

Health History Questionnaire

Date _____ / _____ / _____

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential, unless you sign a waiver allowing your records to be released. If you have any questions, please ask. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the Comments Section on page 4.

Name:		Work Phone () -		Home Phone: () -	
Address:			City:		State:
Zip Code:		Social Security Number:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Age:
Date of Birth: / /		Place of Birth:		Height:	Weight:
Marital Status (check one): <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Living with Partner, Unmarried <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Email:	
Employer Name:			Occupation:		
Education (mark highest level achieved): <input type="checkbox"/> Grade School or Less <input type="checkbox"/> Some College <input type="checkbox"/> Some High School <input type="checkbox"/> College Graduate <input type="checkbox"/> High School Graduate <input type="checkbox"/> Graduate or Professional School <input type="checkbox"/> Vocational or Technical School					
Family Physician: Dr. Name and Clinic Name			Referred by:		
In case of Emergency contact (Name):			Emergency Contact Phone: Day () - Eve () -		
Have you been treated by acupuncture or Oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No					

What is/are the main problem(s) you would like us to help you with: _____

How long ago did this problem begin (be specific)?: _____

Was there a known cause/instigating factor for your problem? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?: _____

Have you been given a diagnosis for this problem? If so, what?: _____

What kinds of treatment have you tried?: _____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____
 High Blood Pressure _____ Heart Disease _____ Rheumatic Fever _____
 Thyroid Disease _____ Seizures _____ Venereal Disease _____
 Other: _____

Surgeries (type of and date): _____

Significant Trauma (auto accidents, falls etc.): _____

Significant Dental Work (type and date): _____

Birth History (prolonged labor, forceps delivery, etc.): _____

Allergies (drugs, chemicals, foods/result): _____

Family Medical History (check): Diabetes Cancer High Blood Pressure Heart Disease
 Stroke Seizures Asthma Allergies
 Other: _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? Yes No Please describe: _____

Have you ever been on a restricted diet? Yes No What kind?: _____

Please Describe Your Average Daily Diet

Morning _____
Afternoon _____
Evening _____

How many packs of cigarettes do you smoke per day? _____ How much coffee, tea or cola do you drink per week? _____

How much alcohol do you drink per week? _____ Please describe any use of drugs for non-medical purposes: _____

Please Check Any Symptoms That have Been Persistent in the Last Three Months

- General**
- Chills
 - Fevers
 - Sweat easily
 - Night sweats
 - Localized weakness
 - Bleed or bruise easily
 - Peculiar tastes or smells
 - Strong thirst (cold or hot)
 - Thirst, no desire to drink
 - Fatigue
 - Sudden energy drop
Time of day? _____
 - Poor sleeping

- Edema
Where _____
 - Tremors
 - Poor balance
 - Cravings
 - Change in appetite
 - Poor appetite
 - Weight gain
 - Weight loss
- Skin and Hair**
- Rashes
 - Itching
 - Change in hair or skin

- Ulcerations
 - Eczema
 - Oozing on skin lesion
 - Hives
 - Pimples
 - Recent moles
 - Loss of hair
 - Dandruff
 - Other hair or skin problems: _____
- Head, Eyes, Ears, Nose
And Throat**
- Dizziness

- Migraines
- Headaches
When: _____
Where: _____
- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts

- Eye dryness
 - Excessive tear
 - Discharge from eyes
 - Poor hearing
 - Ringing in ears
 - Earaches
 - Discharge from ear
 - Nose bleeds
 - Sinus congestion
 - Nasal drainage
 - Grinding teeth
 - Teeth problems
 - Jaw clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips or tongue
- Other head or neck problems:
-
-

CARDIOVASCULAR

- High blood pressure
 - Low blood pressure
 - Chest discomfort/pain
 - Heart palpitations
 - Cold hands or feet
 - Swelling of hands
 - Swelling of feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart or blood vessel problems:
-
-

RESPIRATORY

- Cough
 - Asthma/wheezing
 - Pain with a deep breath
 - Difficulty in breathing when lying down
 - Production of phlegm what color: _____
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems:
-
-

GASTROINTESTINAL

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion

- Diarrhea
 - Constipation
 - Chronic laxative use
 - Blood in stools
 - Black stools
 - Abdominal pain or cramps
 - Gas
 - Rectal pain
 - Hemorrhoids
- Other stomach or intestinal problems:
-
-

GENITO-URINARY

- Pain on urination
 - Urgency to urinate
 - Frequent urination
 - Blood in urine
 - Decrease in flow
 - Unable to hold urine
 - Dribbling
 - Kidney stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Other genital or urinary system problems:
-
-

Do you wake up to urinate?
 Yes No
 How often?

