HEALTH HISTORY QUESTIONNAIRE

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in treatment.
All information is strictly confidential.

SUBSTANCE SURVEY

Please list any **prescription** medications you are currently taking or have taken in the last year:

Medications	Purpose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any **over-the-counter** medications you are currently taking:

Product	Purpose	Quantity and Frequency
_____		
_____		
_____		
_____		
_____		
_____		

Please list any **vitamins, supplements, herbs, or homeopathic** medicines you are currently taking. (Use other side of needed).

Product	Quantity and Frequency
_____	
_____	
_____	
_____	
_____	

I. General Patient Information

Date: ____/____/____ How did you hear about us? _____

Referred by_____

Name:_____

Address:_____ City, State, Zip: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Email _____

May we contact you: _ at home, _ at work, _ Email

Date of Birth: ____/____/____ Height: ____'____" Weight: _____lbs.

Gender: _M _F _Married _Partnered _Single

Occupation:_____Employer:_____

Emergency contact_____ Contact's #(_____)_____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____

2. _____ 5. _____

3. _____ Additional:_____

Other doctors or practitioners seen for this condition? _____ Yes _____ No Who ?_____

How do these conditions impair your daily activities?_____

_____

Is your health complaint related to work? _ Yes _ No _ Maybe

II. Patient Medical History

Hospital Visits/Stays dates starting with most recent:

1._____ 4_____

2._____ 5_____

3._____ 6_____

Previous chiropractic Care: _____ No If yes, Dr.s Name and Date of Last Visit:_____
Acupuncture Care: _____ No If yes, L Ac Name and Date of Visit:_____
Other physician Care: _____ No If yes, Dr.s Name and Date of Last Visit:_____

Circle any you have had in the past:

Diabetes	Allergies	Glaucoma	Rheumatic Fever
Heart Disease	CVA (stroke)	Vein condition	Thyroid disorder
Asthma	Pneumonia	Tuberculosis	Emphysema
Jaundice	Gonorrhea	Mumps	Bleeding tendency
Syphilis	Measles	Chicken pox	Nervous disorder
Meningitis	HIV	Polio	Mononucleosis
Epilepsy	High fever	Hepatitis	Multiple Sclerosis
Paralysis	Cancer	Migraines	High blood pressure

Surgeries:_____

Serious injuries or accidents:_____

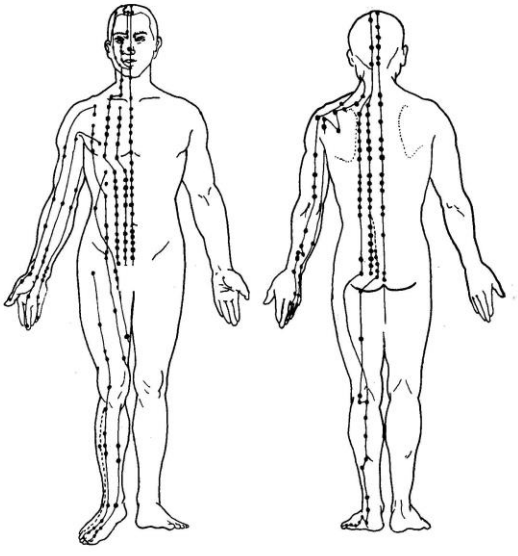
Allergies you have:

Food:_____

Animals:_____

Drugs:_____

III. **Patient Profile**



Please clearly mark any areas of pain with an arrow

Is the pain: Sharp Burning Aching
Cramping Dull Moving Fixed

Other:_____

Does the anything lessen the pain ?

_____

Does the anything worsen the pain

_____

Please check or highlight the following that currently pertain to you

Overall Energy, Dampness

Low energy

General weakness

Easily catch colds

Difficulty keeping eyes open in the daytime

Feel worse after exercise

Low libido Excessive libido

General sensation of heaviness in the body

Mental fogginess

Dizziness

Swollen joints _____

Edema _____)

Overall achy feeling in the body

Overall Temperature (Kidney function)

Can get chilled to the bone
Hot body temperature all day
Hot flashes Night sweats

Easily Perspire Rarely Perspire

Excess sweat Excessive Thirst

Dry: lips mouth nose throat

Eyes: Itchy Watery Dry Bloodshot

Floaters Decreased night vision

Heart & Circulation

Pain traveling to shoulder
Chest tightness
Difficulty falling asleep staying asleep
Nightmares
Wakes tired
Pain radiating down the arm
Varicose Veins

Restlessness Anxiety
Palpitations
Mental confusion

Sores on the tip of the tongue
Mouth sores Tongue sores Bad breath

Lung

Shortness of breath
Asthma Cough
Chest congestion Sore throat
Sinus congestion Sneezing
Nasal discharge

Sadness Melancholy

Sleep apnea
Bleeding gums Painful gums
Dry Skin Cracks in hands or feet

Digestive Power

Recent weight gain
Recent weight loss
Bruises easily

Loose stools Constipated Diarrhea
Incomplete BM

Feel worse before BM
Feel **better** before BM

Constant worry
Acid reflux
Nausea Vomiting
Bloating Belching
Passing gas Mouth sores
Stomach Pain _____

Blood in stools
Undigested food in stools

Frequent BM # per day_____

Liver, Gall Bladder Function:

Depression Tightness in the chest
Bitter taste in the mouth
Tingling sensation Numbness
Spasms Twitching Cramping
Weak fingernails

