Three Wells
ACUPUNCTURE CLINIC
revive - restore - renew

Health History Questionnaire – Women

This is a *confidential* questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. If you need more room, please use the back side of these sheets.

Name: ____ Date: ___________

Home address: ____

City ____ State: _____ Zip: ___________

❑Home (_____)____________ ❑Work (_____)____________ ❑Cell (____)____________

Email Address: ____
(Appointment reminders are sent via email)

May we add you to our email newsletter? ❑ Yes ❑ No (We will never spam or share your information)

DOB ___/___/____ Age: ____ Height: ____ Weight: ____ Weight 1 yr ago: ___ Sex: M F MTF FTM

Occupation: ____________________________ Employer: __________________________

❑ Single ❑ Married ❑ Divorced ❑Separated ❑ Widowed ❑ Partnership ❑ Same sex relationship

Emergency Contact: __________________________ Contact Phone:_____________________

Physician Name: ____________________________ Physician Phone:____________________

How did you hear about our clinic? ____

Have you received acupuncture therapy before? ❑ Yes ❑ No If Yes, where? _________________

HEALTH HISTORY

1. What are the main health concerns for which you are seeking treatment?

____ Date of Onset: _________
____ Date of Onset: _________
____ Date of Onset: _________
____ Date of Onset: _________

2. What previous medical workups, diagnosis, and treatment have you had for these concerns?

____
____
____

3. Please list any allergies to: ❑ Latex ❑ Food ________ ❑ Metals ________ ❑ Drugs ________
Other:____

4. Do you have any of the following:
❑ Hepatitis ❑ HIV ❑ Seizures ❑ Pacemaker ❑ Metal pins or plates

5. List any accidents, surgeries, or hospitalizations (include date):

____
____

Three Wells ACUPUNCTURE CLINIC

6. What medications, sleep aids, stomach remedies, vitamins, and supplements are you currently taking?
(Continue on the back of this page if necessary. If you have a separate list, we can photocopy that for you.)

Medication **Dose** **Reason** **Date Started** **Date of last checkup**

____
____
____
____
____
____

7. Family history

	Mother	Father	Brother(s)	Sister(s)	Spouse	Child(ren)
Health: G=Good P=Poor						
Medical Conditions						
Age, if living						
If deceased, age and cause						

LIFESTYLE HABITS

8. Please indicate the use and frequency of the following: (how much, how many, or how often)

❑ Alcohol ____________________________
❑ Tobacco ____________________________
❑ Second Hand Smoke Exposure ❑ Y ❑ N
❑ Marijuana ___________________________
❑ Other Recreational Drugs _______________
❑ Coffee ______________________________
❑ Tea ________________________________
❑ Soda Pop ____________________________
❑ Water _______________________________
❑ Energy Drinks_________________________

Have you ever been treated for drug/alcohol dependence? ❑ Yes ❑ No

9. Do you follow any particular diet or eating style:
____

How many times a week do you eat at restaurants? ❑ 0-2 ❑ 3-5 ❑ 6 or more

How many meals per day do you eat? _____ How many snacks per day? _____

10. What is your daily activity level including your occupation:

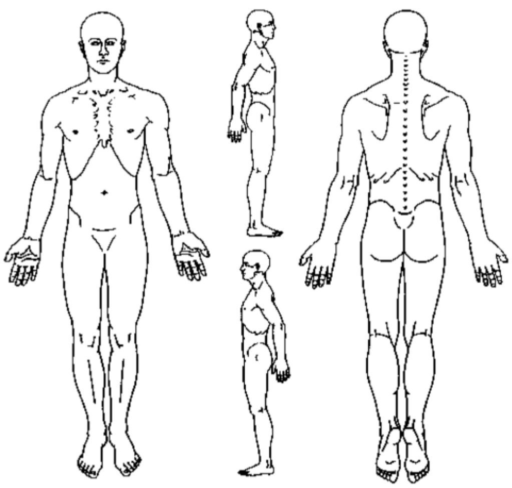
❑ Sedentary, i.e. mostly sitting
❑ Somewhat active
❑ Moderately active
❑ Very active (moving around or up most of the time)
❑ Heavy duty (lifting, moving things, etc.)

