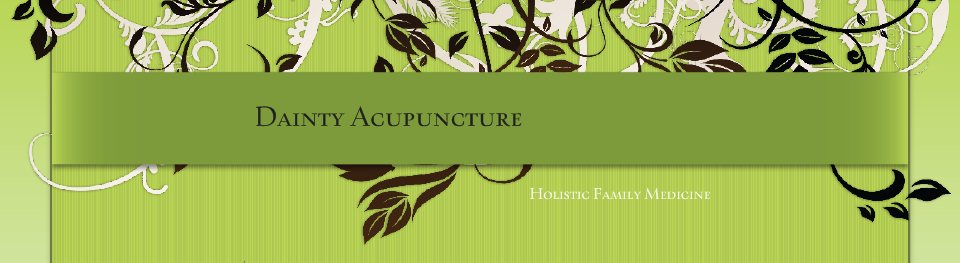


Patient Information

|  |
| --- |
| First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_  Gender M F Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­  Married □ Single □ Domestic Partner □  Name of Spouse/Partner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | |  | |



**Patient Health Questionnaire**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Goals:** What would you most like to achieve through your work at Dainty Acupuncture?

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major Symptoms:**

1. What is your chief complaint?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. When did this begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What have you tried?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. What makes it better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**

**Type Date**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications/Supplements:** Please list all medications that you currently take

**Name Dose Reason**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutrition**

1. Do you follow a special diet (i.e. Vegetarian, Low Carb, etc.)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. What do you eat on a “typical” day?

a. Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Food you tend to crave\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Food you dislike\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. How much coffee/tea/soda per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

1. How much per day do you use the following?

a. Alcohol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Cigarettes/cigars\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Other Drugs\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you ever had a problem with alcoholism? □ Yes □ No

3. Have you ever been dependent on other drugs? □ Yes □ No

4. If so, which one (s) and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Please describe your current exercise regimen:

Hours per week\_\_\_\_\_\_\_\_\_ Activities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. How many hours do you sleep per night during the week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you wake feeling rested? □ Yes □ No

8. Do you feel you sleep well at night? □ Yes □ No

9. Have you been treated for emotional issues? □ Yes □ No

10. Have you ever considered or attempted suicide? □ Yes □ No

**For Women Only**

1. Are you pregnant now? □ Yes □ No □ Unsure

2. Number of occurrences

Live Births\_\_\_\_ Pregnancies\_\_\_\_ Miscarriages\_\_\_\_ Abortions\_\_\_\_

3. Age of first menses\_\_\_\_\_ Menopause (if applicable)\_\_\_\_\_

4. Date of last Pap Smear\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal? □ Yes □ No

5. Date of last Mammogram?\_\_\_\_\_\_\_\_\_\_\_\_\_ Normal? □ Yes □ No

6. Is your cycle regular? □ Yes □ No

7. Are you on birth control (pill, patch)? □ Yes □ No

8. Average number of days of flow? \_\_\_\_\_

9. Flow is □ Normal □ Heavy □ Light

10. The color is □ Fresh Red □ Dark □ Purple □ Brown □ With Clots

11. Do you have the following menstruation related symptoms?

□ Cramps □ Nausea □ Breast Distention □ Emotional Changes

□ Headache □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Do you have the following general symptoms?

□ Pain with Intercourse □ Bleeding Between Periods

□ Vaginal Discharge □ Vaginal Odor

**For Men Only**

1. Please check all that apply

□ Erectile Dysfunction □ Premature Ejaculation

□ Testicular Swelling/Pain □ Enlarged Prostate

□ Prostate Cancer □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you get up at night to urinate? □ Yes □ No If so, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_

3. To what extent do these conditions interfere with your daily activities?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you sought medical intervention for these conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. What treatments have you tried & how successful were they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Please check all that apply & state how you are related to the family member with that condition.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Mother** | **Father** | **Sibling** | **Child** | **Grandparent** |
| Heart Disease |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| Hypertension |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Asthma |  |  |  |  |  |
| Allergies |  |  |  |  |  |
| Migraines |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |
| Substance Abuse |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |

