Acupuncture Health History Form

Confidential Patient Health Record ***Today's Date*:____/_____/_____**

Personal Information

Full Name:_____ Birth Date: ____ /____/_____ Sex: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Contact number (s) (home, cell, etc.): _____
Email
Address:_____Occupation:_____

Emergency Contact

Full Name:_____ Contact number: _____
Relationship: ◊ Spouse ◊ Relative ◊ Friend ◊ Other _____

Current Health Condition

Major Health Concern/ Reason for visit: _____

When did it BEGIN? ___/____/____Has it ever occurred before? ◊ Yes ◊ No When? _____

Is the Condition: ◊ Auto Related ◊ Job Related ◊ Home Injury ◊ Slip or Fall ◊ Lifting
◊ Slept Wrong ◊ Unknown Cause ◊ Other
Explain: _____
Do have any secondary health concerns?

_____

Have you ever had acupuncture? If yes, what was it for:

_____

Previous Care for this Same Condition:

I have previously been for this condition ◊ Yes ◊ No. If yes, What type of treatment?

_____

Current Medication(s)/Supplement(s): **List ANY/ALL you are CURRENTLY taking.**

Medication/ Supplement	Dosage	For What Condition?	How long have you been taking this?

Past Medical History
Childhood Illness (es) i.e. chicken pox, mumps:

_____
_____

Immunizations: **Please list with the date(s), if known**

_____
_____

Major Adult Illness (es) i.e. diabetes, strokes, hepatitis:

_____
_____

Surgery (ies) & Injury (ies): **List all major surgeries and injuries and the date(s)**

_____
_____

Females ONLY: Ob/Gyn **Mark all that apply below**
If you have been pregnant in the past, please fill in the appropriate information below.
_____ Number of complicated pregnancies **_____ Number of uncomplicated pregnancies**
_____ Number of C-sections **_____ Number of vaginal deliveries**
_____ Number of miscarriages **_____ Number of terminated pregnancies**
I… ◊ am currently pregnant **◊ am NOT currently pregnant**
Menstrual History
I… ◊ currently have menses. **◊ currently DO NOT have menses.**
My menses… ◊ are regular. **◊ are NOT regular.**
_____ Age of first menses **_____ Age when menopause began**
Date of last menses: ____/____/_____

List all drug and non-drug Allergies (please include reaction):

_____
_____
Family History:
Please list any major conditions in your family including mother (her parents), father (his parents) and siblings:_____
_____
_____
Social History:
Alcohol? **◊ Yes ◊ No** ***(circle) beer/ wine/ liquor/ other***_____
quantity:_____ ***servings (circle) daily/ weekly/ monthly/ other***_____
Smoke cigarettes? ◊ Yes ◊ No how many packs per day?_____ How many years?_____
Illegal Substances? ◊ Yes ◊ No what types? _____ Method of use: _____
How many years? _____ last time used:_____
Weight: _____ lbs. Height: ____ ft ____inches

Please describe your typical, daily meal(s)/ snack(s) please include beverages and amounts:

_____
_____

I am usually: ◊ Hot ◊ Cold ◊ Temperate

Thank you for taking time and consideration in completing this form

Wandering Dragon Acupuncture Service, LLC

Treatment Consent Form

I, _____, do hereby consent to being treated with acupuncture and other modalities within the scope of acupuncture. I realize that treatments will be performed by a licensed acupuncturist who is either working for or is associated with Wandering Dragon Acupuncture Service, LLC.

I am aware that treatment modalities may include, but are not limited to acupuncture, moxibustion, cupping, electric stimulation, Tiu-Na (Chinese massage), herbal and nutritional recommendations. I am aware that the acupuncturist may recommend modalities that I am able to perform at home and written instructions will be provided if necessary.

I have been made aware of the potential side effects of acupuncture and associated modalities. Side effects include, but are not limited to bruising, a slight pinching sensation upon insertion of an acupuncture needle, numbness or tingling at the site of an inserted needle, infection, dizziness, or fainting. Burning and/or scarring are risks of moxibustion. Potential, but unusual, risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture.

I understand that I am an individual and any complications of my treatment not necessarily anticipated by staff, will be handled professionally and expeditiously. I also understand that results are not guaranteed.

My signature below indicates that I have read, or have had read to me, the above consent to treatment, have been educated about the risks and benefits of acupuncture and other procedures, 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.

Patient/Guardian Signature:_____ **Date:**_____

Printed Name:_____

Witness Signature:_____ **Date:**_____

Printed Name:_____

Wandering Dragon Acupuncture Service, LLC

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

The following policies have been adopted:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.

2. It is the policy of Wandering Dragon to remind patients of their appointments. This may be done by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to policy.

3. You agree to bring any concerns or complaints regarding privacy to the attention of the practitioner.

4. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

5. We agree to provide patients with access to their records in accordance with state and federal laws.

6. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

7. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used by Wandering Dragon concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.