Spring Valley Acupuncture

2840 Keller Springs Rd, Bldg. 10, Ste 1001
Carrollton, TX, 75006

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Date: ___________________________

Patient Name: ____ Age: _________________

Date of Birth: _________________________________ Height: _________________ Weight: ___________________

Address: ____ Marital Status: ___________________

City: ____ State: _________ Zip Code: _______________________

Email address: ____ Sex: Male Female

Home Phone: __________________________________ Cell Phone: _______________________________________

Occupation (job title): _________________________________ Employer: _________________________________

Employer Address: ____________________________________ Work Phone: ______________________________

Which telephone number would you like us to use for appointment reminders? Home/Work/Cell

Emergency Contact: ______________________________________ Phone: _________________________________

Whom may we thank for referring you?

____

Reason for Visit

Describe what hurts, or your reason for this visit: ____

____

How long have you had this condition? __________________ Is it getting worse? ☐ Yes ☐ No

When did your symptoms start? _______________ How did your symptoms begin? ______________________

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

What seems to make it better? ____________

What seems to make it worse? ________________

Does it bother your: ☐ Sleep ☐ Work ☐ Daily activity ☐ ______________________

Have you had acupuncture before? ☐ Yes ☐ No

Have you had herbal medicine before? ☐ Yes ☐ No

List other forms of treatment you have sought: ______________________________

Do you have any additional health concerns or diagnosis? _______________________

List any accidents, surgeries, or hospitalizations (include dates): _______________________

____

____

List any Allergies that you are aware of: ____

List any medications (over the counter or prescription) or supplements you take:

RX / Supplement / Herb Dose Reason for taking How long Prescribed by Last checkup

____

____

____

____

____

____

History of Treatment

Primary care physician: ____ Phone: ____________________________

Date last seen: ______________ Reason for visit: ____

Email: ____

May we update them on your condition? ☐ Yes ☐ No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: ____________

____

Lifestyle History

Do you exercise? ☐ Yes ☐ No Hours per week _______ What activity(s)? ________________________________

Are you dieting? ☐ Yes ☐ No Since: _________________________

Do you smoke? ☐ Yes ☐No _____ packs per day. How long have you been smoking? ________________________

Do you drink alcoholic beverages? ☐ Yes ☐ No _______ drinks per week.

For women: Are you pregnant or nursing? ☐ Yes ☐ No

If pregnant, how many weeks? ______________ Date of last menstrual period: _____________________________

Do you currently use or have you used in the past:
☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ other drugs

Your Diet

Appetite: ☐ Low ☐ Normal ☐ High

Do you consume or crave any of the following:
☐ Coffee ☐ Artificial Sweetener ☐ Salty Food ☐ Soft Drinks ☐ Sugar

Thirst for water: ______________ # of glasses per day

Average Daily Menu:

Morning	Snack	Noon	Snack	Evening	Snack

Your Past Medical History

Check all of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history:

☐ HIV/Aids ☐ Diabetes ☐ Measles ☐ Seizures ☐ Whooping Cough
☐ Alcoholism ☐ Emphysema ☐ Multiple Sclerosis ☐ Stroke ☐ Other (specify)
☐ Allergies ☐ Epilepsy ☐ Mumps ☐ Thyroid Disorders ________________
☐ Appendicitis ☐ Goiter ☐ Pacemaker ☐ Major Trauma ________________
☐ Asthma ☐ Gout ☐ Pneumonia ☐ Tuberculosis ________________
☐ Birth Trauma ☐ Heart Disease ☐ Polio ☐ Typhoid Fever ________________
☐ Cancer ☐ Herpes ☐ Rheumatic Fever ☐ Ulcers ________________
☐ Chicken Pox ☐ High Blood Pressure ☐ Scarlet Fever ☐ Venereal Disease ________________

General Symptoms:

☐ Poor appetite ☐ Poor sleep ☐ Bodily heaviness ☐ Chills ☐ Bleed or bruise easily
☐ Heavy appetite ☐ Heavy sleep ☐ Cold hands or feet ☐ Night sweats ☐ Peculiar taste
☐ Strongly like cold drinks ☐ Dream-disturbed sleep ☐ Poor circulation ☐ Sweat easily ☐ Other (specify)
☐ Strongly like hot drinks ☐ Fatigue ☐ Shortness of breath ☐ Muscle cramps ________________
☐ Recent weight loss/gain ☐ Lack of strength ☐ Fever ☐ Vertigo or dizziness ________________

Head, Eyes, Ears, Nose & Throat:

