Acupuncture & Wellnes Center, LLC
930 SE Cary Parkway, Ste. 104
Cary, NC 27518
(919) 859-2500


## Health History Questionnaire

**Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.**

***All information is strictly confidential***

**General Patient Information**

Last Name: First Name:

Address:

City: State: AL Zip:

Home Phone: Work Phone: Cell Phone:

E-Mail: Social Security Number:

Would you like to receive our monthly electronic newsletter? Select

Age: Date of Birth: Place of Birth:

Gender: Select Height: Weight: Marital Status: Select

Employer: Occupation:

Guardian: (if under 18) Guardian Phone Number:

How did you learn about Acupuncture & Wellness Center?

Major Complaint(s), in order of significance to you:

1.
2.
3.
4.

How do these conditions interfere with your daily activities?

1.
2.
3.
4.

Please list any medications that your are taking:

Please list any vitamins, herbs or supplements you are taking:

Please list any surgeries you have had and when:

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## Medical History

**Check any you have had in the past.**

- ☐ Diabetes
- ☐ Allergies
- ☐ Glaucoma
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ CVA (Stroke)
- ☐ Vein Condition
- ☐ Thyroid Disorder
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Jaundice
- ☐ Gonorrhea
- ☐ Mumps
- ☐ Bleeding Tendency
- ☐ Syphilis
- ☐ Measles
- ☐ Chicken Pox
- ☐ Nervous Disorder
- ☐ Meningitis
- ☐ HIV
- ☐ Polio
- ☐ Mononucleosis
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Cancer
- ☐ Migraines
- ☐ High Blood Pressure
- ☐ High Fever
- ☐ Other Heart Illnesses
- ☐ Other Kidney Illnesses
- ☐ Other Liver Illnesses
- ☐ Other Lung Illnesses
- ☐ Other:
- ☐ Other:
- ☐ Other:

**Recent Tests & Immunizations -** Please indicate test results and date below

| | Test Results | Date |
|---|---|---|
| ☐ Physical | | |
| ☐ Cholesterol | | |
| ☐ Blood | | |
| ☐ HIV/STD | | |
| ☐ Mammography | | |
| ☐ Pap Smear | | |
| ☐ Prostate | | |
| ☐ Other | | |
| ☐ Other | | |

Immunization:

Immunization:

Immunization:

Any Adverse Reactions?

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## Pain Issues

Please clearly state any instances of pain.

**Is the pain...**

- ☐ Sharp
- ☐ Burning
- ☐ Aching
- ☐ Cramping
- ☐ Dull
- ☐ Moving
- ☐ Fixed
- ☐ Other

**Do the following lessen the pain?**

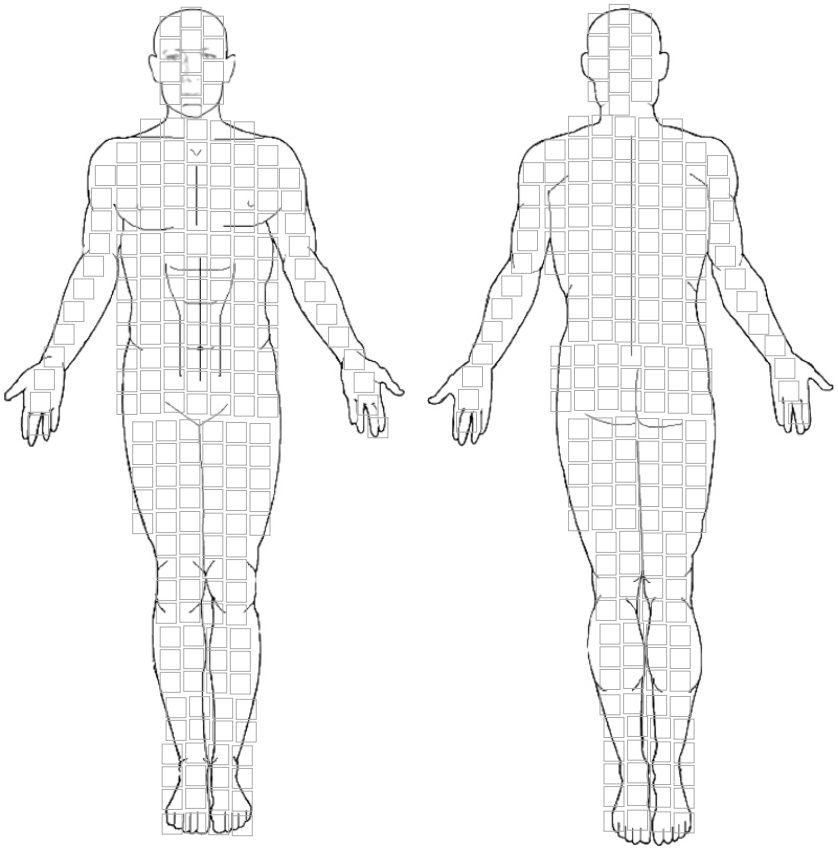
- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other
- ☐ Other

**Do the following worsen the pain?**

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other
- ☐ Other

Click on the images to the right to indicate any areas you are experiencing pain.

You may select as many locations as you like.



