



Health History Questionnaire – Adult

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.

Legal Name: _____ Date: _____

Preferred First Name or Nickname _____

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: ___ Gender: _____

Sex assigned at birth: _____ Pronouns: _____ Sexuality: _____ Relationship status: _____

Occupation: _____ Employer: _____

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: _____

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, where? _____

5. List any accidents, surgeries, or hospitalizations (include date): (Continue on the back of this page if necessary. If you have a separate list, we can photocopy that for you.)

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:

Have you ever been treated for or suspect you have disordered eating behaviors? Yes No

Please describe: _____

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: _____

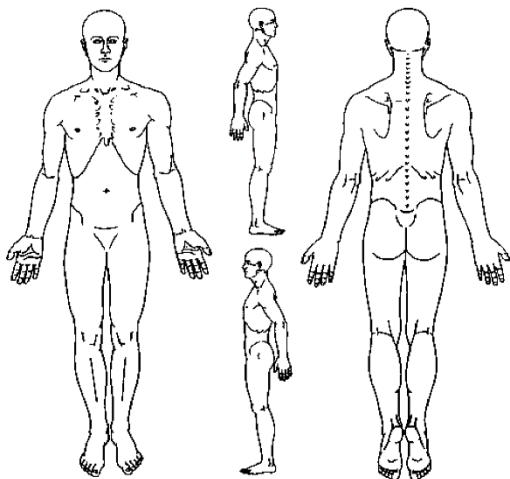
12. What is your average energy level (1 – least, 10 – most): 1 2 3 4 5 6 7 8 9 10

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

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

What is the BEST part of your health right now? _____

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

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self-image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 #3 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 & Adoption:**

Are you currently pregnant? Yes No Not sure Adopted Children _____

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

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

MALE PATIENTS

Date of last prostate exam: _____ Results: _____

Frequency of Urination: Daytime _____ Nighttime _____

Color of Urine: Clear Cloudy Dark Odor: _____

Please check all that apply:

- | | | |
|-----------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Urinary hesitancy | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Increased libido |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Groin pain | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Post-void dribbling | <input type="checkbox"/> Testicular pain | <input type="checkbox"/> Inability to ejaculate |
| <input type="checkbox"/> Retention of urine | <input type="checkbox"/> Testicular masses | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Hernia | <input type="checkbox"/> Difficulty achieving erection |
| <input type="checkbox"/> Urinary pain/burning | <input type="checkbox"/> Discharge/sores | <input type="checkbox"/> Difficulty sustaining erection |
| <input type="checkbox"/> Rectal dysfunction | <input type="checkbox"/> Impaired fertility. Results of Sperm Analysis: _____ | |



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 and dietary supplements, essential oils, 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, nutritional supplements, and essential oils (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 supplements 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 seek medical attention, if needed. **I will also 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 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 have read the above consent and authorize the licensed practitioners at Three Wells Acupuncture Clinic, Inc. to administer acupuncture and traditional Chinese medicine as deemed necessary for my _____ (relationship).

Patient's Name _____ Date _____

Parent/Guardian Signature _____ Date _____



NOTICE OF PRIVACY POLICIES

By signing below, I acknowledge that I have read the Notice of Privacy Practices on the website at <https://threewellsclinic.com/forms/> or asked for a paper copy from the clinic, 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 or Legal Guardian 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 _____
Patient or Legal Guardian Signature Date

EAST ASIAN NUTRITION AND SUPPLEMENT 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, essential oil, or homeopathic remedy. Although a vitamin, mineral, trace element, amino acid, herb, essential oil, 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.

Herbal and dietary supplements, essential oil recommendations, or eastern nutritional advice is not intended as any primary treatment, nor therapy for any disease or symptom. It is provided solely to support normal and healthy physiological 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 by a medical doctor.

I have read and understand the above:

X _____
Patient or Legal Guardian Signature Date



ASSIGNMENT OF BENEFITS

(Optional: 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 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 the 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 processes the claim.

I am responsible for the entire bill or balance of the bill as determined by Three Wells Acupuncture Clinic, Inc. 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.

By signing this document, I also acknowledge that I have received a copy of the organization’s Notice of Privacy Practices or viewed the document online at <https://threewellsclinic.com/forms>. 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.

Signature of Insured

Date