

**Health History Questionnaire – Teens (under 18)**

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: \_\_\_\_\_

Parents'/Legal Guardians' Names: \_\_\_\_\_

Home address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_  Work (\_\_\_\_\_) \_\_\_\_\_  Cell (\_\_\_\_\_) \_\_\_\_\_

Parent/Guardian 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: \_\_\_ Grade: \_\_\_ Height: \_\_\_ Weight: \_\_\_ Weight 1 yr ago: \_\_\_ Sex: M F

Parents/Guardians are:

Single  Married  Divorced  Separated  Widowed  Partnership  Same sex relationship

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 either of the following:  Seizures  Metal pins or plates

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

\_\_\_\_\_  
 \_\_\_\_\_

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

Number of siblings: \_\_\_\_\_  oldest  middle  youngest

	Mother	Father	Brother(s)	Sister(s)
Health: G=Good P=Poor				
Medical Conditions				
Age				
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. Please describe what you ate yesterday:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Was this a typical day?  Yes  No If no, describe: \_\_\_\_\_

10. Do you sleep well?  Yes  No Awaken rested?  Yes  No Avg hrs of sleep: \_\_\_\_

Time to bed: \_\_\_\_\_ Time to arise: \_\_\_\_\_ # Times awake during night: \_\_\_\_\_

11. At what time of day is your energy typically at its best? \_\_\_\_\_

At what time of day is your energy typically at its worst? \_\_\_\_\_

16. What is your average stress level (1 – least, 10 – most): 1 2 3 4 5 6 7 8 9 10  
 What currently causes you stress: \_\_\_\_\_

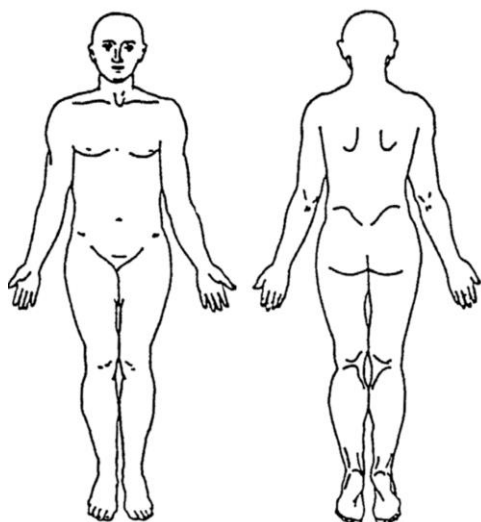
17. How do you feel about the following areas of your life?

	Good	So-So	Bad	Comments
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

19. 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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Appetite <input type="checkbox"/> High <input type="checkbox"/> Low | <input type="checkbox"/> Palpitations/fluttering  | <input type="checkbox"/> Tension headache         |
| <input type="checkbox"/> Thirst <input type="checkbox"/> High <input type="checkbox"/> Low   | <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Migraine                 |
| <input type="checkbox"/> Constipation  | <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Worry/Mind Racing        |
| <input type="checkbox"/> Loose stool/diarrhea  | <input type="checkbox"/> Cough  | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Colitis or diverticulitis   | <input type="checkbox"/> Coughing blood   | <input type="checkbox"/> Poor memory              |
| <input type="checkbox"/> Hemorrhoids   | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Fatigue                  |
| <input type="checkbox"/> Indigestion/Acid reflux   | <input type="checkbox"/> Allergies  | <input type="checkbox"/> Laughing for no reason   |
| <input type="checkbox"/> Ulcers  | <input type="checkbox"/> Catch colds easily   | <input type="checkbox"/> Easily angered/agitated  |
| <input type="checkbox"/> Belching/burping/gas  | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Difficulty w/ decisions  |
| <input type="checkbox"/> Abdominal bloating  | <input type="checkbox"/> Sinus congestion   | <input type="checkbox"/> Dizziness/lightheaded    |
| <input type="checkbox"/> Unexplained weight loss   | <input type="checkbox"/> Recent use of antibiotics  | <input type="checkbox"/> Easily startled          |
| <input type="checkbox"/> Difficult to digest oily food                                       | <input type="checkbox"/> Phlegm: <input type="checkbox"/> Nose <input type="checkbox"/> Chest   | <input type="checkbox"/> Eye problems             |
| <input type="checkbox"/> Gallstones  | Easy to expectorate: <input type="checkbox"/> Y <input type="checkbox"/> N  | <input type="checkbox"/> Ear ringing              |
| <input type="checkbox"/> Mucus in stool  | Color: Clear White Yellow Green   | <input type="checkbox"/> Impaired hearing         |
| <input type="checkbox"/> Bloody or black tarry stool   |   |   |
| <input type="checkbox"/> Undigested stool  |   |   |
| <br>   |   |   |
| <input type="checkbox"/> Acne  | <input type="checkbox"/> Muscle spasms/twitching  | <input type="checkbox"/> Urinary issues _____     |
| <input type="checkbox"/> Eczema  | <input type="checkbox"/> Soft brittle nails   | <input type="checkbox"/> Urine color _____        |
| <input type="checkbox"/> Psoriasis   | <input type="checkbox"/> Easily bruised   | <input type="checkbox"/> Kidney stones            |
| <input type="checkbox"/> Rashes  | <input type="checkbox"/> Yellowish skin/eyes  | <input type="checkbox"/> Edema/swelling           |
| <input type="checkbox"/> Itching   | <input type="checkbox"/> Hair loss/early gray   |   |
| <input type="checkbox"/> Dandruff  | <input type="checkbox"/> Temperature: <input type="checkbox"/> Run cold <input type="checkbox"/> Run warm <input type="checkbox"/> Neutral                                    |   |
|  | <input type="checkbox"/> Sweating: <input type="checkbox"/> Easily <input type="checkbox"/> Rarely <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats |   |

Have you gone through puberty?  Yes  No Are you sexually active?  Yes  No

**FEMALE PATIENTS ONLY**

1. Age of first period \_\_\_\_\_ Date and result of most recent Pap exam \_\_\_\_\_

**2. Menstruation:**

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. General:**

Vaginal Discharge  Uterine bleeding (not related to periods)

Fibroids  Fibrocystic Breasts  Endometriosis  Ovarian Cysts  PID  PCOS

**4. 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.)

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**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 \_\_\_\_\_  
 Parent/Guardian's Signature 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 \_\_\_\_\_  
 Parent/Guardian's Signature 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 \_\_\_\_\_  
 Parent/Guardian's Signature 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 \_\_\_\_\_  
Insured Parent/Guardian's Signature

\_\_\_\_\_  
Date