To The Point Acupuncture, LLC
1215 Jones Franklin Road, Suite 202
Raleigh, NC 27606
(919) 621-3363

CONFIDENTIAL HEALTH HISTORY QUESTIONAIRE

Please take the time to fill out this questionnaire to the best of your ability. Please add details when relevant. All responses are kept confidential.

NAME:_____ DATE:_____
DOB:_____
ADDRESS (include street, apt. #, city, state, zip)
_____
_____
EMAIL:_____ Is it ok to email confidential information and reminders? (Y/N)
HOME PHONE:_____ WORK:_____ CELL:_____
Is it ok to leave a text message, appointment reminder, or voicemail at any of the above numbers? (Y / N)
AGE:_____ HEIGHT:_____ WEIGHT_____ OCCUPATION:_____
FAMILY PHYSICIAN:_____ Phone number:_____
HEALTH INSURANCE COMPANY:_____
EMERGENCY CONTACT (name, phone number, and relation to you-please list guardian if under 18)
_____
HOW DID YOU HEAR ABOUT THIS OFFICE? _____
HAVE YOU EVER RECEIVED ACUPUNCTURE BEFORE?_____

MAIN PROBLEM:

What has brought you to *To The Point Acupuncture, LLC*?
Please include: To what extent this problem interferes with daily activities, how long ago this problem began, what aggravates or alleviates this condition, diagnosis (if any) given for this problem, and other treatment you have tried.
_____
_____
_____
_____
_____

PATIENT MEDICAL HISTORY:

RECENT TESTS:

□ Physical	□ Cholesterol	□ Mammography	□ Pap Smear
□ Blood	□ HIV/STD	□ Prostate	□ Other:_____

Test results and dates:_____

PAST AND PRESENT MEDICAL HISTORY: (please check all applicable)

□ HIV	□ STD	□ Tuberculosis	□ Cancer	□ PTSD
□ Bleeding Tendency	□ Anemia	□ Blood disorders	□ Heart disease	□ Rubella
□ High Blood Pressure	□ High Cholesterol	□ Diabetes	□ Low blood sugar/hypoglycemic	
□ Glaucoma	□ Thyroid disease	□ Kidney stones	□ Multiple Sclerosis	
□ Polio	□ Measles	□ Mumps	□ Rheumatic fever	
□ Chicken Pox	□ Mononucleosis	□ Epilepsy	□ Seizures	□ Gout
□ Hepatitis	□ Gallbladder stones	□ Jaundice	□ Fatty liver/Liver disease	

FAMILY MEDICAL HISTORY:

□ High Blood Pressure □ Heart Disease □ High Cholesterol □ Stroke □ Cancer
□ Diabetes □ Seizures □ Mental illness □ Allergies □ Other:_____

Current Medications/Herbs/Vitamins/Supplements:
(please include dosage, when began taking, how often, and reason for taking)**:**

_____
_____
_____

Allergies (drugs, chemicals, foods)

_____

Please list any Hospitalizations/Surgeries/Significant Trauma/Major illness or disease:

_____
_____
_____

Any implants, devices, or prosthetics (metal or plastic)?

LIFESTYLE:

Caffeine (intake per day):_____ **Water** (intake per day):_____
Smoking/Chew (# of packs/day):_____ **Alcohol** (# of drinks daily):_____ **Recreational Drugs:** (Y / N): _____
How many hours per week do you work?_____
Do you have a regular exercise program? (type of exercise and times per week)_____

	Lowest									Highest
Stress Level:	1	2	3	4	5	6	7	8	9	10
Energy Level:	1	2	3	4	5	6	7	8	9	10

OVERALL TEMPERATURE:

□ Cold hands/feet □ Raynaud's disease □ Cold abdomen
□ Cold body temp. (sensation) □ Hot body temp. (sensation) □ Night sweats
□ Sweaty hands/feet □ Heat in hands, feet, chest □ Hot flashes (any time of day)
□ Spontaneous sweating □ Lack of perspiration □ Chills

SKIN & HAIR

□ Dry □ Oily □ Acne □ Dandruff □ Loss of hair
□ Eczema/Psoriasis □ Itching □ Rashes □ Hives □ Ulcerations
□ Lumps/cysts □ Warts □ Recent moles
□ Change in hair or skin texture?
□ Any other hair or skin problems:_____

