Lakeview Center Chiropractic, Acupuncture & Massage
Acupuncture Patient Health History Questionnaire

Please help us provide you with a complete evaluation by filling out this questionnaire carefully. All of your answers are strictly confidential. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the Comments section. Thank you!

Name _____ DOB _____/_____/_____ [ ]M [ ] F [ ] MTW [ ] WTM
Address _____ City _____ State _____ Zip _____
Phone _____ Email _____
Emergency Contact _____ Physician Name &
Phone_____

Please list your chief complaint(s) for this visit or your condition(s) in order of importance:	Date first noticed:	Indicate the severity of each symptom: None Severe	Please check the box below indicating how much of the time you feel the symptom:
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10	□ 0-25% □ 26-50% □ 51-75% □76-100%
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10	□ 0-25% □ 26-50% □ 51-75% □76-100%
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10	□ 0-25% □ 26-50% □ 51-75% □76-100%

CURRENT LIFESTYLE

Have you consulted an MD, ND, DO for your reasons for this visit? [ ] Yes [ ] No MDs Diagnosis: _____
Do you exercise regularly? [ ] Yes [ ] No If yes, please describe: _____
List any stress factors (physical, psychological, chemical): _____
Briefly describe your average daily diet:
_____
_____
_____

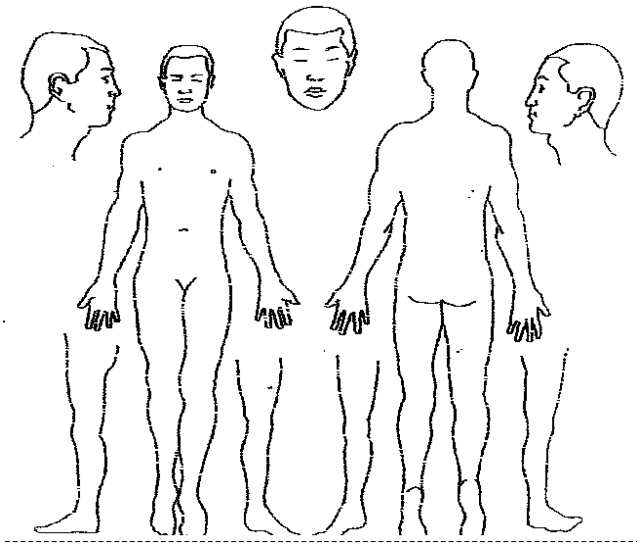
Please check the following habits that apply. How much, how often do you use them?

☐ Cigarette smoking _____ ☐ Coffee, tea or cola _____ ☐ Alcoholic Beverages _____

List medications taken within last two months (vitamins, drugs, herbs, etc.):
_____
_____
_____
_____

List any drug use for non-medical purposes:
_____
_____
_____
_____

Have you ever had any form of counseling, therapy, interventions, etc? [ ] Yes [ ] No If yes, please describe:
_____
_____
_____
_____



Please mark an X for painful or distressed areas on the chart on the left. Please describe the pain:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Please put a mark [X] next to any condition you've experienced in the last three (3) months. Circle all those you've experienced in the past. Indicate the length of time you have had this condition.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night Sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop
- ☐ Poor balance

SKIN & HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Dryness
- ☐ Lesions
- ☐ Changes in texture of hair or skin

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Glaucoma
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches
- ☐ Jaw clicks

CARDIOVASCULAR

- ☐ Nausea/Vomiting
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ COPD
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Difficulty breathing laying down
- ☐ Excessive phlegm
- ☐ Shortness of breath
- ☐ Lung cancer

GASTROINTESTINAL

- ☐ Ulcers
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Mucus in stools
- ☐ Black stools
- ☐ Bad breath
- ☐ Gas/Belching
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use

GENITOURINARY

- ☐ Pain while urinating
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pain
- ☐ Shoulder pains
- ☐ Hip pain

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper

☐ Dizziness ☐ Poor memory ☐ Depression ☐ Easily susceptible to stress
☐ Loss of balance ☐ Lack of coordination ☐ Anxiety ☐ PsychoEmotional issues

FEMALE ONLY: REPRODUCTIVE AND GYNECOLOGIC

☐ Premenstrual changes ☐ Heavy menstrual flow ☐ Lumps in breast ☐ A bortions
☐ Menstrual clots ☐ Light menstrual flow ☐ Nipple discharge ☐ Miscarriages
☐ Painful menses ☐ Irregular menses ☐ Premature births ☐ Other: _____
☐ Hot flashes

Is there a possibility you currently may be pregnant? **[ ] Yes [ ] No**

Age at first menses: _____ Age at menopause: _____ Number of pregnancies: _____

Time between cycles: _____ Duration of bleeding: _____ First day of last menses: _____

Do you practice birth control? _____ If so, what type? _____ For how long? _____

MEN ONLY

☐ Burning with urination ☐ Difficulty starting urination ☐ Nightly urination
☐ Dripping after urination ☐ Prostate cancer ☐ Impotence / ED
☐ Other: _____

PAST MEDICAL HISTORY (Please include dates)

☐ Allergies
☐ Cancer
☐ Diabetes
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Seizures
☐ Rheumatic Fever
☐ Surgeries
☐ Venereal Disease
☐ Thyroid Disease
☐ Birth Trauma (prolonged labor, forceps delivery, etc.)
☐ Heart Disease
☐ Suicidal ideation/Suicide attempt
☐ Other Significant illness/Trauma (Please describe)