**Please check all that apply.**

**General Cardiovascular Female**

Past/Current Condition Past/Current Condition Past/Current Condition

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| □ | □ | Poor Appetite | □ | □ | High Blood Pressure | □ | □ | Frequent UTI |
| □ | □ | Excessive Appetite | □ | □ | Low Blood Pressure | □ | □ | Vaginal Infections |
| □ | □ | Insomnia | □ | □ | Blood Clots | □ | □ | Genital Itch/Pain |
| □ | □ | Fatigue | □ | □ | Palpitations | □ | □ | PID |
| □ | □ | Night Sweats | □ | □ | Phlebitis | □ | □ | Abnormal Pap Smear |
| □ | □ | Sweat Easily | □ | □ | Chest Pain | □ | □ | Irregular Menses |
| □ | □ | Localized Weakness | □ | □ | Irregular Heartbeat | □ | □ | Menopause |
| □ | □ | Change in Appetite | □ | □ | Cold Hands/Feet | □ | □ | Breast Lumps |
| □ | □ | Bleed/Bruise Easily | □ | □ | Fainting | □ | □ | Hot Flashes |
| □ | □ | Strong Thirst | □ | □ | Swollen Hands/Feet | □ | □ | PMS |

**Skin Head & Neck Eyes & Ears**

Past/Current Condition Past/Current Condition Past/Current Condition

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| □ | □ | Rashes | □ | □ | Dizziness | □ | □ | Blurry Vision |
| □ | □ | Hives | □ | □ | Fainting | □ | □ | Visual Changes |
| □ | □ | Proriasis | □ | □ | Neck Stiffness | □ | □ | Poor Night Vision |
| □ | □ | Eczema | □ | □ | Enlarged Glands | □ | □ | See Spots in Vision |
| □ | □ | Pimples/Acne | □ | □ | Headaches | □ | □ | Ear Infections |
| □ | □ | Dryness | □ | □ | Migraines | □ | □ | Ears Ringing |
| □ | □ | Tumors/Lumps | □ | □ | Concussion | □ | □ | Decreased Hearing |

**Nose, Throat, Mouth Genito-Urinary Muscular-Skeletal**

Past/Current Condition Past/Current Condition Past/Current Condition

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| □ | □ | Nose Bleeds | □ | □ | Kidney Stones | □ | □ | Stiff Neck/Shoulders |
| □ | □ | Sinus Infections | □ | □ | Pain on Urination | □ | □ | Low Back Pain |
| □ | □ | Allergies | □ | □ | Frequent Urination | □ | □ | Upper/Mid Back Pain |
| □ | □ | Sore Throat | □ | □ | Blood in Urine | □ | □ | Muscle Spasms |
| □ | □ | Grinding Teeth | □ | □ | Urgency to Urinate | □ | □ | Joint Pain/Arthitis |
| □ | □ | Difficulty Swallowing | □ | □ | Incontinence | □ | □ | Sore/Cold/Weak Knees |

**Neurological Psychological Male**

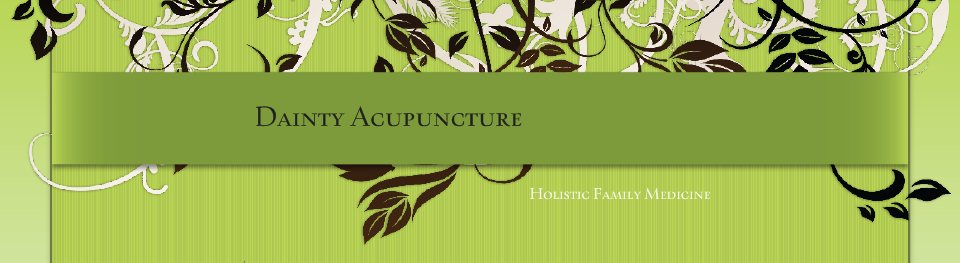
Past/Current Condition Past/Current Condition Past/Current Condition