11. Do you sleep well? ❑ Yes ❑ No Awaken rested? ❑ Yes ❑ No Average hours of sleep: ____

12. What is your average energy level (1 – least, 10 – most): 1 2 3 4 5 6 7 8 9 10
13. What is your average stress level (1 – least, 10 – most): 1 2 3 4 5 6 7 8 9 10

14. How much change are you willing to/able to make at this time to improve your health?
❑ Minimal ❑ Some ❑ Complete

PAIN



Please mark on the picture where you have pain right now:

A=Ache B=Burning N=Numbness
P=Pins & Needles S=Stabbing O=Other

How long: ____ Years ____ Months ____Weeks

How painful is it? (0=none to 10= excruciating) ___________

Better with: ❑ Movement ❑ Rest ❑ Pressure ❑ Heat ❑ Ice
❑ Medicine _____________ ❑ Other ______________

Worse with: ❑ Movement ❑ Rest ❑ Pressure ❑ Heat ❑Ice
❑ Medicine _____________ ❑ Other ______________

SYMPTOM SURVEY

Check symptoms experienced *in the past 3 months*. Leave blank if never experience.
Please indicate as follows: One check = ✔ = Sometimes Two checks = ✔ ✔ = Frequently

___ Appetite ❑ High ❑Low
___ Thirst ❑ High ❑Low
___ Constipation
___ Loose stool/diarrhea
___ Colitis or diverticulitis
___ Hemorrhoids
___ Indigestion/Acid reflux
___ Ulcers
___ Belching/burping/gas
___ Abdominal bloating
___ Unexplained weight loss
___ Difficult to digest oily food
___ Gallstones
___ Mucus in stool
___ Bloody or black tarry stool
___ Undigested stool

___ Palpitations/fluttering
___ Chest pain
___ Bronchitis
___ Cough
___ Coughing blood
___ Shortness of breath
___ COPD/Emphysema
___ Allergies
___ Catch colds easily
___ Asthma
___ Sinus congestion
___ Recent use of antibiotics
___ Phlegm: ❑ Nose ❑Chest
Easy to expectorate: ❑ Y ❑ N
Color: Clear White Yellow Green

___ Tension headache
___ Migraine
___ Worry/Mind Racing
___ Difficulty concentrating
___ Poor memory
___ Fatigue
___ Laughing for no reason
___ Easily angered/agitated
___ Difficulty w/ decisions
___ Dizziness/lightheaded
___ Easily startled
___ Eye problems
___ Ear ringing
___ Impaired hearing

___ Acne
___ Eczema
___ Psoriasis
___ Rashes
___ Itching
___ Dandruff

___ Muscle spasms/twitching
___ Soft brittle nails
___ Easily bruised
___ Yellowish skin/eyes
___ Hair loss/early gray
___ Temperature: ❑ Run cold ❑ Run warm ❑ Neutral
___ Sweating: ❑ Easily ❑ Rarely ❑ Hot flashes ❑ Night sweats

___ Decreased libido
___ Urinary problems
___ Urine color _________
___ Edema/swelling
___ Kidney stones

Three Wells ACUPUNCTURE CLINIC

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	❑	❑	❑	❑	❑	______
Family	❑	❑	❑	❑	❑	______
Friendships	❑	❑	❑	❑	❑	______
Diet	❑	❑	❑	❑	❑	______
Exercise	❑	❑	❑	❑	❑	______
Sex	❑	❑	❑	❑	❑	______
Self image	❑	❑	❑	❑	❑	______
Work	❑	❑	❑	❑	❑	______
Spirituality	❑	❑	❑	❑	❑	______

Do you have any history of physical, sexual, or emotional abuse? ❑ Yes ❑ No

FEMALE PATIENTS

1. Age of first period _____ Date and result of most recent Pap exam ____________________________

2. **Menstruation:** (If in menopause, skip to next section below)

First day of most recent period ________ Length between periods ________ Birth control _________

Regularity: ❑ Regular ❑ Irregular ❑ Usually early ❑ Usually late # Days of Flow: ________

Flow is typically: ❑ Heavy ❑ Moderate ❑ Light

Color is typically: ❑ Pale pink ❑ Red ❑ Bright red ❑ Dark red ❑ Purplish ❑ Brownish

Consistency is typically: ❑ Thin ❑ Thick ❑ Clotted

Discomfort with period: ❑ Abdominal bloating ❑ Lower back soreness ❑ Cramping/pain

Premenstrual Syndrome (PMS): ❑ Other ____

❑ Irritability ❑ Bloating ❑ Mood swings ❑ Breast tenderness ❑ Water retention

Other symptoms related to menses:

❑ Vaginal dryness ❑ Headache ❑ Nausea ❑ Diarrhea ❑ Constipation ❑ Insomnia

❑ Ravenous appetite ❑ Low appetite ❑ Night sweats ❑ Hot flashes ❑ High libido ❑ Low libido

3. **Menopause:** Age of final period _____ Any menopause symptoms? _______________________

4. **All women:**

❑ Vaginal Discharge ❑ Uterine bleeding (not related to periods)

❑ Fibroids ❑ Fibrocystic Breasts ❑ Endometriosis ❑ Ovarian Cysts ❑ PID ❑ PCOS

❑ Gonorrhea ❑Syphilis ❑ Chlamydia ❑ Herpes ❑ HIV ❑ HPV

5. **Pregnancy:**

Are you currently pregnant? ❑ Yes ❑ No ❑ Not sure

Number of: Pregnancies ______ Live births _____ Miscarriages ______ Terminations ______

