? _____

Reason for Visit:

Please describe in detail why you are here and major health goal: _____

Date of Onset: _____ Sudden/Gradual Have you had this in the past? No Yes

When _____ Severity (1 – 10, 10 worse) _____

What makes it better? _____

What makes it worse? _____

Is the condition: Getting Worse Improving Constant Comes and Goes

How often are your symptoms present? Constant Frequent Sporadic

Are your symptoms preventing you from daily activity: All activity Some Not at all

Have you seen a physician or other practitioner for this condition: No Yes

Please describe what treatments you have taken for the above condition and the results (Surgery, Chiropractic, Medications, Injections, Herbal...): _____

Family Medical History:

Please check any illness or condition that a family member may have had in the past.

- AIDS Asthma Allergies Alcoholism Antibiotic use
Arthritis Artificial Joint Bleeding Tendencies Blood Disorder Breast Lumps
 Cancer Chicken Pox Convulsions or Seizures Depression Diabetes
Glaucoma Gonorrhea Heart Disease Hepatitis High Blood Pressure HIV
Jaundice Kidney Disease Lupus Meningitis Mononucleosis Multiple
Sclerosis Measles Mental Illness Polio Rheumatic Fever Stroke
Thyroid Disease Other: _____

Personal Medical History:

Describe your overall health: _____

Please check any illness or condition that you may have now or in the past.

- AIDS Asthma Allergies Alcoholism Antibiotic use
Arthritis Artificial Joint Bleeding Tendencies Blood Disorder Breast Lumps
 Cancer Chicken Pox Convulsions or Seizures Depression Diabetes
Glaucoma Gonorrhea Heart Disease Hepatitis High Blood Pressure HIV
Jaundice Kidney Disease Lupus Meningitis Mononucleosis Multiple
Sclerosis Measles Mental Illness Polio Rheumatic Fever Stroke
Thyroid Disease Other: _____

Please list any surgeries including date and physician: _____

Please list any other traumas, injuries ... and the dates they occurred: _____

Prescription Medications and Supplements:

Please list current medications, supplements, and herbs that you are taking including dose and frequency: _____

Do you have any history of or currently experience any of the following:

HEAD: Headaches What area _____ Frequency: _____
Dizziness Memory Loss Confusion Loss of Balance
Other: _____

SKIN: Dry Itchy Moist/Clammy Burning Change in moles/lumps (cysts)
Boils Acne Rashes Hives Hair Loss/thinning Dry Scalp
Skin Puffy/edema Where? _____
List all scars from accidents or surgeries _____
Other: _____

SWEATING: Night Sweats Rarely Sweat Excessive Sweating

CIRCULATION: Feelings of Hot Cold What area? _____
Cold Limbs Bruise Easily Other: _____

BLOOD PRESSURE: Normal High Low Unsure Other: _____

MUSCULOSKELETAL PAIN: Neck Shoulders Arms/Hands Elbow
Fingers Hip Thighs Knee Calves Ankles Toes Upper Back
Mid Back Low Back Leg cramps at night Weakness in legs/knees/ankles
Weakness arms, hands, fingers Tingling or Numbness in Hands/Feet
Muscle Spasms, cramps, twitches Bones sore/painful/weak Painful Joints
Stiff all over Bursitis Other: _____

NEUROLOGICAL: Tremors Numbness/tingling in limbs Muscle weakness
Seizures Nerve Pain Shingles Paralysis Other: _____

EYES: Pain Dry Blurry Vision Dark circles under eyes Floaters
Other: _____

EARS: Poor Hearing Earaches Discharge/Infections Ringing High/Low
Other: _____

NOSE: Frequent Nosebleeds Sinus Trouble Frequent Colds Constant Discharge
Allergies Please list: _____
Other: _____

THROAT/MOUTH: Sore throat When/Frequency _____
Hoarseness Difficulty Swallowing Jaw Problems Teeth Problems Speech Problems
Bleeding/Swollen/Painful Gums Mouth/Tongue Sores Unusual Tastes
Other: _____