HEAD, EYES, EARS, NOSE, MOUTH and THROAT:

□ Glasses/Contacts □ Night blindness □ Dizziness/Vertigo □ Facial pain
□ Blurry vision/Eye strain □ Color blindness □ Sinus problems □ Nose bleeds
□ Tearing/Dryness □ Hearing loss □ TMJ/Jaw problems □ Recurrent sore throats
□ Floaters/spots □ Ear ringing/Tinnitus □ Teeth grinding/clenching □ Sores on lips/tongue
□ Cataracts □ Earaches/infections □ Teeth problems □ Bleeding gums
□ Concussions □ Headaches/Migraines (location on head/frequency):_____
□ Any other face or head problems: _____

CARDIOVASCULAR:

□ Irregular heart beat □ Chest pain/tightness □ Palpitations
□ High blood pressure □ Low blood pressure □ Varicose veins
□ Swelling of the hands/feet □ Blood clots □ Murmur
□ Phlebitis □ Fainting □ Pacemaker
□ Any other heart or blood vessel problems:_____

RESPIRATORY:

□ COPD □ Persistent cough □ Difficulty breathing/Shortness of breath
□ Emphysema □ Asthma □ Frequent colds
□ Bronchitis □ Coughing blood □ Pain with a deep breath
□ Pneumonia □ Post nasal drip □ Allergies
□ History of smoking (How long did you smoke for? When did you quit?)_____
□ Production of phlegm- color?_____ □ Any other lung/breathing problems:_____

DIET:

□ Strong thirst □ No thirst □ Water retention □ Particular tastes/smells
□ Weight gain □ Weight loss □ Increase/decrease in appetite
□ Cravings:_____
Do you follow a prescribed diet or have food restrictions/sensitivities? _____
AVERAGE DAILY DIET:

BREAKFAST:	LUNCH:	DINNER:	SNACKS:

GASTROINTESTINAL:

□ Passing gas □ Belching □ Heartburn/Acid reflux/GERD
□ Ulcers □ Abdominal bloating □ Abdominal/Epigastric Pain
□ Nausea □ Vomiting □ IBS □ Crohn's disease
□ Polyps □ Diverticulitis □ Colitis
□ Any other problems with your stomach or intestines:_____

ELIMINATION/BOWELS:

□ Constipation □ Diarrhea □ Loose stools □ Black stools/blood in stool
□ Hemorrhoids □ Rectal pain □ Undigested food in stools □ Chronic laxative use
□ How often do you have a bowel movement?_____ □ Strong odor

URINARY:

□ Pain upon urination □ Frequent urination □ Blood in urine
□ Urgency to urinate □ Unable to hold urine □ Incontinence
□ Decrease in flow □ Frequent UTI or bladder infections □ Cloudy urine
□ Scanty urination □ Profuse urination □ Strong odor
□ Do you wake to urinate? How often?_____ Color of urine:_____
□ Any other problems with your urinary system:_____

Libido: □ High □ Normal □ Low □ Pain during or after intercourse

MALE REPRODUCTIVE:

□ Erectile Dysfunction □ Prostate problems □ Testicular pain/swelling
□ Impotence □ Premature ejaculation □ Cold/numbness in external genitals
□ Any other problems with your reproductive system:_____

FEMALE REPRODUCTIVE:

□ Are you pregnant?_____ □ Is it possible you are pregnant?_____ □ Difficulty Conceiving
□ Live Births#_____ □ Premature births#_____ □ Miscarriages#_____ □ Abortions#_____
Of the live births, were there any problems or complications during the pregnancy or during delivery? _____
_____
□ Last PAP:_____ □Birth control? What type and for how long_____
□ Fibrocystic breasts □ Yeast infections □ Vaginal dryness □ Vaginal Discharge – Color:_____

MENSTURAL CYCLE:

□ Age of first menses _____ □ Duration of menses _____ □ Time between menses_____
□ Light flow □ Medium flow □ Heavy flow
□ Clotting □ Irregular cycles □ Bleeding between periods □ Spotting
□ Color of the blood:_____
□ Cysts □ Endometriosis □ Polyps □ Fibroids
PMS:
□ Breast tenderness □ Moodiness □ Cramping □ Bloating/water retention □ Headaches

