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~ 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 Other Age: _____ Height: _____ Weight _____ Blood Pressure _____

Place of birth: _____ Marital Status: _____ Dominant Hand: L / R

Occupation: _____ Primary Language: _____

Emergency contact: _____ Phone: _____ Relation: _____

Referred by: _____ Have you tried acupuncture before? _____ When? _____

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

For office use only: ***Time of service/OOP*: _____ / _____ /_____**

Insurance company: _____ ID#_____ Co-Pay: _____

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.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Herbal and Vitamin Supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medical History

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

Family History	**You**	**Mother**	**Father**
Cancer/Tumors			
Depression or Mental Illness			
Diabetes			
High Blood Pressure/Heart Disease			
Seizures/Epilepsy			
Stroke			
Other			

Major Hospitalizations (Pregnancies not included)

Year	**Surgeries/Illnesses**

Serious injuries/accidents: (Please indicate year and injury)

_____

_____

_____

Musculoskeletal

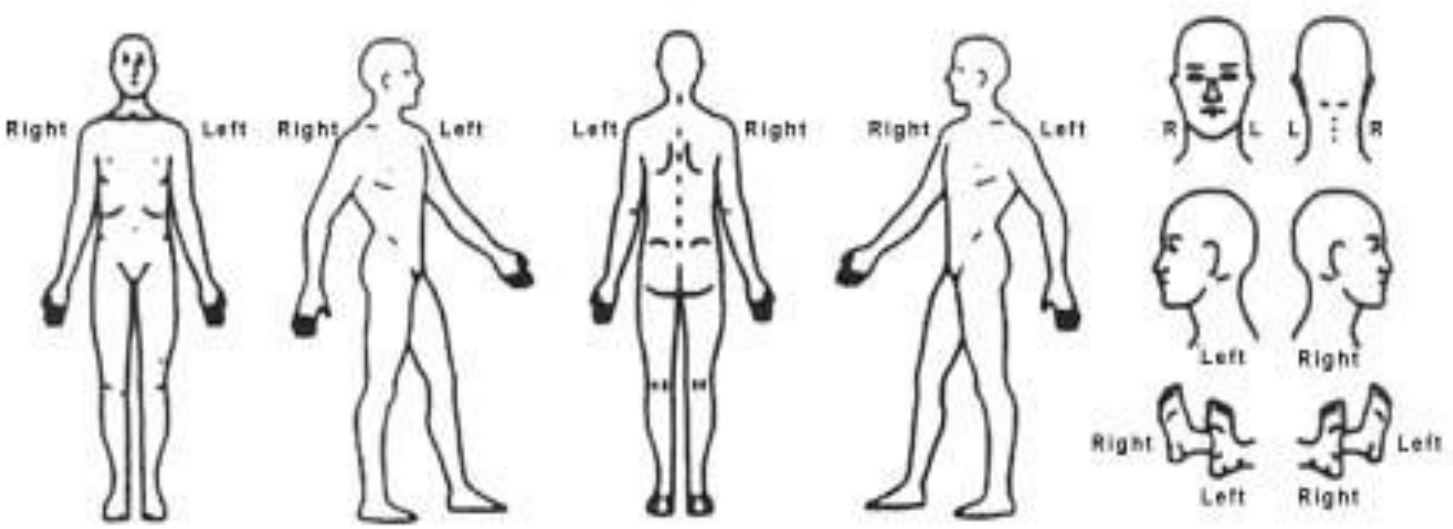
Do you have or have you had? (Check all that apply)

☐ Muscle pain	☐ Back pain	☐ Arthritis
☐ Muscle weakness	☐ Neck pain	☐ TMJ
☐ Ankle pain	☐ Elbow pain	☐ Knee pain

Pain elsewhere in the body, & if so, where? _____

Pain is worse with **(circle one)**: **COLD - DAMP - HEAT – WIND – HOT & HUMID – COLD & HUMID**

Please mark clearly where you are experiencing pain (with XXX'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, yardwork etc. Yes/No. Please explain:

_____

_____

Have you had an MRI or X-ray? What were the results? (Bulging disc and location for example.)

