NEW ACUPUNCTURE CLIENT CONFIDENTIAL HISTORY QUESTIONNAIRE

Name: ______________________ Prefer to be called: ____________ Address City/Zip: ______________________

Date: ____________ Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________ DOB:__________ Age: ________

Sex: M F Relationship Status: S M D W Other No. of Children: ________

Occupation: ______________________ Employer: ____________ Hrs work/wk: ______ Have you been to an acupuncturist? Y N

Email: ______________________ Referred by: ______________________

Please complete the following as accurately as possible:

Sleep Patterns

What time do you usually go to bed?______________________
What time do you usually wake up?______________________
Do you ever wake up during the night? Y N
If you wake up during the night, do you find it difficult to fall back asleep? Y N

Nutrition & Exercise

Do you exercise regularly? Y N
What kind of exercise ______________________
How long ____________ How often ____________

Dietary Restrictions______________________
List food or plant allergies ______________________

____

Present Illness

What is your chief complaint?

____

When did this condition begin?______________________
How did this condition begin?______________________
What treatment have you received already?

____

Medical History

What surgeries have you had?

____

When did you have them?

____

What other serious injuries or illnesses have you had? ______________________

Do you have any medication allergies that you know of? ______________________

Which, if any, of your blood relatives have had any of the following?

Stroke
Heart disease
Bleeding disorder
High blood pressure
Cancer
Tuberculosis
Diabetes

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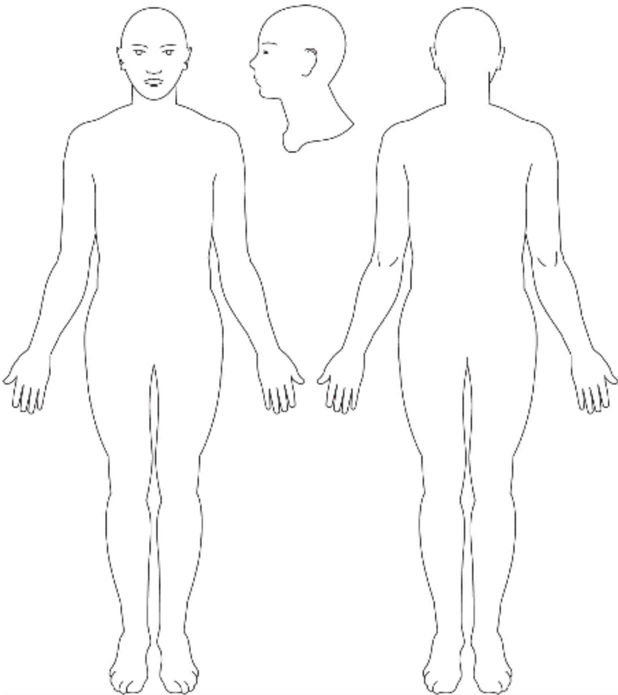
Menstrual History

Age of your first period: ______________________
Vaginal discharge: __________________________
Length of cycle: ____________________________
Length of flow (days): ________________________
Date of your last period: ______________________
Do you believe you are pregnant: Y N

Recreational Substance Abuse

History of smoking? Y N
How many years: ___________________________
How many per day: __________________________
Number of drinks/week: ______________________
Recreational drug use: Y N
Sodas per day: _____________________________
Cups of coffee per day: ______________________

Mark below with an X where you feel pain or discomfort



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Please list the medication name, dosage, and frequency for all medications and supplements you currently use (e.g. Lisinopril 5 mg 3X/day or Dimetapp 1 teaspoon 2X/day):

Medication/Supplement Dosage Frequency

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ______________________________

11. ______________________________

12. ______________________________

13. ______________________________

14. ______________________________

15. ______________________________

MEDICAL HISTORY QUESTIONNAIRE

CHECK ALL CURRENT AND PAST CONDITIONS

*(Please write the word PAST next to those conditions which you have had **only** in the past and are no longer present)*

HEAD AND NECK:
_____ Dizziness
_____ Fainting
_____ Neck Stiffness
_____ Enlarged lymph glands
_____ Headaches
__________________ Other

