Spring Valley Acupuncture

972-955-2909
springvalleyacupuncture.com

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?

_____

P

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

_____

_____

_____

_____

_____

_____

P

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 <u>women</u>: 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
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating
☐ Diarrhea
☐ Constipation
☐ Laxative use
☐ Black stools
☐ Bloody stools
☐ Mucous in stools
☐ Itchy anus
☐ Burning anus
☐ Rectal pain
☐ Hemorrhoid
☐ Anal fissures
☐ Intestinal pain
☐ Bad breath

Bowel movements:
Frequency_____
Color_____
Texture/form _____
Odor_____

Skin and Hair:

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

Neuropsychological:

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

Gynecology:

Age menses began_____
Length of avg cycle_____ day 1 to day 1
Duration of flow_____
☐ Irregular periods
☐ Painful periods
☐ PMS
☐ Vaginal discharge
☐ Vaginal sores
☐ Vaginal odor
☐ Clots
☐ Breast lumps
# of Pregnancies_____
# of live births_____
☐ Premature birth(s)
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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APPOINTMENT CANCELLATION POLICY

In an effort to reduce patient waiting times and guarantee your reserved appointment time, we recommend scheduling your appointments in advance. Since our staff is usually booked a week or more in advance, **we require a one-day (24 hour) notice to cancel or reschedule appointments**. Patients that do not show for scheduled appointments or call at the last minute will be in violation of this policy and will be assessed a $75* cancellation fee.

Patient Signature: _____

Date: _____

*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.