_____

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. _____

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

Drinks: Do you prefer **hot, cold, or room temperature drinks**? (Please circle which one) Are you always thirsty? _____

Dietary restrictions? (Vegetarian, vegan, paleo, etc.) _____

List any foods, drugs, or environmental substances to which you are sensitive/allergic. i.e.: gluten, soy, corn, etc.

_____

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

Do you experience any of the following?

- ☐ Panic Attacks ☐ Anxiety ☐ PTSD
- ☐ Depression ☐ Self-doubt ☐ Easily Startled

Have you ever taken antidepressants? _____ What kind? _____

Sleep

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

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

Gastrointestinal: Are you currently experiencing any of the following?

- ☐ Indigestion/Heart burn/GERD ☐ Bloating ☐ Constipation/Diarrhea/Loose Stools (Circle one)

Bowel movements: how often? _____ x day, am/pm/both/often

Urinary (check all that apply)

- ☐ Frequent UTIs ☐ Urgent or frequent urination ☐ Unable to hold urine/Leaking

Do you wake up at night to urinate? _____ If so, how often? _____

Head and ENT

- ☐ Frequent headaches/Migraines ☐ History of Concussions ☐ Ringing in ears/Tinnitus

Respiratory: Do you currently experience any of the following?

- ☐ Allergies ☐ Chronic cough ☐ Smoking
- ☐ Frequent colds ☐ Asthma ☐ COPD/Emphysema

Skin and Hair

- ☐ Do you perspire w/o exertion? ☐ Eczema/Skin rashes/Psoriasis ☐ Hair loss

Cardiovascular

- ☐ High blood pressure ☐ Palpitations ☐ Cold hands and/or feet
- ☐ Artificial Heart Valve ☐ Pacemaker ☐ Tachycardia (treated)

Reproductive and Gynecologic: Women

Are you still menstruating? YES / NO Age at first menses: _____ Age of Menopause: _____

Length of menstrual cycle: _____ Duration of bleeding: _____ Heavy/ light menstrual flow (circle one)

PMS? What symptoms? Irritable _____ Sad _____ Weepy _____ Moody _____ Tender breasts _____

Heavy flow, what day/s of cycle? _____ Painful periods, what day of cycle? _____

Fatigue before/during/after bleeding? _____ Blood clots? _____ Spotting? _____

Uterine Fibroids? _____ Endometriosis? _____ Cystic Breasts? _____ History of Ovarian cysts? _____ PCOS? _____

Are you pregnant or trying to get pregnant? YES / NO Are you currently using Birth Control? YES / NO

Number of pregnancies? _____ Number of children? _____ Ages: _____ Miscarriages _____ Abortions _____

Perimenopausal, what symptoms: Hot flashes _____ Night sweats_____ Mood changes _____

Menopausal: Date of last menstrual period: _____ Hormone replacement therapy? _____

Hysterectomy? YES / NO. If yes, date of procedure and reason? _____

Urogenital: Men

Prostate Problems _____ Prostate Cancer _____ Slow urination flow _____ Erectile Disfunction _____

Emotional.
When you feel out of balance, which emotion is most present? Please check all that apply.

Wood

☐ Irritability	☐ Anger	☐ Indecision

Fire

☐ Anxiety	☐ Sadness	☐ Lack of joy

Earth

☐ Worry	☐ Suspicious	☐ Overthinking

Metal

☐ Difficulty letting go	☐ Easily disappointed	☐ Judgmental/Critical

Water

☐ Fearful	☐ Paranoid	☐ Difficulty with trust

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 and goals

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 do you do? _____

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? _____

_____

_____

Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures on me (or on the patient named below, for whom I am legally responsible) by Erin Prucha, L.Ac., MSOM

I understand that methods or treatment may include, but are not limited to acupuncture, moxibustion, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection, and scarring. There may be some bruising after cupping.

