~ Acupuncture & Chinese Herbal Medicine ~
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Welcome to my practice! Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers are confidential. If you have questions, please ask. If there is anything you wish to bring to my attention which is not asked on the form, please note it. Thank you!

Patient Heath History

Name: ______________________________ Date:____________________

Address: ______________________ City: ____________ Zip:______________

Best phone number to reach you:________________ Email:____________________

Birthdate: __________ M F Age: _____ Height:_____ Weight _____ Blood Pressure _____

Place of birth:______________ Marital Status: _____ Number of children:____________

Occupation: ______________________

Primary Language: __________________ Dominant Hand: ____________________

Emergency contact:________________ Phone:____________ Relation:________

Have you tried acupuncture before? __________ Referred by: ____________________

Payment Information: If using your insurance for treatment, please provide a copy of your insurance card.

For office use only: **Cash pay: _____Co-Pay: _____**

Insurance company: ______________________ ID#____________________

Motor vehicle accident? Y N Date of accident: ______________________Med pay: Y N

What are your main health concerns? (Primary concern first)

1. ____ Date of onset:________
2. ____Date of onset:________
3. ____Date of onset:________

To what extent do these problems affect your daily activities (Work, sleep, eating, etc.)? ____________________

Have you been given a diagnosis for this problem by any other provider? If so, please describe: ______________

What other treatment or therapy have you tried? ____________________Was it effective? __________

Medications

Please list all other prescriptions, over the counter medications, and supplements you are taking, and for what conditions.
*If you have a pre-written list, please give to us to be copied.

____ ________________________________
____ ________________________________
____ ________________________________

Supplements

____ ________________________________
____ ________________________________
____ ________________________________

Medical History

Please check any of the below syndromes that you or your family has experienced.

Family History	You	Mother	Father	Sibling	Child
Allergies					
Cancer/Tumors					
Depression or Mental Illness					
Diabetes					
Drug Abuse					
High Blood Pressure/Heart Disease					
HIV					
Pacemaker					
Seizures/Epilepsy					
Stroke					
Thyroid disorder					
High Cholesterol					

Serious injuries/accidents: ____

Major Hospitalizations (Pregnancies not included)

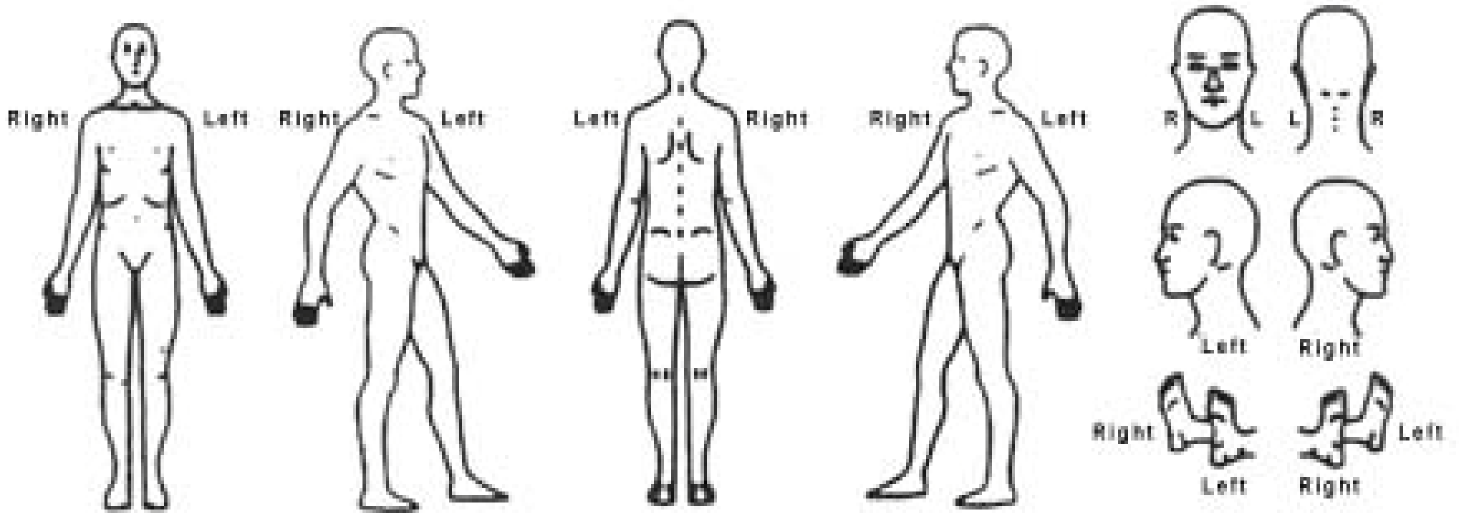
Year	Surgeries/Illnesses

Musculoskeletal

- ☐ Neck pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Back pain
- ☐ Mid back pain
- ☐ Shoulder pain
- ☐ Muscle weakness
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Finger/toe pain
- ☐ Tendon pain