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| □ | □ | Seizures | □ | □ | Depression | □ | □ | Genital Pain/Itching |
| □ | □ | Tremors | □ | □ | Anxiety | □ | □ | Genital Lesions |
| □ | □ | Numb/Tingling Limbs | □ | □ | Irritability | □ | □ | Discharge |
| □ | □ | Concussion | □ | □ | Mania | □ | □ | Impotence |
| □ | □ | Paralysis | □ | □ | Suicidal | □ | □ | Enlarged Prostate |
| □ | □ | Stroke |  |  |  | □ | □ | Prostate Cancer |
| □ | □ | Poor Coordination |  |  |  |  |  |  |

**Gastro-Intestinal Respiratory Infectious Screening**

Past/Current Condition Past/Current Condition Past/Current Condition

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| □ | □ | Nausea | □ | □ | Asthma | □ | □ | HIV |
| □ | □ | Vomiting | □ | □ | Bronchitis | □ | □ | TB |
| □ | □ | Diarrhea | □ | □ | Pneumonia | □ | □ | Hepatitis |
| □ | □ | Constipation | □ | □ | Frequent Colds/Flus | □ | □ | Gonorrhea |
| □ | □ | Belching | □ | □ | Cough | □ | □ | Chlamydia |
| □ | □ | Gas | □ | □ | Coughing Blood | □ | □ | Syphilis |
| □ | □ | Black/Bloody Stools | □ | □ | Coughing Phlegm | □ | □ | Genital Warts/HPV |
| □ | □ | Bad Breath | □ | □ | Fever | □ | □ | Herpes/Oral |
| □ | □ | Hemorrhoids | □ | □ | Chills | □ | □ | Herpes/Genital |
| □ | □ | Acid Reflux | □ | □ | Wheezing |  |  |  |



**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Dainty Acupuncture (DA), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

We will not release this information unless we receive a subpoena or an Authorization to Release Records signed by you.

DA may call my home or other designated location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance information, and any call pertaining to my clinical care.

DA may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patients statements marked Personal and Confidential.

DA may email me appointment reminders and patient statements.

I have the right to request that DA restrict how it uses or discloses my PHI to carry out TPO. By signing this form, I am consenting to DA use and disclosure of my PHI to carry out TPO.

I may revoke my consent at any time in writing. If I do not sign this consent, DA may decline to provide treatment to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

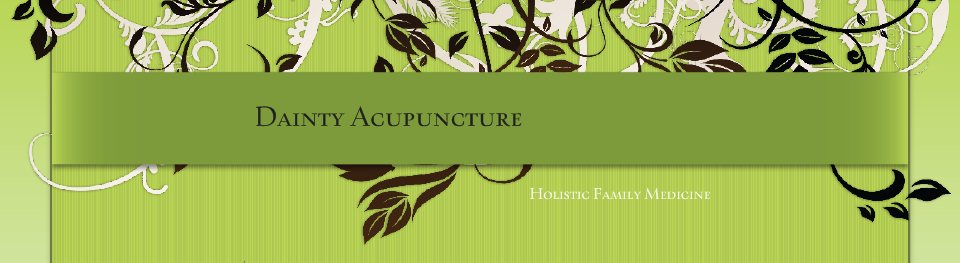
Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date



**Terms and Conditions of Service**

Acupuncture Information and Guidelines

Acupuncture is designed to naturally balance, heal, and rejuvenate the body. In order to fully absorb and integrate the benefits of your treatment, avoid strenuous activity or stressful situations for the remainder of the day. Please drink plenty of water after your treatment. Please inform your practitioner of any sensitivities, injuries, or transmittable diseases to ensure your safety, and the safety of your practitioner.

Office Policies

Cancellations and rescheduling of appointments must be done at least 24 hours in advance. You will be charged the full price of your service for any cancellations made less than 24 hours before the scheduled appointment. A bill will be mailed to the address you provided to us. A $25.00 fee will be charged for any returned checks. Returned checks must be replaced by a secured form of payment (credit card or cash). Payment is due when services are rendered. By signing below, you authorize the release of any information necessary to your insurance company in order to process your claim. Should accounts be referred to an attorney or collection agency, attorney’s fees and collection expenses incurred shall be payable in addition to the other previous amounts due.

Medical Records

Dainty Acupuncture will not release your records to anyone unless you have signed the “Release of Records” form, or we are instructed to do so by a subpoena or your insurance company. You give Dainty Acupuncture permission to obtain medical records from previous physicians or medical centers.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date