Five Point Holistic Health

3234 W. Fullerton Ave., Chicago, IL 60647 Date: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If you have any questions, please ask. Thank You.

Name: _____ Preferred Name: _____

Street: _____ Date of Birth: _____ Height: _____ Weight: _____

City, State, Zip: _____ Sex: ☐ M ☐ F ☐ Another Gender Optional: _____

Phone: _____ Pronoun: ☐ he/his ☐ she/hers ☐ _____

Email: _____ Occupation: _____

May we leave voicemail messages regarding appointments? Emergency Contact: _____

☐ Yes ☐ No Emergency Number: _____

Preferred method of contact: ☐ Call ☐ Email ☐ Text ☐ Other

List 3 issues you would like help with and when they began – please be specific.
Please indicate on a scale from 1-10 how severe the issue: (1 = least severe and 10 = most severe)

1) _____ 1 2 3 4 5 6 7 8 9 10

2) _____ 1 2 3 4 5 6 7 8 9 10

3) _____ 1 2 3 4 5 6 7 8 9 10

What kind of treatments have you tried? _____

Other concurrent therapies: _____

Past Medical History – please note dates:

Cancer: _____ HIV/AIDS: _____ Thyroid Disease: _____

Diabetes: _____ High BP: _____ Rheumatic Fever: _____

Hepatitis (A/B/C): _____ Heart Disease: _____ Venereal Disease: _____

Are you currently taking any of the following medications: ☐ warfarin/blood thinners ☐ lithium

---

Habits

Are you on a specific diet? (vegetarian, vegan, paleo, etc) _____

Food allergies or sensitivities? If yes, please list: ☐ Yes ☐ No _____

Please indicate usage per day or per week:

Cigarettes _____ per _____ Tea _____ per _____

Alcohol _____ per _____ Soft Drinks _____ per _____

Drugs _____ per _____ Coffee _____ per _____

Marijuana _____ per _____

Supplements and medications
Please list any supplements and medications not listed above, you are taking:

Reproductive Health

History

Age of first period_____

# of Pregnancies_____ # of Births_____ # of Abortions _____

Currently pregnant? ☐ No ☐ Yes If yes, how far along?_____

Last Gynecological Exam _____ Results Normal?_____

Age of Menopause (if applicable) _____

History of (circle all that apply)

PCOS PID STDs Endometriosis Fibroids Cysts

Infertility Miscarriages PMDD Cancer Cervical Dysplasia

Abnormal Uterine Bleeding Vaginal Discharge _____

Other: _____

Anything else you'd like us to know about?

Previous Acupuncture Experience

Have you had acupuncture or herbs previously? If yes, with whom? When?

☐ No ☐ Yes _____

How did you hear about us?

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances approved by the NCCAOM by a licensed acupuncturist at Five Point Holistic Health. I also consent to be treated with bodywork by a certified massage therapist. I also consent to the performance of chiropractic procedures, including various modes of physio-therapy, and any supportive therapies on me. I understand that acupuncturists, massage therapists, and chiropractors practicing in the state of Illinois are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances approved by the NCCAOM may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage 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 contact Five Point Holistic Health as soon as possible.*

Bodywork: I understand that bodywork is performed by the touching and moving of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local soreness, pain, or discomfort, and the possible aggravation of symptoms existing prior to bodywork treatment.

Acupressure: I understand that I may also be given acupressure as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

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, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I understand that Five Point Holistic Health is a multi-practitioner practice and by signing below I give permission for my file and health information to be shared among the practitioners contracted at Five Point Holistic Health.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____

Five Point Holistic Health
3234 W. Fullerton Ave., Chicago, IL 60647

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, emails or telephone conversations to or from other healthcare practitioners.
- From healthcare providers, and other third part administrators (e.g. requests for medical records, claim payment information)

I understand that this information serves as:

- A basis for planning my care and treatments
- A means of communications among the many healthcare professionals who contribute to my care
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for newsletter and information dissemination purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third-parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Patient Signature: _____ Date: _____

Five Point Holistic Health
3234 W. Fullerton Ave., Chicago, IL 60647

OFFICE POLICIES

- As a courtesy to our other guests and a dedicated time for health and healing, we ask that you please set your phones to silent for the duration of your visit.
- Please keep your voice low while in the Community Room.
- Please avoid perfumes or strongly scented personal products before your treatment. It can be disruptive to other patients with sensitivities or asthma.
- Minors must be accompanied by their guardian for the first visit. If they are over the age of 16, they may come for subsequent treatments with the written approval of the guardian. Minors under the age of 16 must be accompanied by an adult, for any treatment.
- For Community Acupuncture, minors must be over the age of 10.
- We reserve the right to refer you to another medical professional, or in acute situations, the Emergency Room. You have the right to refuse.
- If you currently have an active diagnosis of cancer or present with high blood-pressure (>150/95), you must be under the care of a physician before we can provide treatment.
- Emails and voicemails will be returned with-in 48 hours.
- Our policy is to receive payment at time of service. We accept all credit cards, cash or check.
- We send reminder emails for all upcoming appointments 48 hours in advance. If you need to reschedule, or cancel an appointment, we ask for 24 hours notice.
- We understand that things come up but we request that you be respectful of your time, other patients, and our time. Please cancel appointments no less than 24 hours in advance, if you do not, you may be subject to a late cancellation/no show fee of 75% of the full cost of the service payable upon your next visit. This ensures spaces are available for those who need treatment.
- Due to our tight scheduling, if you are late to your appointment, we cannot guarantee a full treatment that day. We will try to accommodate you.
- All products and services are non-returnable.

Thank you!

_____ ***Please initial that you have read and understand these policies.**