The Healing Arts Center

HEALTH HISTORY QUESTIONNAIRE

Name			Date
Address	City	State	Zip
Home Phone	Work Phone		
Date of Birth	Height	Weight	Status: S M P D W
Email Address	Appointment Reminder Preference (Circle one) Email Phone No Reminders		
Emergency Contact	Emergency Phone		
Insurance Company	Primary Care Physician		

How did you hear about us? Circle one:
Internet Search Advertisement Word of Mouth
Physician Referral: _____ Friend Referral: _____

Have you been treated by acupuncture or oriental medicine before?
Main problem you would like us to help you with?
How long ago did this problem begin?
Did some even trigger this problem?
To what extent does this problem interfere with daily activities such as work and sleep?
Have you been diagnosed with this problem? If so, what?
What kinds of treatments have you tried?

Past Medical History (Please Include Date)

Cancer Diabetes Heart Disease Hepatitis A B C High Blood Pressure

Seizures HIV/AIDS Thyroid Disease Asthma Other:

Surgeries
Significant Trauma (Auto accidents. Falls, breaks)
Allergies

Are There Any Emergency Situations For Us To Be Aware Of?
(Example: Seizures, Allergies Leading to Anaphylactic Shock, Etc.)
_____

Family Medical History (Circle all that apply)

Cancer Diabetes Heart Disease High Blood Pressure Stroke Seizures HIV/AIDS

Thyroid Disease Asthma Other:

Medicines Taken Within Last 3 Months

Occupational Stress (Chemical, Physical, Psychological, Etc.)

Are You On Any Kind Of Restricted Diet (Vegetarian, Vegan, Low Salt, Etc)?

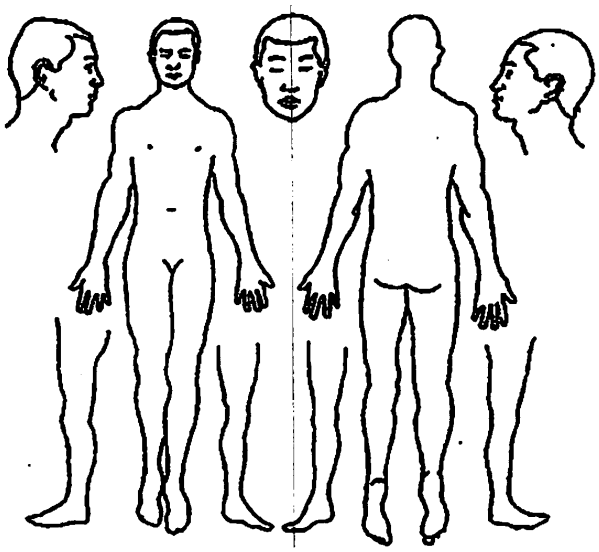
Do You Have a Regular Exercise Program? Describe:

How Much Water Do You Drink Per Day?

How Much Caffeinated Coffee, Tea, or Soft Drinks Do you Drink Per Week?

Do You Smoke? If Yes, How Much?

INDICATE ANY PAINFUL OR DISTRESSED AREAS:



Describe any pain indicated above (i.e. throbbing, burning, dull, sharp, constant, non-constant, etc)

Note: Only complete this section if you are being seen for fertility, infertility, and/or women's health issues. Thank you

When was your last menstrual period?

Do you have regular periods? (circle one) YES NO
How many days between cycles? _____ Days

How long have you been trying to conceive?

Any previous pregnancies? (circle one) YES NO

Name of fertility doctor/clinic

Any family history of infertility? (circle one) YES NO UNSURE

Healing Arts Center of Philadelphia

123 Chestnut St, 204, Philadelphia, PA 19106 | 2012 Walnut St, Philadelphia, PA 19103
610 Old Lancaster Rd, 202, Bryn Mawr, PA 19010 | 625 Clarke Ave, 17B, KOP, PA 19406

ACUPUNCTURE INFORMED CONSENT

Please read over each of the following points and sign at the bottom:

I request and consent to receive Acupuncture treatments and other procedures within the scope of the practice of Acupuncture by the licensed acupuncturists named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back up for the acupuncturists named above, including those working at the office listed above, and/or any other office or clinic, whether signatories to this form or not.

I understand that treatments may include, but are not limited to, the insertion of sterilized, disposable acupuncture needles into my body, the use of moxa, (a therapeutic herb), press balls and tacks, gua sha, cupping, a heat lamp, electroacupuncture, laser acupuncture, or the insertion of intradermal needles. I understand that each of these therapies will be explained to me before they are preformed, and that I may verbally revoke my consent to receive any of these therapies at any time.

I understand that acupuncture is a safe method of treatment, but occasionally there my be some bruising, numbness, or tingling near the treatment site that lasts a few days. I understand that gua sha and cupping may cause bruising that will subside after a few days.

The herbs and nutritional supplements (which are from plant, animal, or mineral sources) that may be recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that certain types of therapies are contraindicated if I become pregnant, and I will inform the staff if I am or become pregnant.

I agree to remain lying down or sitting down in the position decided upon by myself and the acupuncturist for the duration of my treatment and not to remove, manipulate, or reinsert any of the needles used for my treatment. I understand that if any of my needles cause me discomfort I may ask the acupuncturist to remove them.

I understand that I am expected to arrive at my appointment at the scheduled time, and that if I am unable to come in for my treatment I am expected to call the clinic 24 hours before my treatment is scheduled to begin, or pay half of the usual fee for the time that was reserved.

I understand that my medical record will not be released without my written consent.

I understand that if my behavior does not comply with the policy of the clinic that I may be refused treatment, suspended from treatment, or asked not to return to the clinic.

I have read, or have had read to me, the above consent to treatment and clinic policy. I have had an opportunity to ask questions, and by signing below I agree to the above.

Name (Print) _____

Signature_____ Date_____

Relationship to Patient, if signed on their behalf _____