_____
_____
_____
_____
_____
_____
_____

FAMILY MEDICAL HISTORY

☐ Allergies ☐ Cancer ☐ High Blood Pressure ☐ Stroke
☐ Diabetes ☐ Heart Disease ☐ Seizures ☐ Other
☐ Asthma

COMMENTS

Please list any other concerns you would like to discuss: _____

_____

_____

_____

Lakeview Center Chiropractic, Acupuncture & Massage

Acupuncture and East Asian Medicine
10512 NE 68th St C-102
Kirkland, WA 98033
(425) 889-4701

ADVICE TO CONSULT A PHYSICIAN

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

We, the undersigned, do affirm that _____ (Patient), has been advised by the Acupuncture provider to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____ _____ ☐ _____

Patient Signature **Date** **Declined copy (initial)**

_____ _____

Licensed Acupuncturist's Signature **Date**

INFORMED CONSENT

I hereby request and consent to Oriental Medicine diagnosis and treatment by the above named Practitioner. I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, Gua Sha, electrical stimulation and Tui Na (Chinese massage), and Chinese or Western herbal medicine and nutritional counseling.

I have had the opportunity to discuss the nature and purpose of treatment with the Practitioner. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness and 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. Though we use sterile disposable needles for each patient. Bums and/or scarring are a potential risk of moxibustion, l understand that while this document describes the main risks, other side effects and risks may occur. I also understand that the herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I also understand that they come from plant, animal and mineral sources and that some herbs may be inappropriate during pregnancy.

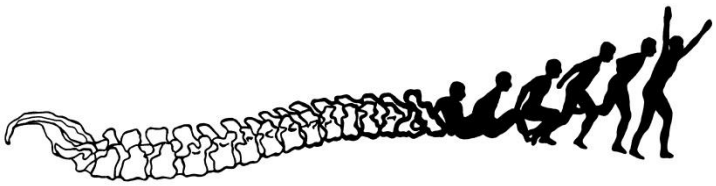
I do not expect the Practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the Practitioner to exercise judgment during the course of the treatment that the Practitioner feels is correct at the time, based upon the facts then known, is in my best interests.

I understand that my records will be kept confidential and will not be released without my written consent. I will inform the Practitioner if I should become pregnant

It have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above mentioned procedures. 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.

_____ _____ _____

Patient Name (Print) **Patient Signature** **Date**



Lakeview Center Chiropractic Acupuncture & Massage
Office Policy

The following is an explanation of our clinic policies. We believe that clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

No Charge Consultation

Lakeview Center will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if our services can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient's health needs are paramount; therefore our payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

New Patient Care Services

We require payment of the first visit charges on the same day of service. If we are billing your insurance then payment of your deductible and any applicable co-pay is expected on the first day of service. Properly documented worker's compensation and accident claims are not required to pay at this time if appropriate forms and leins are signed. However, if at any time your auto insurance denies payment - you are responsible for paying that amount. Payment will be expected within 30 days.

Established Patient Care Services

Patients under care are required to make regular payments, at the time of visit, or in advance, on all unpaid balances, except for properly documented worker's compensation or auto injury claims. However, if at any time your auto insurance denies payment - you are responsible paying that amount. Payment will be expected within 30 days. We may at our option charge on percent interest on all account balances over 30 days.

You will receive a monthly statement with all of your charges itemized. Please review these and retain for your records (taxes, etc.)

Our Policy on Health Insurance

Today most insurance policies do cover chiropractic/massage/acupuncture care. We will be happy to file your primary insurance claim for you and do anything we can to assure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover.

Most insurance policies do cover chiropractic/massage/acupuncture care. However, if yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Your freedom to choose your own health care provider is a fundamental right. If we can help in any way please let us know. Lakeview Center Chiropractic Acupuncture and Massage has patient payment options for those without health insurance.

It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Lakeview Center Chiropractic Acupuncture and Massage will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to Lakeview Center Chiropractic Acupuncture and Massage will be credited to your account on receipt.

However, you must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment.

Appointments

It is important that you keep all of your agreed to and scheduled appointments. We ask that you call if you are unable to make your appointment or if you will be late. All missed appointments need to be made up as soon as possible in order to achieve positive response to care. Please help us to help others. We reserve the right to charge for missed appointments.

Emergency or After Hour Calls

In case of an emergency you may contact the office for a special appointment any time during regular office hours. If you, a friend or family member require after hours or weekend assistance, you may call the clinic for special assistance.

Questions And Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

I have read the Lakeview Center Chiropractic Acupuncture and Massage Policies and will honor them:

_____ _____

Patient's Signature Date

Disclaimer:
This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPPA regulations.

NOTICE: PATIENT PRIVACY Date: APRIL 1, 2003

We are committed to preserving the privacy of your personal health information. In fact, we are requires by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provided to you, and related administrative activities supporting your treatment.

We may be required or permitted by certain law to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have the available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

If you have any questions, concerns or complaints about the Notice or your medical information please contact Dr. Daren J Penry at Lakeview Center Chiropractic.

_____ _____

NAME DATE

Lakeview Center Chiropractic 10512 NE 68th Street Kirkland, WA 98033 (425)889-4701