EARS:
_____ Infection
_____ Ringing
_____ Decreased hearing
__________________ Other

EYES:
_____ Blurred vision
_____ Visual changes
_____ Poor night vision
_____ Spots/Floaters
_____ Eye inflammation/Styes
__________________ Other

NOSE, THROAT & MOUTH:
_____ Bleeding
_____ Sinus infection
_____ Hay fever or allergies
_____ Sore throat
_____ Hoarseness
_____ Changes in taste
_____ Difficulty swallowing
_____ Changes in smell
_____ Oral ulcers/Canker sores
__________________ Other

SKIN:
_____ Hives
_____ Rashes
_____ Eczema
_____ Psoriasis
_____ Seborrhea
_____ Night sweating
_____ Excess sweating
_____ Dryness
_____ Bruises easily
_____ Changes in moles or lumps
__________________ Other

NEUROLOGICAL:
_____ Numbness or tingling of limbs
_____ Seizures
_____ Tremors
_____ Pain
_____ Paralysis
_____ Epilepsy or Convulsions
__________________ Other

INFECTION HISTORY:
_____ HIV/AIDS, or HIV risks: Self or partner
_____ TB: Self or household
_____ Hepatitis, or Hepatitis risk: Self or partner.
_____ History of sexually transmitted diseases: self or partner.
_____ Gonorrhea
_____ Chlamydia
_____ Syphilis
_____ Genital warts `
_____ Herpes (oral)
_____ Herpes (genital)
_____ MRSA, Staph, CRE, or other Drug-Resistant Infections

RESPIRATORY:
_____ Chronic cough
_____ Coughing up blood
_____ Coughing phlegm frequently
_____ Difficulty breathing
_____ Wheezing/Asthma
_____ Frequent Colds
_____ Emphysema
_____ Pneumonia repeatedly
__________________Other

CARDIOVASCULAR:
_____ Palpitations
_____ Chest pain or tightness
_____ Rapid heartbeat
_____ Irregular heart beat
_____ Heart Disease
_____ Poor circulation
_____ Swelling of ankles
_____ Phlebitis
_____ Cold hands/feet
_____ Cardiac Pacemaker
_____ High blood pressure
_____ Stroke
__________________ Other

GASTROINTESTINAL:
_____ Indigestion
_____ Nausea
_____ Stomach pain
_____ Irritable bowel disease
_____ Colitis
_____ Crohn's Disease
_____ Pancreatitis
_____ Celiac Disease
_____ Recent change in bowel habits
_____ Diarrhea (______ /day)
_____ Constipation (______ /week)
_____ Dry, hard stools
_____ Soft, difficult, sticky stools
_____ Irregularly or poorly-formed stools
_____ Poor appetite
_____ Excessive hunger
_____ Blood in stool or black stools
_____ Hemorrhoids
_____ --with pain or blood
_____ Gall bladder disorder
_____ Vomiting blood
_____ Peptic Ulcer
_____ Recent change in weight
_____ Food cravings
__________________ Other

MUSCLES AND JOINTS:
_____ Joint disorder
_____ Sore muscles
_____ Weak muscles
_____ Difficulty walking
_____ Spinal curvature
_____ Backache
_____ Back pain
_____ Fibromyalgia
__________________ Other

MALE:
_____ Pain/itching of genitalia
_____ Genital lesions/discharge
_____ Impotence
_____ Premature ejaculation
_____ Prostate problems
_____ Infertility (e.g., abnormal sperm)
__________________ Other

FEMALE:
_____ Frequent vaginal infections
_____ Infertility
_____ Pain/itching of genitalia
_____ Genital lesions/discharge
_____ Pelvic inflammatory disease
_____ Abnormal Pap smear
_____ Irregular periods
_____ Emotional changes with menses
_____ Clots with menses
_____ Painful menstrual periods/cramps
_____ Premenstrual Syndrome
_____ Abnormal bleeding
_____ Menopausal symptoms (hot flashes, etc.)
_____ Breast lumps/cysts
_____ Breast swelling and/or pain
__________________ Other