☐ Glasses ☐ Night blindness ☐ Sores on lips/tongue ☐ Swollen glands ☐ Migraines
☐ Eye strain ☐ Glaucoma ☐ Dry mouth ☐ Lumps in throat ☐ Concussions
☐ Eye pain ☐ Cataracts ☐ Excessive saliva ☐ Enlarged thyroid ☐ Other (specify)
☐ Red eyes ☐ Teeth problems ☐ Sinus problems ☐ Nose bleeds ________________
☐ Itchy eyes ☐ Grinding teeth ☐ Excessive phlegm ☐ Ringing in ears ________________
☐ Spots in eyes ☐ TMJ color of phlegm: ☐ Poor hearing ________________
☐ Poor vision ☐ Facial pain ________________ ☐ Earaches ________________
☐ Blurred vision ☐ Gum problems ☐ Recurrent sore throat ☐ Headaches ________________

Respiratory:

☐ Difficulty breathing when lying down ☐ Asthma/wheezing Color of phlegm? ______________
☐ Shortness of breath ☐ Cough ☐ Coughing blood
☐ Tight chest Wet or dry?______________ ☐ Pneumonia
Thick or thin? ____________

Cardiovascular:

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Tachycardia ☐ Phlebitis
☐ Blood clots ☐ Fainting ☐ Difficulty breathing ☐ Heart palpitations ☐ Irregular heartbeat

Musculoskeletal:

☐ Neck/shoulder pain ☐ Upper back pain ☐ Joint pain ☐ Limited range of motion ☐ Other (specify)
☐ Muscle pain ☐ Low back pain ☐ Rib pain ☐ Limited use ________________

Gastrointestinal:

☐ Nausea	☐ Diarrhea	☐ Itchy anus	☐ Bad breath
☐ Vomiting	☐ Constipation	☐ Burning anus	Bowel movements:
☐ Acid regurgitation	☐ Laxative use	☐ Rectal pain	Frequency______________________
☐ Gas	☐Black stools	☐ Hemorrhoid	Color__________________________
☐ Hiccup	☐ Bloody stools	☐ Anal fissures	Texture/form __________________
☐ Bloating	☐ Mucous in stools	☐ Intestinal pain	Odor___________________________

Skin and Hair:

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/skin texture
☐ Hives	☐ Psoriasis	☐ Itching	☐ Fungal infections
☐ Ulcerations	☐ Acne	☐ Hair loss	☐ Other (specify) __________

Neuropsychological:

☐ Seizures	☐ Poor memory	☐ Irritability	☐ Considered/attempted suicide
☐ Numbness	☐ Depression	☐ Easily stressed	☐ Seeing a therapist
☐ Tics	☐ Anxiety	☐ Abuse survivor	☐ Other (specify)________________

Gynecology:

Age menses began______________	☐ Irregular periods	☐ Vaginal sores	# of Pregnancies____________
Length of avg cycle____________ (day 1 to day 1)	☐ Painful periods	☐ Vaginal odor	# of live births____________
	☐ PMS	☐ Clots	☐ Premature birth(s)
Duration of flow_______________	☐ Vaginal discharge	☐ Breast lumps	Age at menopause_________

Family Health History

Are any of the following diseases in your family:

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

Please list all major diseases (such as Bone/Joint Diseases, Heart Problems, Stroke, etc.) in your family and the family member's relation to you

____

____

____

Symptom Checklist

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		Musculoskeletal			**Cardiovascular**			**Genitourinary**
☐	☐	Neck Pain	☐	☐	Angina/Chest Pain	☐	☐	Bladder Infection
☐	☐	Upper/Mid Back Pain	☐	☐	Fainting	☐	☐	Frequent Urination
☐	☐	Low Back Pain	☐	☐	Heart Attack	☐	☐	Painful Urination
☐	☐	Shoulder Pain	☐	☐	High Blood Pressure	☐	☐	Kidney Stones
☐	☐	Elbow/Upper Arm Pain	☐	☐	Stroke	☐	☐	Prostate Problems
☐	☐	Wrist/Hand Pain	☐	☐	Blood Clots			**Ear/Nose/Throat**
☐	☐	Hip/Upper Leg Pain	☐	☐	Vascular Disease	☐	☐	Allergies/Asthma
☐	☐	Knee/Lower Leg Pain			**Metabolic**	☐	☐	Chronic Sinusitis
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			**Systemic Conditions**
☐	☐	Arthritis	☐	☐	Low Bone Density	☐	☐	Cancer/Tumors
☐	☐	Joint Swelling/Stiffness	☐	☐	Excessive Thirst	☐	☐	Chronic Fatigue
☐	☐	Joint Dislocation	☐	☐	Hormone Therapy	☐	☐	Systemic Lupus
☐	☐	Headaches	☐	☐	Thyroid Problems	☐	☐	Spinal Infection
☐	☐	Jaw Pain			**Gastrointestinal**	☐	☐	HIV/AIDS
		Neurological	☐	☐	Abdominal Pain	☐	☐	Hepatitis
☐	☐	Concussion	☐	☐	Liver/Gallbladder Disorder	☐	☐	Anemia
☐	☐	Memory Loss	☐	☐	Ulcer			**Psychological**
☐	☐	Epilepsy			**Dermatological**	☐	☐	Depression
☐	☐	Excessive Weakness	☐	☐	Dermatitis/Eczema	☐	☐	Anxiety
☐	☐	Loss of Sensation/Bowel/Bladder Function	☐	☐	Psoriasis	☐	☐	Alcohol/Drug Abuse
☐	☐	Dizziness	☐	☐	Acne	☐	☐	Mood Swings