Gall stones (history or current)
Seizures
Convulsions
Headache at the side(s) of the head
Restless Leg Syndrome
Cold Hands Cold Feet
Difficult time making decisions

Irritability
Anger easily
Frustration

Kidney, Urinary Bladder Function:

Frequent dental problems
Easily broken bones
Weakness in low back
Poor memory

Excessive hair loss
Ringing in ears
High Low

Kidney stones
Wakes to urinate
Lack of bladder control

Fear
shame

Urination: Burning Dark yellow Painful Bloody
Difficult Cloudy Urgent Profuse Interrupted

Sexually transmitted disease _____

Women only

Pregnant? Yes No Age of first menstruation:_____ Menopause_____

Number of pregnancies:_____ Number of children:_____ Miscarriage_____

Average number of days of flow:_____ Bleeding between periods Cramping Clots

Unusual vaginal discharges _____

Day 1 bleeding : Light Spotty Heavy Brown Pink Fresh red

Nausea
Migranes
Anxiety

Bloating
Food Cravings
Irritability

Breast Distention
Decreased Sexual Desire

Men only

Swollen testes	Testicular pain	Unusual discharges from the penis
Vasectomy	In fertility	Low sexual desire
Impotence	Premature ejaculation	Erectile Dysfunction
Feeling of coldness or numbness in external genitalia		Other_____

Life Style Assessment:

Stress level: ☐very high ☐ high ☐ medium ☐ low ☐ very low

Check the following items which apply to you

_____coffee _____ alcohol _____ tea _____ soft drinks _____ candy
_____artificial sweetener _____ antacids_____ laxatives _____ ice cream
_____cigarettes _____ other tobacco products _____fast food

Describe your major life stresses: _____

What is your dominant emotion? _____ Easy to express it ?_____

How do you deal with emotions? _____

Do you easily say NO when you don't want to do something?_____

Can you easily forgive yourself and others?_____

How often do you exercise?_____

What do you do to have fun?_____

Describe your marriage/partnership: _____

Informed Consent for Treatment

Traditional Chinese Medicine includes various modalities such as herbology, tuina, massage cupping, gua sha, moxibustion, acupressure, acupuncture and other types of hands-on healing, These ancient oriental techniques utilize a natural system of healing within the body.

I, the undersigned, hereby authorize the licensed staff of Rest Nourish Heal to perform the above listed modalities, including nutritional/herbal support, Reiki, Life coaching, massage, and aromatherapy.. The nature, consequences, and potential risks and benefits of these procedures have been explained to me.

POTENTIAL RISKS: Discomfort at the insertion site of a needle, bruising, weakness, fainting, nausea, and possible short term aggravation of symptoms existing prior to treatment.

POTENTIAL BENEFITS: To allow for drugless relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures. I understand these techniques are not a substitute for conventional medical care. I realize that no guarantees have been given to me regarding cure or improvement of my condition and that no treatment program is effective for everyone. (initial_____)

I understand that I am free to discontinue my treatment at any time. I also understand that my medical and/or clinical records will be kept confidential and only disclosed with my permission or summarized anonymously. (initial _____)

I hereby authorize the licensed staff of Rest Nourish Heal to verify my history or condition with my physician, if required, and to release my medical records to my insurance company if they so require in order to honor my insurance claim.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from medical practitioners, and communicating progress and side effects to the health care provider . I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

Payment is due at the time services are rendered. Initial appointment fees for acupuncture are $149. Follow up acupuncture appointment fees are $75. Herbal preparations and supplements are additional. Pricing and packages for facial rejuvenation are available by calling the office.

We require 24 hour notice given to change or cancel your appointment. We understand emergent situations but otherwise you will be charged for the missed visit. (initial_____)

I hereby authorize the practitioner to treat my condition as they deem appropriate through use of Nutritional/Herbal support, Facial Rejuvenation, Reiki, Life coaching, Massage, Traditional Chinese Medicine, and Aromatherapy. The patient also agrees that he/she is responsible for all bills incurred at this office and that the patient is personally responsible for payment at the time the services are provided.

I clearly understand and agree that all services rendered to me are charged directly to me. (initial_____)

The practitioner will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this treatment program. I have been informed that I am to contact the practitioner if any problems are encountered during my treatment.
I understand the conditions stated above, and hereby consent to participate in this type of treatment.

By signing below I agree to the terms and procedures set forth above.

Patient Name (printed)_____

Patient Signature:_____

Parent or Guardian signature _____

Date _____

We welcome you as a new client.
We greatly appreciate your cooperation and look forward to treating you

Please do not wear perfumes or scented lotions to your appointments.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help you with your health care or with payment for you health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our offices to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, of health care operations…or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive it electronically

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA: The U.S Department of Health toll free 877-696-6775

Office of Civil Rights: 200

Washington, D.C. 20201

Notice of Privacy Practices Acknowledgement

A record of the health care services that we provide to you is used and disclosed by this office when providing you with treatment, collecting payments for treatment provided to you and in other health care operations.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, our obligations in protecting your health information and your rights regarding the information contained in your medical record.

We will not use or disclose the information contained in your record in any way that is inconsistent with the policies detailed in our current Notice of Privacy Practices.

If you have questions or would like additional information about this notice, please notify our office.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____ _____

Signature of patient or legally authorized individual | Date | Time

_____ _____

Printed name if signed on behalf of patient | Relationship to patient (parent, legal guardian, etc.)

This form will be retained in your medical record.