URINARY:
_____ Frequent urinary tract/bladder infections
_____ Weak urinary stream
_____ Recent change in bladder habits
_____ Kidney Disease
_____ Frequent day urination (_________ X)
_____ Frequent night urination (_________ X)
____________________Other

GENERAL:
_____ Fatigue
_____ Thirst
_____ Aversion to cold
_____ Insomnia
_____ Frequent dreams/nightmares
_____ Depression
_____ Agitation
_____ Irritability
_____ Anxiety
_____ History of psychiatric treatment
_____ Poor memory
_____ Difficulty concentrating
_____ Sores that don't heal
_____ Congenital abnormalities
_____ Surgical implants
_____ Unusual bleeding or discharge
_____ Jaundice
_______ Hernia
_____ Epstein Barr virus (EBV)
_____ Rheumatic Fever
_____ Diabetes mellitus
_____ Thyroid Disorder
_____ Cancer
_____ Anemia or other blood disorder
_____ Lupus erythematosis
____________________ Other

NOTIFICATION OF EVALUATION

***Form to be completed by client, notifying the Acupuncturist of whether he/she has been evaluated by a Physician*

(Pursuant to the requirements of 22 T.A.C. §183.7 of the Texas State Board of Acupuncture Examiners' rules (relating to Scope of Practice) and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (client's name) ____, am notifying Jennifer Hoger, L.Ac. of the following:

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed.

_______ Yes _______ No

I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_______ Initials ______________Date

I have received a referral from my chiropractor within the last 30 days for acupuncture.

_______ Yes _______ No

After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

______________________________ ______________________________

Client Name Parent/Guardian Name (if client is younger than 18)

______________________________ ______________________________

Client Signature Parent/Guardian Signature

____

Date

INFORMED CONSENT TO ACUPUNCTURE TREATMENT & CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by Jennifer Hoger, LAc., at Jennifer Hoger Acupuncture.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine and nutritional counseling. I understand that the herbal medicine needs to be consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or bitter taste. I will immediately notify my acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising (especially on the face), numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest.

I understand that a series of acupuncture treatments are required to significantly change my condition, I consent to the treatment procedures as Jennifer Hoger, L.Ac. deems fit for my care and understand that results are not guaranteed.

Certain medications or social habits are known to lessen the potential results of acupuncture and these include alcohol, tobacco, steroids, or narcotics. I have informed my acupuncturist of any substances included in this list.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures 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.

Client Name

Parent/Guardian Name (if client is younger than 18)

Client Signature

Parent/Guardian Signature

Date

FEE SCHEDULE AND CANCELLATION POLICY

Occasionally we may go over our allotted time in a session. We will only charge you for the time period you are scheduled.

<u>Standard Fees:</u>   As of February 1st, 2014

Acupuncture:

New Client Session and Regular Acupuncture session $50-$75*

*Sliding scale model is designed so that you can pay what YOU are comfortable with financially. This model will only survive if there is an even distribution of price paid. In other words, if finances are tight for you and you require frequent visits, please visit on the low end of the sliding scale. If you are happy with your service, and you have the financial means, please pay on the higher end of the scale (which is still a low rate!), so that others may also benefit from this model and we may continue to provide affordable, accessible acupuncture. ☺

*** Fees are due at time of service. ***

<u>Cancellations:</u>

We understand that situations occur and life throws us off at times. If you anticipate not being able to make your scheduled appointment, please let us know as soon as possible so we may offer the time to another client. We ask for a minimum notice of 24 hours in advance of your appointment time during business hours.

You may be charged the median price for acupuncture ($62), for a missed appointment or cancellation with less than 24 hours notice.

We will make every effort to be on time for your appointment. If circumstances arise that make us unable to fulfill your appointment as scheduled, we will give you as much advanced notice as possible and will reschedule you at your convenience.

Thank you for your consideration. Please inquire with any questions you may have regarding this policy.

____________________ ____________________ _______________
Client Name Client Signature Date