

Access Acupuncture, Inc.

24619 Washington Ave. Ste. 206

Murrieta, CA 92562

951.698.0102

New Patient Health History

(In order for us to give you the best care possible, please print legibly)

Name: _____ Date: ____/____/____
(first) (middle) (last)

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____ Cell _____

Emergency contact information Name _____ Relation _____ Number _____

Date of Birth: ____/____/____ Age: _____ Gender: M F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient, physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information legibly and indicate areas that might require further explanation with a question mark. Thank you.

1. When and where did you last receive health care? _____

For what reason? _____

Primary Physician's Name and Phone # _____

2. Have you had Acupuncture before? Y N Herbal Medicine? Y N

3. Chief Complaint _____

_____ Date of onset _____

3a. Please tell us your motivation level, on a scale of 1-10, to actively participate in your treatment and healing process: _____

4. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

5. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

6. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

9. Height: _____ Weight: _____ Maximum: _____ When? _____

8. Family History:

Allergies Arteriosclerosis Asthma Alcoholism Cancer Diabetes Heart Disease
 High Blood Pressure Seizures Stroke Other _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever /Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries, Imaging Studies:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Mental Tension/Stress Anxiety Depression

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
 Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
 Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Colds Difficulty Breathing Emphysema
 Persistent Cough Pleurisy Asthma Tuberculosis
 Shortness of Breath Other Respiratory Problems: _____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure
 Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Bloating	Constipation	Diarrhea	Acid Reflux	Distention	Changes in BM
Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain	Passing Gas	Abdominal Pain
Belching	Gall Bladder Disease	Liver Disease	Hepatitis B or C	Hemorrhoids	Pancreatitis
Other _____					

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent UTI	Frequent Urination
Kidney Stones	Impaired Urination	Blood in Urine	Frequent Urination at Night

21. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles	Breast Lumps/Tenderness	Nipple Discharge	Heavy Flow
Vaginal Discharge	Premenstrual Problems	Clotting	Bleeding Between Cycles
Menopausal Symptoms	Difficulty Conceiving	Painful Periods	Endometriosis
Fibroids	Cysts	STD (if so, what) _____	

22. **Menstrual/Birthing History:**

1. Age of First Menses: _____	4. Birth Control Type: _____	7. # of Abortions: _____
2. # of Days of Menses: _____	5. # of Pregnancies: _____	8. # of Live Births: _____
3. Length of Cycle: _____	6. # of Miscarriages: _____	

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties	Prostate Problems	Testicular Pain/Swelling	Penile Discharge
STD (if so, what) _____			

24. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain	Muscle Spasms/Cramps	Arm Pain	Upper Back Pain	Mid Back Pain
Low Back Pain	Leg Pain	Weakness		
Joint Pain	Osteoporosis	Arthritis		

25. **Neurological** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness	Paralysis	Numbness/Tingling	Loss of Balance	Seizures/Epilepsy
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26. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid	Hyperthyroid	Hypoglycemia	Diabetes Mellitus	Night Sweats	Feeling Hot or Cold
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27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia

Cancer

Rashes

Eczema/Hives

Cold Hands/Feet

Acne

28. Lifestyle:

- a. Do you typically eat at least three meals per day? Y N If no, how many? _____
- b. Exercise routine: _____
- c. Spiritual practice (i.e. prayer, meditation, etc.) _____
- d. How many hours per night do you sleep? _____ Do you wake rested? Y N
- e. Occupation: _____ Employer: _____ Hours/Week: _____
Do you enjoy work? Y/N Why/Why not? _____
- f. Nicotine/Alcohol/Caffeine Use: _____
- g. Have you experienced any major traumas? Y N Explain: _____

Is there anything else we should know? _____

Should you need to reschedule an appointment, **24 HOURS NOTICE** is required. If you fail to notify us 24 hours in advance, **you will be charged \$40 for your missed appointment.** A missed appointment is a loss for everyone. For a Monday cancellation, please call on Friday.

PATIENT SIGNATURE (or Patient Representative indicating relationship) _____ **DATE** _____

I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Signature _____ **Date** _____

<p>Would you like to receive our newsletter? _____</p> <p>How did you hear about us? _____</p>
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Privacy Policies

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorized.

Safeguards in place at our office include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – e.g. your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy.

By signing below I agree that I have read and acknowledge the above HIPAA regulations:

Signature: _____

Date: _____