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 Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

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

HIPPA: I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above- named 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's Name _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____

Acupuncture & Chinese Herbal Medicine

Erin S. Prucha, L.Ac., MSOM

24 Hour Appointment Cancellation Policy

Canceling or Changing Appointments:

Keeping your appointments is an important commitment to your health. I realize that sometimes you need to reschedule or cancel your appointment, and I understand that emergencies arise. However, if you need to cancel or change an appointment, please be sure to do so 24 hours in advance so that another patient can be accommodated. My voicemail is available 24 hours a day. Because **your appointment is a guaranteed reservation** for you, please note the following:

*Less than 24-hour notice to cancel or reschedule an appointment will incur a $50 charge.

*** No-shows will incur the FULL CHARGE of your missed appointment.**

*** You will be charged even if you would normally use insurance to cover your treatment.**

This also applies to the use of gift certificates, prepaid services, those for whom we bill insurance, or alternative payment methods.

Please note that scheduling an appointment is your acceptance of this policy.

Thank you for your understanding and cooperation with this policy.

I, _____ HAVE READ AND UNDERSTAND THE CANCELLATION POLICY OF ERIN S. PRUCHA, L.Ac., MSOM. I ACKNOWLEDGE THAT IF I DO NOT PROVIDE CANCELLATION NOTICE 24 HOURS IN ADVANCE OF MY APPOINTMENT, I WILL AUTOMATICALLY BE CHARGED FOR $50.00. I WILL BE CHARGED THE FULL FEE OF MY APPOINTMENT FOR NOT SHOWING.

My Credit card information is on the back of this form. I authorize the office of Erin Prucha, Acupuncture and Chinese Herbal Medicine, to charge my card in the event that I do not give 24-hour notice or that I do not show for my appointment.

Patient Signature _____ Date _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card type: Mastercard Visa Discover Other:

Cardholder Name (as shown on card): _____

Card Number: _____ CVC _____

Expiration Date (mm/yy): _____

Cardholder ZIP code (from credit card billing address): _____

I, _____, authorize the office of Erin S. Prucha, Acupuncture & Chinese Herbal Medicine to charge my credit card above for agreed upon transactions, including full charge of treatment for not showing to an appointment as scheduled, and $50 if cancelled appointment in less than 24 hours. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

Office Policies – If you will be using your Insurance for Acupuncture

Welcome to the Acupuncture office of Acupuncture & Chinese Herbal Medicine, with Erin S. Prucha, L.Ac.,MSOM. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES: The fees charged in this office are comparable to those charged by other healthcare providers in this area, with similar qualifications. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds. **Initial _____**

INSURANCE COVERAGE: Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement below. Please be aware that billing rates for insurance are generally higher than out of pocket/time of service payments. If you have any questions, please let us know. **Initial _____**

NON-COVERED SERVICES: Some insurance companies will pay for limited services. If it is recommended that you have additional services you will be informed and, if agreed, will pay an additional, pre-agreed upon, charge. Such therapies as (but not limited to) the following: cupping, electrical stimulation, manual therapy, trigger point therapy, extra set of needles**. Initial** _____

RELEASE OF INFORMATION: Your insurance company may require medical reports to document our treatment and progress. Your initials authorize the release of medical information necessary to process your claim. **Initial _____**

CANCELLATIONS: As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50.00 cancellation fee for less than 24-hour notice. You will be charged the FULL FEE for NO SHOWS. If you are using insurance, you will be charged the full time of service fee/out of pocket fee of $100.00. This applies to any non-emergency situations. **Initial _____**

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____ am receiving or about to receive health care services in this office. I understand that I am responsible to pay all applicable co-pays/coinsurance, deductibles, and non-covered insurance related fees when services are rendered, including herbs, etc. In addition, I authorize insurance payment of medical benefits to be payable to Erin S. Prucha.

By signing below, I agree to comply with the policies stated above which I have read and understand. I also authorize the use of this signature on all insurance submissions.

_____ _____

Signature **Date**