Joint pain? _______ Pain is worse with: **cold - damp - heat – windy - hot & humid - cold & humid (circle one)**

Please mark clearly where you are experiencing pain (with XXX's) Numbness (with 000's)



Pain intensity: (scale of 1-10, 10 the worst): _______

Makes it worse: (please circle one) Walking/Standing/Sitting/Lying down …. Heat/Cold

Makes it better: (please circle one) Walking/Standing/Sitting/Lying down …. Heat/Cold

Affects daily activities, such as housekeeping, driving, etc. Yes/No. Please explain:

____

____

What kind of exercise do you do? ____

Do you have a stretching routine? ____

Does movement/exercise help the pain or make it worse? Please Explain:

____

____

Please fill out carefully

Oriental Medicine often uses unusual or seemingly insignificant body changes to diagnose the cause of health problems. Some of the following questions may not appear to be related to your primary health problem, but your best answer to each question will provide me with the information I need to make a precise diagnosis

What is your energy level? Scale 1-10, 10 being very energetic. _________

Please describe your average daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Cravings: Salty____ Sweet ____ Sour ____ Bitter ____ Pungent ___ Dairy ___ Chocolate _____ Alcohol ____ Tobacco ___

Drinks: Do you prefer hot or cold drinks? (please circle which one) Are you always thirsty? ____________________________

List any foods, drugs, or environmental substances to which you are sensitive/allergic?

____

____

Do you perspire during the day without exertion? ______ Do you have night sweats? _______

What kind of exercise do you do? Stretching/Cardio/Daily walks/ Other: ________________________________

Do you have or have you had any of the following:

- ☐ Panic Attacks
- ☐ Anxiety
- ☐ Fear
- ☐ Poor memory
- ☐ Restlessness
- ☐ Difficulty concentrating
- ☐ PTSD
- ☐ Depression
- ☐ Major stress

Have you ever taken antidepressants? _________ What kind? ________________________________

Sleep

- ☐ Insomnia
- ☐ Night sweats
- ☐ Wake feeling rested: yes/no
- ☐ Disturbed sleep
- ☐ Difficulty falling asleep
- ☐ Snores Cpap?
- ☐ Nightmares
- ☐ Difficulty staying asleep
- ☐ Waking up at am/pm

Do you take supplements or medications to sleep? What kind? ________________________________

Gastrointestinal:

- ☐ Belching
- ☐ Chronic laxative use
- ☐ Constipation
- ☐ Cravings
- ☐ Indigestion/heart burn
- ☐ Poor appetite
- ☐ Weight loss/gain
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Nausea
- ☐ Bad breath
- ☐ Strong Thirst
- ☐ Ulcers
- ☐ Gas
- ☐ Loose Stools
- ☐ Vomiting
- ☐ Abdominal pain or cramps
- ☐ Bowel movements: how often? ___ x day, am/pm/both/often

Genitourinary

- ☐ Pain on urination
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Urgent or frequent urination
- ☐ Frequent UTIs
- ☐ STDs
- ☐ Unable to hold urine
- ☐ Prostate Problems
- ☐ Kidney stones

Do you wake up at night to urinate? ______ If so, how often? ______________________
Urine color: dark, medium, light, clear (please circle)

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Blurry vision
- ☐ Poor vision/glasses
- ☐ Spots in front of the eyes
- ☐ Teeth problems
- ☐ History of Concussions
- ☐ Frequent headaches
- ☐ Migraines
- ☐ Poor hearing/Hearing aids?
- ☐ Ringing in ears/Tinnitus
- ☐ Frequent nose bleeds
- ☐ Chronic sinus problems
- ☐ Recurrent sore throats
- ☐ TMJ
- ☐ Sores on lips or tongue

If yes to Headaches? Where and When? ____
Any other Head or neck problems? ____

Respiratory

- ☐ Chronic cough
- ☐ Frequent colds
- ☐ Allergies
- ☐ Postnasal drip
- ☐ Asthma
- ☐ Dry mouth
- ☐ Smoking
- ☐ Emphysema
- ☐ History of bronchitis

Cardiovascular

- ☐ High blood pressure
- ☐ Cold hands and/or feet
- ☐ Varicose veins
- ☐ Irregular heartbeat
- ☐ Low blood pressure
- ☐ History of fainting
- ☐ Difficulty breathing
- ☐ Palpitations
- ☐ Swelling of feet/hands
- ☐ Blood clots
- ☐ Artificial Heart Valve
- ☐ Rapid heartbeat