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Consent to Treat

I, ___________________________________ , voluntarily consent to be treated with Acupuncture administered by Amanda Bryant Melo.

I understand that the Acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by application of heat, or by some combination of the foregoing, at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my Acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I accept that No Guarantee is made concerning the results of my Acupuncture treatment, and I have been informed that I may stop at any time.

I consent also to the submission of any data relating to my Acupuncture treatments to any health insurer with whom I have coverage, and understand that this does not otherwise waive my right to confidentiality of my records.

All questions I have asked have been fully answered.

Signature of Patient (or Guardian)____

Dated____

DOB____

Evaluation Request

I have been treated by a physician or a dentist for the condition being treated within twelve months prior to having acupuncture performed. Yes No

I received a referral from my chiropractor within the last thirty days for acupuncture. Yes No

I recognize that I should be evaluated by a physician / chiropractor for the condition being treated by the acupuncturist. In being referred by my chiropractor, if after 60 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me back to a physician / chiropractor for a reevaluation. This does not apply to the following conditions: chronic pain, alcoholism and substance abuse, smoking cessation or weight loss.

Signature of Patient (or Guardian) ____

Dated____

DOB____

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Patient Consent for use and Disclosure of Protected Health Information

Medical groups must provide patients with a notice describing how protected health information may be used and disclosed. This information includes patient's rights and medical group's duties.

I hereby give consent for ***Spring Valley Clinic a/k/a Spring Valley Acupuncture*** to use and disclose protected health information (PHT) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by ***Spring Valley Clinic a/k/a Spring Valley Acupuncture*** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. ***Spring Valley Clinic a/k/a Spring Valley Acupuncture*** reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices is kept in the lobby at our office at 6009 Belt Line Rd., Ste 110, Dallas, Texas 75254.

With this consent, ***Spring Valley Clinic a/k/a Spring Valley Acupuncture*** may call my home or other alternative location and leave a message on voice mail or by person, mail correspondence through USPS or similar means or electronic mail (email) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including diagnostic testing results, among others.

_________________________ I acknowledge that I have been informed that I can request a copy of the Notice of Privacy Practices from ***Spring Valley Clinic a/k/a Spring Valley Acupuncture*** and consent to allow them to use and disclose my PHT to carry out TPO.

________________________ I have received a copy of Notice of Privacy Practices from ***Spring Valley Clinic a/k/a Spring Valley Acupuncture.***

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, ***Spring Valley Clinic a/k/a Spring Valley Acupuncture*** may decline to provide treatment to me.

Signed By: ____
(Signature of patient or Legal Guardian) (Date) (Relationship to patient if other than self)

____
(Print Patient Name) (Print name of Legal Guardian if applicable)

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FINANCIAL POLICY

Payment in full is required at the time of your appointment.
There are no refunds for product purchases. Unopened products may be returned within 30 days for a credit towards another product or future appointment.
Cash, checks and credit cards are accepted.

APPOINTMENT CANCELLATION POLICY

We care about your time and want to provide the best possible care. If you are running late, please call and let us know. If you are more than 10 minutes late we may have to reschedule your appointment for another day and time. In this case, you will be charged for the full price of the missed appointment. Because Amanda is usually booked a week or more in advance, we require at least **one-day (24 hour) notice to cancel or reschedule your appointment**. If you fail to show up for a scheduled appointment or call to cancel with less than 24 hours notice, you will be in violation of this policy and will be required to pay for the appointment. By signing this document you give us the right to bill your credit card for the missed appointment. If you do not have a credit card on file, you will be billed directly.

Patient Signature: ________________________

Date: _____________