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~ Acupuncture & Chinese Herbal Medicine ~
Erin S. Prucha, L.Ac, MSOM, MA
2460 West 3rd St., Ste 240 ~ Santa Rosa, CA 95401 * www.AcupunctureSantaRosa.org

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 -- FTM/MTF Age: _____ Height: _____ Weight _____ Blood Pressure _____

Place of birth: _____ Primary Language: _____ Occupation: _____

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.

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? _____

Are you interested in Chinese Herbal Therapy and Custom Herbal Formulas for your condition? Yes _____ NO _____

**** What results do you wish to gain from acupuncture and/or Chinese herbal medicine?** _____

_____

_____

Medications: Please list the major prescription medications you are taking. *If you have a pre-written list, please give it to us to be copied.

_____

_____

_____

Medical History

Please check if you have or had any of the following conditions:

□ **Diabetes**	□ **COPD**	□ **Depression**	□ **Jaundice/Hepatitis**
□ **Heart Disease**	□ **CVA (Stroke)**	□ **Concussions**	□ **Thyroid**
□ **Asthma**	□ **Pneumonia**	□ **Emphysema**	□ **Vein Condition**
□ **Allergies**	□ **Gonorrhea**	□ **Mental Illness**	□ **Tuberculosis**
□ **Meningitis**	□ **Measles**	□ **High Blood Pressure**	□ **Chicken Pox**
□ **Epilepsy/Seizure**	□ **HIV**	□ **Nervous Disorder**	□ **Polio**
□ **Paralysis**	□ **Anxiety**	□ **Mononucleosis**	□ **Migraines**
□ **Fainting**	□ **Cancer**	□ **Multiple Sclerosis**	□ **Artificial Heart Valve**

Major Hospitalizations and Injuries that you have had since birth:

Year	**Surgeries/Illnesses/Injuries/Accidents (Car accidents, broken bones, etc.)**

Chinese Medicine Pattern Differentiation

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.

Please check the boxes that apply to you:

General energy levels: Scale of 1-10, 10 being very energetic: _____

☐ Energy drops in the: ☐ Morning ☐ Afternoon ☐ Early evening

Sleep Quality

☐ Poor ☐ Average ☐ Excellent ☐ Difficulty falling asleep ☐ Overactive mind/toss and turn ☐ C-pap
☐ Wake for no reason. Time: ____ ☐ Frequent nightmares ☐ Vivid dreams ☐ Wake to urinate. # of times? __

Stress Level

How much balance do you have in your life on a 1-10 scale? _____ How much stress 1-10 scale? _____
On a scale of 1-10, how content are you in life? (10 being very content, 1 being not at all) _____

How does stress affect your body? Circle all that apply:
Heart palpitations/digestive issues/ emotional/ depression/ panic attacks/body aches/insomnia

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Digestion

☐ Normal ☐ Heartburn ☐ Acid reflux ☐ Gas/ Bloating ☐ Abdominal pain ☐ Nausea
☐ Burping ☐ Loose stool ☐ Diarrhea ☐ Hemorrhoids ☐ Constipation

Emotions: What emotion(s) dominate your life experience?

☐ Anger ☐ Irritability ☐ Anxiety ☐ Worry ☐ Obsessive thinking ☐ Sadness ☐ Grief ☐ Depression
☐ Joy ☐ Fear ☐ Timid/shy ☐ Indecision

Do you experience any of the following?

Panic Attacks _____ PTSD _____ History of trauma _____

Urinary (check all that apply)

☐ Normal ☐ Urgent or frequent ☐ Unable to hold urine/Leaking

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)

Menstruation

☐ Regular ☐ Irregular ☐ No cycle
☐ Cycle length: ☐20-27 days ☐28-33 days ☐>33 days Menses: ☐ 1-2 days ☐ 3-7 days ☐>7 days
☐ PMS: what are your symptoms?
_____
☐ Total days of bleeding_____Painful periods: ☐ No ☐ Before ☐ During ☐ After ☐ Clots
History of: ☐ Fibroids ☐ PCOS ☐ Endometriosis ☐ Hysterectomy Other: _____
# of pregnancies _____ # of births _____ # of abortions/miscarriages _____

Please indicate any other symptoms that arise with menstruation (headaches/ fatigue/ bloating/ digestive issues/irritability):

Anything else you'd like to add? _____

Menopausal

☐ Peri- ☐ Post _____# of Hot Flashes a day _____# of night sweats a week ☐ Vaginal dryness ☐ Loss of sex drive
☐ Mood changes. ~~ HRT? Yes ___ No ____. If yes, what are you using? _____

Urogenital: Men

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

Habits: □ Coffee __ x day/week □ Alcohol _____x day/week □ Marijuana _____x day/week
□ Other recreational drugs _____ x day/week □ Sugar _____ x day/week □ Tobacco ____x day/week

What are your 2 most important life goals?

1._____ 2. _____

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PAIN – Musculoskeletal

On a scale of 1-10, where 1 would be barely noticeable, 3 would be bothersome, 5 would be painful, 7 would impact your activities, 9 would make you immobile, 10 would incapacitate you, please rate below:

Complaint:	**1-10**
Headache/Migraine	
TMJ/Jaw pain	
Back	
Neck/Shoulder	
Elbow	
Knee	
Hand/Finger/Wrist	
Ankle	
Foot/Toe	
Hip/Sciatic	
Other:	

Please circle the quality of your pain:

Sharp, Stabbing, Dull, Achy, Numb, Constant, Intermittent, Throbbing, Hot, Cold

Other: _____

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

OTHER: _____

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

_____

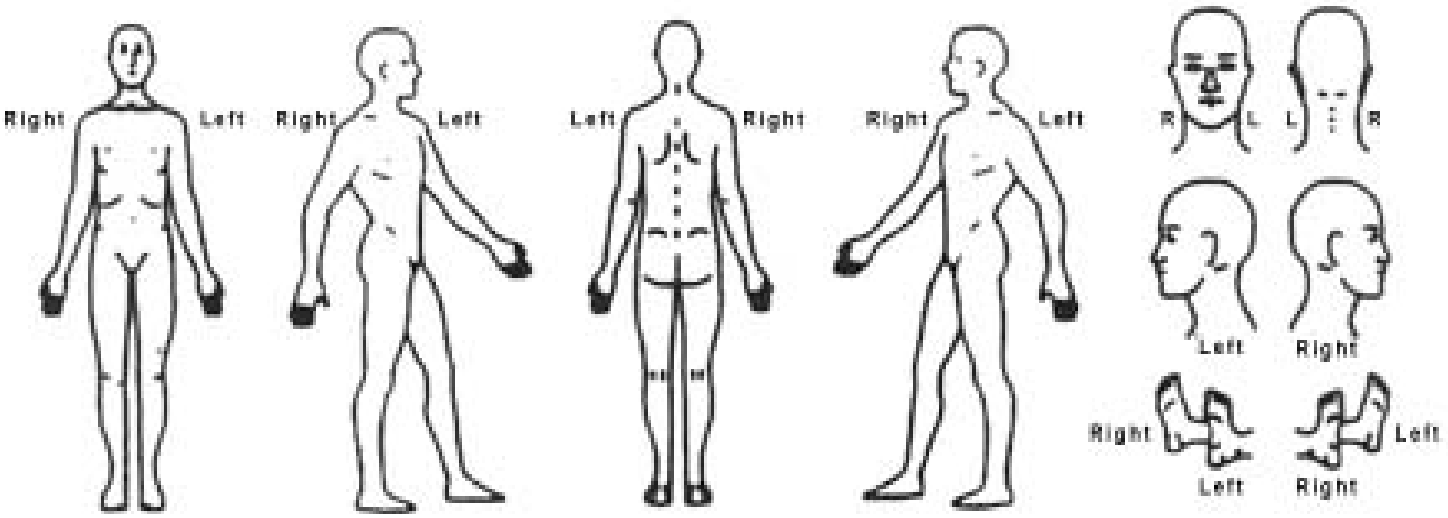
What type of exercise do you do? i.e. yoga, walking, swimming, etc. _____

What type of exercise do you wish you could do, but can't due to your pain? _____

Please list any additional questions or concerns here: _____

_____

_____



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Informed Consent to Treatment

I understand that the methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, Chinese and Western Herbal medicine, nutritional and lifestyle counseling.

I hereby request and consent to the performance of acupuncture 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.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain and treating certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there will be some bruising, numbness or tingling near the needling site that may last a few days, and dizziness and fainting can occur on rare occasions. There have been very rare incidences reported in the literature of infection, scarring, spontaneous miscarriage, nerve damage, and/or organ puncture. Such serious problems have not occurred in this clinic. Generally, there will be slight bruising after cupping that may last a few days. This clinic uses only pre-sterilized, disposable needles and maintains a clean and safe environment.

The herbs and nutritional supplements recommended here (which are from plant, animal, and mineral sources) have a long history of use in Traditional Chinese Medicine. We source only high-quality herbs and products, considered safe in normal dosages, a few can be toxic if large doses are ingested. I understand that some herbs may be inappropriate during pregnancy, and if I become pregnant, I will inform my acupuncturist. If I experience any gastrointestinal upset or allergic reactions to the herbs or nutritional supplements I will inform my acupuncturist. I understand that to receive the greatest benefit from herbs and supplements I need to comply with the instructions and recommended dosages given to me by my acupuncturist.

HIPPA: I understand that 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 written consent or when required by law.

CANCELLATION POLICY: As a courtesy to our office and others, I agree to give at least 24 hours' notice in the event I need to change, cancel, or miss an appointment. I understand that if I do not show up for my appointment, the business is at a loss for my unfilled appointment time. Therefore, I will be liable for a $75 appointment fee if my appt is canceled with less than 24-hour notice and FULL APPOINTMENT FEE for a missed appointment/NO SHOW. If I am using insurance, I will be responsible for the full time of service/out of pocket fee. In the event of an emergency this 24-hour cancellation policy will be waived.

Please Initial: _____

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.

Printed Name: _____ **Date:** _____

Signature: _____

Parent/Guardian Signature: _____ **Date:** _____

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Financial Policy

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.

FEES OUT OF POCKET: 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. Fees are discounted for payment at the time of service. These fees will be paid when the service is rendered. We also offer ACUPUNCTURE TREATMENT PACKAGES that include a pre-paid discounted rate.

If you plan to use this method of payment: **Initial** _____

For Insurance Coverage: We accept a limited group of insurance plans. If we are not in network with your insurance, we can provide you with a Super Bill for you to submit to your insurance on your behalf for reimbursement.

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 the 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** _____

Your copay is due as services are rendered. **You are also responsible for portions of your bill that exceed your insurance limits and for procedures not covered by your insurance.** If a claim is denied, the balance for care received up to that date is due in full in 30 days. **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): cupping, electrical stimulation, manual therapy, trigger point therapy, extra set of needles. Initial** _____

VA: If your Acupuncture is covered by the VA you will not be responsible for copays or any out of pocket fees (you are responsible for herbs/supplements). However, if you no-show more than 3 x the office is required to inform the VA and this may terminate your authorization for care. Keep in mind that keeping your appointment is important, and a missed appointment takes the time for someone else to receive care. 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** _____

I understand that all responsibility for payment of services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. I permit this office to endorse co-issued remittances for the conveyances of credit to my account. **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**