MENOPAUSE:

□ Menopause Age:_____ □ Menopausal Symptoms (please describe):_____
□ Any other problems with your reproductive system:_____

SLEEP:

□ Hard time falling asleep □ Hard time staying asleep □ Insomnia
□ Vivid dreams □ Night terrors □ Restless
How many hours of sleep per night do you get?_____ Do you wake feeling rested? (Y / N)

MUSCULOSKELETAL:

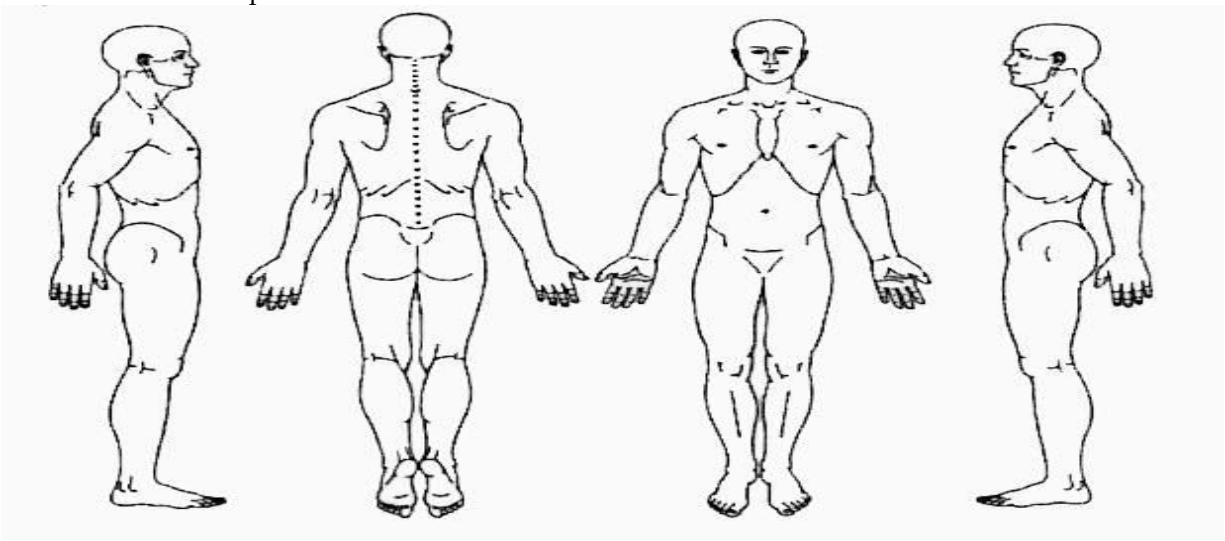
□ Neck/Upper Back Pain □ Shoulder Pain □ Hip Pain
□ Mid Back Pain □ Arm Pain □ Leg Pain
□ Low Back Pain □ Hand/Wrist Pain □ Foot/Ankle Pain
□ Joint Pain (location):_____

QUALITY OF PAIN:

□ Sharp □ Dull □ Burning □ Fixed □ Moving □ Achy □ Cramping
□ Other:_____

	Lowest									Highest
Pain Level:	1	2	3	4	5	6	7	8	9	10

Please mark areas of pain with an **X**:



WHAT MAKES THE PAIN **BETTER**:

□ Pressure □ Heat □ Cold □ Exercise □ Other:_____

WHAT MAKES THE PAIN **WORSE**:

□ Pressure □ Heat □ Cold □ Exercise □ Other:_____

□ Does weather affect the pain: Type of weather:_____

□ Any other muscle, joint, or bone problems:_____

NEUROLOGICAL:

□ Stroke □ Paralysis □ Numbness/Tingling

□ Loss of Balance □ Seizures/Epilepsy □ Dizziness □ Poor Memory

□ Any other neurological problems:_____

EMOTIONAL/PSYCHOLOGICAL:

□ Anxiety □ Depression □ Bad Temper/irritable □ Panic attacks

□ Over-thinker/worry □ Grief/sadness □ Fear □ Easily susceptible to stress

□ Bipolar □ Manic depressive

□ Have you ever been treated for any mental or emotional conditions:_____

□ Have you ever attempted or considered suicide:_____

□ Any other emotional issues/concerns:_____

Comments:

Please let me know of any other problems you would like to discuss

_____

_____

_____

_____

_____

_____

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CONSENT TO TREATMENT

I, _____, hereby authorize Jill Doan, Licensed Acupuncturist of *To The Point Acupuncture, LLC* to administer any style of Chinese Medicine relevant to my diagnosis and treatment, included but not limited to the following:

ACUPUNCTURE: I understand that acupuncture is performed by the insertion of various styles and sizes of needles through the skin at various depths and locations. This is done in an attempt to treat dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that acupuncture is generally a very safe method of treatment with few, but possible side effects. This could include, but are not limited to: local bruising, minor bleeding, fainting, and pain or discomfort. I understand that no guarantees are given to me concerning its use and effectiveness and that I am free to stop acupuncture treatment at any time.

MOXIBUSTION/HEAT: I understand that a conventional heat lamp or moxibustion (*Artemesia vulgaris*) may be used during treatment to promote healing and stimulate the flow of qi and blood. With any type of heat, there is always a risk of burn.

CHINESE HERBS: I understand that Chinese herbal formulas may be recommended to me during my course of treatment. I am not required to take these substances, but must follow the directions for administration if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call To The Point Acupuncture, LLC immediately.*

CUPPING/GUA SHA: I understand that if I receive cupping or gua sha during my treatment, there is a likelihood that bruising or discoloration on the skin may occur on the area that was treated lasting 1-5 days. Slight tenderness may persist after the treatment.

ELECTRO-ACUPUNCTURE: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, or the possible aggravation of symptoms existing prior to treatment.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved in the treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Signature of patient/guardian: _____ Date: _____

Printed name of patient: _____

Signature of Acupuncturist: _____ Date: _____

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OFFICE AND FINANCIAL POLICY

IN THE WAITING ROOM:
All types of electrical equipment (i.e. cell phones) must be turned off during the treatment and while in the waiting room. Please keep voices to a minimum, as others may be receiving treatments at this time.

PAYMENT:
Payment is due at the time of service. Cash, checks, credit cards, and Health Savings/FSA cards are all acceptable forms of payment.

This office **does not** file insurance forms. If your insurance company covers acupuncture, I will gladly give you a receipt for all of your treatments so you can submit them to your insurance company for reimbursement.

Please be advised that any returned checks will be charged a $25. handling fee.

CANCELLATIONS, MISSED APPOINTMENTS, AND LATE POLICY:
Your appointment time is reserved specifically for you. Please give a minimum of 24 hours notice when canceling your appointment. **Patients who miss their appointment or call less than 24 hours prior to their treatment WILL be charged the full treatment cost.** Insurance will not pay for a missed appointment.

A patient more than 20 minutes late may not be seen unless I have been notified of the tardiness ahead of time. Also, the treatment will still end at the regularly scheduled time. For example, if a patient had an appointment from 5-6pm and arrives at 5:15, the treatment will still end at 6pm and the patient will be expected to pay the full cost of the treatment.

REASONS FOR BEING DISMISSED/DENIED TREATMENT:
Patients who show inappropriate conduct, non-or late payment of fees, or safety concerns may be denied treatment.

PLEASE INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THESE POLICIES BY SIGNING BELOW.

Signature of patient/guardian: _____ Date:_____

Printed name of patient: _____

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use your health information for treatment or disclose it to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluation practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. We may also disclose your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you to support some of their health care operations.

On Your Authorization: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.

Courtesy Calls and Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders, courtesy calls, etc. via voicemail, email, postcards, and letters.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities (disease and statistic reporting, child abuse reporting, work-related illness or injury)
- To report abuse, neglect, or domestic violence
- In response to court and administrative orders and other lawful processes

YOUR RIGHTS - You Have The Right To:

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information
- Revoke any authorizations that you made previously in regards to your protected health information

OUR RESPONSIBILITIES - We Have The Right To:

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practices
- Abide by the terms of this notice

PLEASE INDICATE YOUR UNDERSTANDING AND ACCEPTANCE OF THIS LETTER BY SIGNING BELOW.

Signature of patient: _____ Date:_____

Printed name of patient/guardian: _____