Any particular color to your urine?

PREGNANCY AND GYNECOLOGY

- Number of pregnancies _____
 - Number of births _____
 - Premature births _____
 - Miscarriages _____
 - Abortions _____
 - Age at first menses _____
 - Period between menses _____
 - Duration _____
- First date of last menses:
 _____ / _____ / _____
- Unusual character
 - heavy
 - light
 - Painful periods
 - Irregular periods
 - Changes in body/psyche prior to menstruation
 - Clots
 - Menopause:
 - Age _____
 - Year _____

- Vaginal discharge
 - Postcoital bleeding
 - Vaginal sores
 - Last Pap
 - Breast lumps
 - Nipple discharge
- Do you practice birth control?
 Yes No
- What type and for how long?
-
-

MUSCULOSKELETAL

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pains
- Hip pain
- Knee pain
- Foot/ankle pains
- Muscle pains
- Muscle weakness

NEUROPSYCHOLOGICAL

- Seizures
 - Areas of numbness
 - Weakness
 - Sleep disorder
 - Concussion
 - Bad temper
 - Loss of control/violence potential
 - Vertigo
 - Lack of coordination
 - Depression
 - Easily susceptible to stress
 - Loss of balance
 - Poor memory
 - Anxiety
 - Substance abuse
- Other neurological or psychological problems
-
-

Have you ever been treated for emotional problems?
 Yes No

Have you ever considered or attempted suicide?
 Yes No

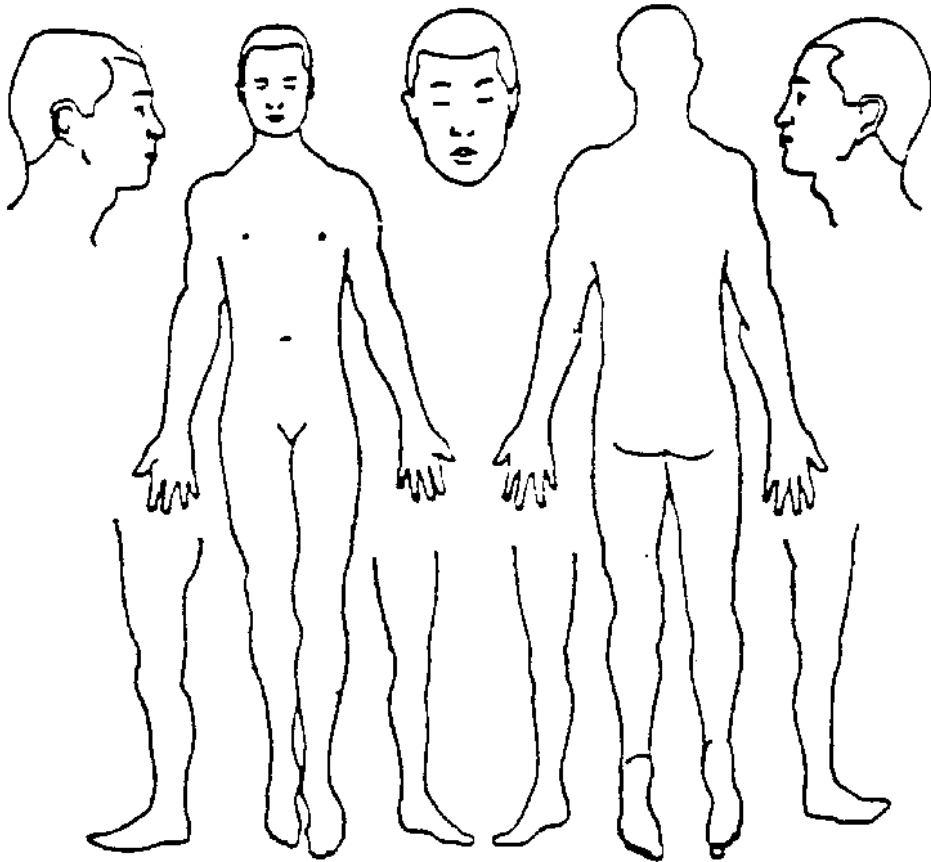
Please note the degree of severity of your problem now:



Please note the greatest degree of severity of your problem within the last week:



Indicate painful or distressed areas:



Comments (please tell us any other problems you would like to discuss): _____

INSURANCE INTAKE FORM

Chris Huson M.Ac., L.Ac.