Please list note any difficulties during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)

____

____

CONSENT TO TREATMENT

I voluntarily consent to receive (or have the patient named below, for whom I am legally responsible, receive) acupuncture and traditional Chinese medicine administered by licensed acupuncturists working at Three Wells Acupuncture Clinic, Inc. who are licensed by the State of Illinois and certified by the National Certification Commission of Acupuncture and Oriental Medicine. **I understand that his/her training is in acupuncture and traditional Chinese medicine and that (s)he is not, nor claims to be, a medical doctor. I understand that the evaluation given to me in no way purports to be, or replaces, allopathic (western) medical evaluation, diagnosis, or treatment.**

I have provided a full history and description of complaints which are complete and accurate. I understand that no guarantee has been made concerning the use and effects of acupuncture and traditional Chinese medicine. I understand that I may discontinue treatment at any time.

I understand that acupuncture is the insertion of fine, sterile, single-use needles. As part of traditional Chinese medicine, the methods of treatment may include, but are not limited to, liniments (herbal ointments), gua sha (muscle scraping technique), cupping (myofascial release), moxa (heat therapy), tui na massage, electro-stimulation, herbal supplements, and eastern nutritional counseling, as appropriate to treatment.

I have been informed that acupuncture is a generally safe method of treatment but that, although rare, certain side effects may result. These may include slight bleeding, minor bruising, or some discomfort at the site of needle insertion. Other possible risks from acupuncture include dizziness, fainting, or light-headedness. Extremely rare risk of acupuncture includes nerve damage, organ puncture, and infection. Extremely rare risk of heat therapy includes discomfort or burning. The herbs and nutritional supplements (from plant, animal, and mineral sources) that have been recommended are considered safe in the practice of Traditional Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate in pregnancy. Rare but possible side effects of taking these supplements could be nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **I will immediately notify my acupuncturist if I feel any of the aforementioned symptoms during or after an acupuncture treatment, or any unpleasant or unanticipated effects associated with the consumption of herbal supplements obtained from this clinic**. I do not expect the acupuncturist or clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I will notify the acupuncturist or clinical staff if I am or become pregnant, if I have a severe bleeding disorder, or if I am wearing a pacemaker or other electronic medical device.

By signing below, I show that I have read, or have had read to me, the above consent to treatment 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.

____ _________________________

Signature of Patient Date

CONSENT TO TREAT A MINOR CHILD (for children and teens under 18)

I authorize the licensed practitioners at Three Wells Acupuncture Clinic, Inc. to administer acupuncture and traditional Chinese medicine as deemed necessary to my _______________________(relationship).

Patient's Name ____ Date________________

Parent/Guardian's Signature____ Date________________

NOTICE OF PRIVACY POLICIES

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices (see separate PDF on the Forms page of the website or provided by the receptionist) and have therefore been notified of how health information about me may be used and disclosed by Three Wells Acupuncture Clinic, Inc., and how I may obtain access to and control of this information. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the operations of Three Wells Acupuncture Clinic, Inc. and its practitioner(s).

X ____ ___________________

Patient Signature or Personal Representative Date

PAYMENT AND CANCELLATION POLICY

Payment due is to be paid at time of service. Your appointment time is specifically reserved for you. Appointment reminders via email are provided as a courtesy whenever possible, but may not always be given. ***In the event of a missed appointment or less than 24 hours' notice of cancellation, a $25 cancellation fee will be charged.***

By signing below, I understand and accept these policies.

X ____ ___________________

Patient Signature or Personal Representative Date

EASTERN NUTRITION INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "drug" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."* A vitamin is not a drug, neither is a mineral, trace element, amino acid, herb, or homeopathic remedy. Although a vitamin, mineral, trace element, amino acid, herb, or homeopathic remedy may have an effect on a disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested eastern nutritional advice is not intended as any primary treatment, nor therapy for any disease or symptom.

Herbal supplements, vitamin recommendations, or eastern nutritional advice is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Likewise, if requested by the patient, a hair analysis from ARL laboratories is not intended as a diagnosis and does not replace the recommendations given to you by your medical doctor.

I have read and understand the above:

X ____ ___________________

Patient Signature or Personal Representative Date

ASSIGNMENT OF BENEFITS
(To be signed by patients who have insurance coverage for acupuncture)

I request that payment of authorized insurance benefits be made on my behalf to Three Wells Acupuncture Clinic, Inc. for any approved medical services provided to me by Three Wells Acupuncture Clinic. Inc.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original will be kept on file by Three Wells Acupuncture Clinic, Inc.

I understand that I am financially responsible to Three Wells Acupuncture Clinic, Inc. for any charges not covered by health care benefits. It is my responsibility to notify Three Wells Acupuncture Clinic, Inc. of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Three Wells Acupuncture Clinic, Inc. and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services and products received.

X ____ _________________________
Signature of Insured Date