Skin and Hair

- ☐ Sweaty palms/feet
- ☐ Skin rashes
- ☐ Acne
- ☐ Eczema
- ☐ Hair loss
- ☐ Hives
- ☐ Psoriasis
- ☐ Itching
- ☐ Dandruff

Any other hair or skin problems: ____

Reproductive and Gynecologic: Women

Do you have or have you had? (Check all that apply)

- ☐ Irregular menses
- ☐ Blood clots
- ☐ Painful menses
- ☐ Endometriosis
- ☐ PMS – mood changes
- ☐ Breast tenderness
- ☐ Unusual menses
- ☐ Cystic breasts
- ☐ Light menstrual flow
- ☐ Heavy menstrual flow
- ☐ Uterine fibroids
- ☐ History of Ovarian cysts

Age at first menses: ____________ Date of last period: _______________
Number of pregnancies: ________ Premature Births ________ Miscarriages _____ Abortions _____
Length of menstrual cycle: ________ Duration of bleeding: ____________
Birth control: Yes/No If yes, what type: _____________ Are you pregnant or trying to get pregnant? Yes / No
Age at menopause: ______________ Hot flashes? ________ Night sweats? _______ Mood changes? ________

Emotional. Please check all that apply.

Wood

- ☐ Irritability
- ☐ Anger
- ☐ Depression
- ☐ Easily Stressed
- ☐ Indecision
- ☐ Phobias

Fire

- ☐ Restless/Agitated
- ☐ Easily startled
- ☐ Lack of joy
- ☐ Passionate
- ☐ Rage
- ☐ Sadness
- ☐ Panic attacks
- ☐ Anxiety
- ☐ Self-doubt

Earth

- ☐ Worry
- ☐ Nurturing
- ☐ Overthinking
- ☐ Loyal
- ☐ Suspicious
- ☐ Like to be reassured

Metal

- ☐ Difficulty letting go
- ☐ Easily disappointed
- ☐ Concern for safety
- ☐ Grief
- ☐ Self-righteous
- ☐ Judgmental/Critical

Water

- ☐ Fearful
- ☐ Paranoid
- ☐ Cautious
- ☐ Creative
- ☐ Difficulty with trust
- ☐ Insecure

Have you ever been treated for emotional problems? ______Have you ever considered or attempted suicide? ___________
History of abuse/trauma? ___________ Any other psychological or neurological problems ________________________

Lifestyle habits – Please circle your answers

What is your favorite thing to do? ____

On a scale of 1-10, how content are you in life? (10 being very content, 1 being not at all) _____________

Do you have a religious/spiritual practice? Y N

How much balance do you have in your life on a 1-10 scale? ______ How much stress 1-10 scale? _________

How many days/hours do you work per week? ___Days ___Hours. Do you think this is: Just right/Not enough/Too much

Do you take time in your schedule to relax/do selfcare? (i.e. massage, naps, sleep in, vacations, etc…) Y/N ______________

What are your 2 most important health goals?

1.____ 2.____

What are your 2 most important life goals?

1.____ 2. ____

What are your two biggest sources of stress? (i.e. family, friends, body image, lack of money, work , health, relationship etc…)

1.____ 2.____

How do you manage your stress?

1.____ 2.____

Cigarettes? (How much) __________ Coffee/Tea?(How much?)__________ Alcohol?(How much?____________

What results would you like to gain from Acupuncture? ____

____

H.I.P.A.A.

Health Insurance Portability and Accountability Act

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

In the course of your care as a patient with Erin Prucha, L.Ac., MSOM, we may use or disclose personal information and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

- Your health care records as well as your billings may be disclosed to another party, such as an insurance carrier, and HMO, a PPO, or your employer (if they are or may be responsible for the payment of your services).

- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to other health related information that may be of interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. You have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your personal health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive acupuncture care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive information in a different form, please advise us in writing as to your preferences.

Over

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information.

WE are required by state and federal law to maintain the privacy of your patient file and the health-protected information therein. WE are also required to provide you with this notice of our privacy practices with respect to your health information.

WE are further required by law to abide by the terms of this notice while it is effect. WE reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any changes in our privacy notice will apply for all your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you should direct your complaint as well as any questions about our privacy policies and practices to the office manager at (707) 888-4940.

______________________________ ___________________________ ___________

Name (Printed) Signature Date

If you are a minor, or if you are being represented by another party:

______________________________ ___________________________ ____________

Personal Representative (printed) Signature Date