Verify Benefits _____

PATIENT Name _____ Address _____ _____ Employer _____	Date of Birth _____ Phone (Home) _____ Phone (Work) _____ Single ____ Married ____ Male ____ Female _____ ID# _____ Group# _____ Phone# _____
PRIMARY PLAN INFORMATION Plan Name _____ Address _____ _____	INSURED INFORMATION, IF OTHER THAN YOURSELF Name _____ Address _____ _____
RELATIONSHIP TO INSURED Self ____ Child ____ Spouse ____ Other _____	Date of Birth _____ ID# or Claim# _____ Adjuster's Name _____ Date of Injury _____ Name of Insured _____
SECONDARY INSURANCE INFORMATION Plan Name _____ Address _____ _____ Phone# _____	

I agree to the release of any medical information my health insurance may need in order to process payment. I assign some benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment.

I understand that I am personally responsible for all fees incurred unless other arrangements have been made.

Signature _____ Date _____

Chris Huson M.Ac., L.Ac.

(Acupuncture License #217)

126 10th Ave E.

Seattle, WA 98102

(206) 323-3277

FINANCIAL POLICY

David is a preferred provider for numerous insurance companies, and will directly bill your insurance if he is contracted with them. If you are not sure if you are eligible for insurance coverage, please check with your workplace benefits coordinator or directly with your insurance company. It would be helpful if you can find out if you have already met your deductible, and what your office co-payment is.

Co-payments and unmet deductibles are due at the time of the visit, unless you would prefer to pay for a series of payments at once. If you are waiting for a referral that has not yet been confirmed, you will need to pay out of pocket until the referral is finalized. If your insurance coverage is declined due to ineligibility or other reasons, you must pay for services rendered. Balances are due upon receipt of statement.

If your insurance does not cover our services, payment is due at time of visit. We accept cash, personal checks, and Visa/Mastercard. For any returned checks, a \$10 fee will be charged to you. If you have other medical insurance that will reimburse you, we will provide you with a billing statement that you can submit.

If you do have health insurance that is accepted by our office, missed appointments are not billable to your insurance company. There is a charge of \$25 for any missed appointments or for cancellation with less than 24 hours notice. Unavoidable emergencies will be considered reasonable exceptions. I have read and understand the above financial policies and agree to adhere to them in all respects.

Signature _____ Date _____

Chris Huson M.Ac., L.Ac.

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CONSENT FOR ORIENTAL MEDICINE

Scope of Practice

The "scope of practice" for an acupuncturist in the state of Washington includes but is not limited to the following list of techniques:

- Use of acupuncture needles to stimulate acupuncture points and meridians
- Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians
- Moxibustion
- Acupressure
- Cupping
- Dermal friction technique (gua sha)
- Infra-red
- Sonopuncture
- Laserpuncture
- Dietary advice based on traditional Chinese medical theory
- Point injection therapy (aquapuncture)

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: Side effects may include, but are not limited to the following: pain following treatment in insertion area, minor bruising, infection, needle sickness, broken needle, temporary discoloration of the skin, aggravation of symptoms existing prior to the treatment.

Patients with bleeding disorders, pacemakers, seizure disorders, or women who are currently pregnant, please notify the practitioner.

Potential benefits: Drugless relief of presenting symptoms, improved general health, elimination of the presenting problem, reduction of pain and associated symptoms.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by David Lerner regarding cure or improvement of my condition. I hereby release David Lerner from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate care.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Signature of Patient or guardian _____

Date _____

Chris Huson M.Ac., L.Ac.

126 10TH AVE. EAST

SEATTLE, WA 98102

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

I keep medical records of the health care services I provide for you. You may ask to see and copy your records. You may ask to correct your records. Your records will be kept confidential unless you give me written permission to release them or I am required to do so by law. I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. You may see your records or get more information about them by contacting my office.

For more information about our privacy practices please inquire with me.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Signature of patient or legal representative

Date