CHEST: Hard to Breathe Wheezing Shortness of Breath Palpitations
Mucus/rattling with breathing Pain or Pressure in Chest
Persistent Cough How Long _____ Coughing Blood How Long _____
Coughing Phlegm How Long _____ Color and Consistency _____

APPETITE: Excessive Appetite Poor Appetite Appetite keep changing
Feel tired after eating Feel tired, weak or irritable if a meal is missed
Food Cravings What are they? _____
Excessive Thirst Never Thirsty

DIGESTION: Stomach gas Lower bowel gas/cramping Heartburn Belching
Nausea Vomiting Stomach pains/cramp Bad Breath Weight Gain
Weight Loss Abdominal Bloating Food Allergies _____
Other: _____

URINE: Difficulty Painful or Burning Blood in Urine Loss of Bladder Control
Frequent Infections Frequent at Night Color: _____
Other: _____

BOWELS: Diarrhea Constipation Alternating Diarrhea/Constipation
Bloody Stools Black Stools Mucus in stools Hemorrhoids Lower Bowel gas
Colon Problem Number of Bowel movements daily _____ Other: _____

NUTRITION: How many meals a day do you eat _____ When is the biggest meal _____
Do you eat breakfast? Yes No Sometimes
Do you eat fresh fruit and vegetables at least twice per day? Yes No Sometimes
Are you vegan or vegetarian? Explain _____
Do you eat when you are not hungry? Yes No Sometimes
Do you eat until you feel full? Yes No Sometimes
Do you “crash” diet? Yes No Sometimes
Have you ever fasted? Yes No Type: _____
How many glasses of water do you drink a day? _____
How do you like your liquids? Hot Ice Cold Room Temperature

SLEEP: Restful Trouble falling asleep Trouble staying asleep # Hrs of sleep _____
Excess dreaming/nightmares Other: _____

EMOTIONAL: Depression Anxiety Worry Suicidal Easily Angered
Easily irritated Frequent crying Mood swings How is your stress level?
None/Low Moderate Severe Cause _____
How do you feel you are handling your stress? _____
Are you being treated for emotional/psychological problems Yes No _____
Do you have a group of family or friends for emotional support Yes No Unsure
In general what is your day to day mood (ex: happy , stressed, overwhelmed...) _____

Are you currently in a satisfying:

Marriage/Partnership Yes No Unsure
Career/School Yes No Unsure
Have you set goals for yourself? Yes No Unsure
Do you have a sense of being fulfilled in life or being on your “path”? Yes No Unsure
Other: _____

ENERGY LEVEL: High (Time of Day) _____ Low (Time of Day) _____
Other: _____

LIFESTYLE/HABITS:

Alcohol Consumption: Yes No How many times per week: _____
Coffee/ Sodas: Yes No Type: _____ How Often: _____
Exercise: Yes No Sometimes : Type: _____
How often: _____
Recreational Drug Use: Now Past Type: _____ How often: _____
Tobacco Use: Yes No Type: _____ How Often: _____ How Long: _____
Meditate/Pray Yes No Sometimes How Often: _____
What activity do you do to relax/unwind (ex: exercise, yoga, music, shopping...) _____

MALES

Impotence Low Sex Drive Lack of Sex drive Pain/Itching in genitalia
Genital lesions/discharge Numbness/Cold in genitalia Weak Urinary System
Premature Ejaculations Other: _____

FEMALES

MENSTRUAL HISTORY:

Age first period started: _____
How many days does the period last: _____ How many days between your periods: _____
If irregular, please explain frequency: _____
What is the color of the flow? Dark Red Purple Bright Red Brown Pink
If varies please explain: _____
Clots with the period? None Few Many Cramps: None Moderate Severe
If yes at what point in the period do the cramps start? Before During After
What helps the pain? _____
What worsens the pain? _____
Nausea or Vomiting with or before period
Diarrhea or loose stool with or before period
Bleeding or discharge between periods, please describe: _____
Premenstrual symptoms: None Moderate Severe Describe symptoms: _____

GYNECOLOGICAL HISTORY:

Have you had or currently have any disease or surgery on the following: Breast Uterus
Cervix Tubes Ovaries Abnormal Pap Smears Genital Warts
Menopausal Symptoms List: _____
Pain during sex Genital warts Frequent Vaginal Infections Pelvic Infections
Infertility Yes No Unsure If yes, list length of time _____, methods or
procedures used to try to conceive along with dates: _____
Other: _____

CONTRACEPTIVE HISTORY:

Are you currently using birth control Yes No Type _____
Prior methods of birth control: Birth Control Pill Type _____ Foam IUD
Diaphragm Sponge Condom Cap Withdraw Rhythm
List any problems with past methods: _____

PREGNANCY HISTORY:

<i>Type</i>	<i>Number</i>	<i>Dates</i>
Live Birth	_____	_____
Caesareans	_____	_____
Miscarriage	_____	_____
Stillbirths	_____	_____
Ectopic (tubal)	_____	_____

Problems during pregnancy (toxemia, depression, diabetes, birth defects, preterm labor...)

Have you ever had an acupuncture treatment? When and for what reason? _____

Any concerns about acupuncture/herbal medicine or afraid of needles? _____

I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature

Date

Informed Consent and Disclosure

I hereby request and consent to acupuncture treatment and other procedures within the scope of the practice of acupuncture, and/or herbal supplement recommendations for me (or legal charge) provided by Deborah Farley.

I have read the information below and understand the possible risks involved and that I have had an opportunity to discuss these risks with the acupuncturist or clinic office staff named below, and that I understand that the results are not guaranteed.

- Acupuncture is a safe and effective method of treatment. Slight bleeding that is typically resolved when pressing dry cotton to the area, may occur. There may also be some slight bruising. The risk of infection is small when using sterile needles. It is the practice of this clinic to use pre-packaged, sterile, one-time-use only needles as required by law.
- Acupressure/TuiNa involves rubbing, kneading, pressing and stroking...of an area that may result in muscle soreness at the massage site that may last up to several days.
- Indirect Moxibustion requires the burning of an herbal material at a site near the skin or acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of contact and burns exist.
- Cupping involves localized suction produced by heating a small glass cup. There is a possibility of bruising from the suction as well as slight burning or blistering from the heat involved in the procedure.
- Gu sha involves scraping over a small area by using a smooth edge instrument. There is a possibility of local bruising at the site Gu sha is performed.
- Tapping, Plum Blossom, Bleeding, Pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment may occur. Only single use needles are used in this procedure.
- Electrical Stimulation / TENS uses microcurrent electricity to stimulate acupuncture points. A mild tingling of electricity may be felt.

Payment and Cancellation Agreement

I understand that payment is expected at the time of visit and I agree to make full payment at the time of my appointment.

I understand that when I schedule an appointment, I am agreeing to pay for the time set aside, as well as any treatment that I may receive during that designated time. I agree to provide this office with at least 24 hours notice when cancelling an appointment. I understand that if I cancel an appointment without a 24 hours notice, that I may be required to pay a charge which may include the cost of the appointment.

Patient Signature

Date

Practitioner Signature

Date

Patient Consent Use & Disclosure of Protected Health Information

Our **Notice of Privacy Practices** contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If our Notice changes, you may obtain a revised copy by contacting the clinic.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. Acupuncture Clinic of Richmond is not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Acupuncture Clinic of Richmond has a Notice of Privacy Practices and the patient may review this Notice
- Deborah Farley reserves the right to change the Notice of Privacy Policies
- Patient has the right to restrict use of their information, but the Practice is not required to agree to restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Deborah Farley may condition treatment upon the execution of this Consent.

I have received, read and understand the **Notice of Privacy Practices** and I authorize and consent to the use and disclosure of protected health information in manner described.

Patient Signature

Date

Practitioner Signature

Date