## Symptoms And Conditions

Please check the following that currently pertain to you. If you have symptoms in the following categories, it indicates that you have a problem with that organ's function:

### Overall Temperature- Kidney Function

- ☐ Cold hands
- ☐ Cold fingers
- ☐ Cold feet
- ☐ Cold toes
- ☐ Sweaty hands
- ☐ Sweaty feet
- ☐ Hot body temperature (sensation)
- ☐ Cold body temperature (sensation)
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Heat in the hands, feet, and chest
- ☐ Hot flashes any time of the day
- ☐ Thirsty
- ☐ Perspire easily
- ☐ Lack of perspiration
- ☐ Take water to bed

### Overall Energy- Lung/Kidney Function

- ☐ Shortness of breath
- ☐ Difficulty keeping eyes open- daytime
- ☐ General weakness
- ☐ Easily catch colds
- ☐ Low energy
- ☐ Feel worse after exercise

### Overall Blood Liver/Spleen/Heart Function

- ☐ Dizziness
- ☐ See floating black spots

### Heart Function

- ☐ Palpitations
- ☐ Anxiety
- ☐ Sores on the tip of the tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Pacemaker
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Drink coffee-# cups per day: Select

### Lung Function

- ☐ Nasal Discharge-Color:
- ☐ Cough
- ☐ Nose Bleeds
- ☐ Sinus Congestion
- ☐ Dry Mouth
- ☐ Dry Throat
- ☐ Dry Nose
- ☐ Dry Skin
- ☐ Allergies- To What?
- ☐ Alternating Fever and Chills
- ☐ Sneezing
- ☐ Headache: Select
- ☐ Overall Achy Feeling In The Body
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Sore Throat
- ☐ Difficulty Breathing
- ☐ Smoke Cigarettes-# Per Day: Select
- ☐ Sadness
- ☐ Melancholy

### Spleen Function

- ☐ Low Appetite
- ☐ Abrupt Weight Gain
- ☐ Abrupt Weight Loss
- ☐ Abdominal Bloating
- ☐ Abdominal Gas
- ☐ Gurgling Noise In Stomach
- ☐ Fatigue After Eating
- ☐ Prolapsed Organs-Diagnosed
- ☐ Easily Bruised
- ☐ Hemorrhoids
- ☐ Pensive
- ☐ Over-Thinking
- ☐ Worry

### Spleen, Stomach, Large Intestine Function

- ☐ Loose Stool
- ☐ Constipated
- ☐ Incomplete Evacuation
- ☐ Diarrhea
- ☐ Blood In Stools
- ☐ Mucous In Stools
- ☐ Undigested Food In Stools

### Dampness In The Body

- ☐ General Sensation Of Heaviness In The Body
- ☐ Mental Heaviness
- ☐ Mental Sluggishness
- ☐ Mental Fogginess
- ☐ Swollen Hands
- ☐ Swollen Feet
- ☐ Swollen Joints
- ☐ Chest Congestion
- ☐ Nausea
- ☐ Snoring

## Symptoms And Conditions - Continued

### Stomach Function

- [ ] Burning Sensation After Eating
- [ ] Large Appetite
- [ ] Bad Breath
- [ ] Mouth (Canker) Sores
- [ ] Bleeding, Swollen Or Painful Gums
- [ ] Heartburn
- [ ] Acid Regurgitation
- [ ] Ulcer- Diagnosed
- [ ] Belching
- [ ] Hiccoughs
- [ ] Stomach Pain
- [ ] Vomiting

### Liver/Gall Bladder Function

- [ ] Alternation Diarrhea And Constipation
- [ ] Chest Pain
- [ ] Tight Sensation In The Chest
- [ ] Bitter Taste In The Mouth
- [ ] Anger Easily
- [ ] Frustration
- [ ] Depression
- [ ] Irritability
- [ ] Frequently Unable To Adapt To Stress
- [ ] Skin Rashes
- [ ] Headache At The Top Of The Head
- [ ] Tingling Sensation
- [ ] Numbness
- [ ] Muscle Spasms
- [ ] Muscle Twitching
- [ ] Muscle Cramping
- [ ] Seizures
- [ ] Convulsions
- [ ] Lump In The Throat
- [ ] Neck Tension
- [ ] Limited Range-Of-Motion, Neck
- [ ] Shoulder Tension
- [ ] Limited Range-Of-Motion, Shoulder
- [ ] Drink Alcohol
- [ ] High-Pitched Ringing In The Ears
- [ ] Gall Stones
- [ ]

### Eyes- Liver Function

- [ ] Itchy
- [ ] Bloodshot
- [ ] Hot
- [ ] Dry
- [ ] Watery
- [ ] Gritty
- [ ] Blurry Vision
- [ ] Decreased Night Vision
- [ ] Near-Sighted
- [ ] Far-Sighted

### Kidney/Urinary Bladder Function

- [ ] Frequent Cavities
- [ ] Easily Broken Bones
- [ ] Sore Knees
- [ ] Weak Knees
- [ ] Cold Sensation In The Knees
- [ ] Low Back Pain
- [ ] Memory Problems
- [ ] Wake Twice Or More To Urinate
- [ ] Low-Pitched Ringing In The Ears
- [ ] Kidney Stones
- [ ] Bladder Infections
- [ ] Lack Of Bladder Control
- [ ] Fear
- [ ] Easily Startled
- [ ] Excessive Hair Loss

### Urination

- [ ] Normal Color
- [ ] Dark Yellow
- [ ] Clear
- [ ] Reddish
- [ ] Cloudy
- [ ] Scanty
- [ ] Profuse
- [ ] Strong Odor
- [ ] Blood
- [ ] Painful
- [ ] Discharge
- [ ] Difficult
- [ ] Painful
- [ ] Urgent
- [ ] Frequent

**Libido:** Select

## For Women Only

**Regular Menstrual Cycle?**
Select

**Pregnant At This Time?**
Select

**Number of Children**
Select

**Number Of Pregnancies?**
Select

**Age of First Menstruation**
Select

**Age Of Menopause?**
Select

**Average # Of Days Of Flow?**
Select

**Average # Of Days Of Cycle?**
Select

**Vaginal Discharge?**
Select

**Bleeding Between Periods?**
Select

**Do You Experience Any Of The Following Pre-Menstrual Syndromes?**

- ☐ Nausea
- ☐ Vomiting
- ☐ Water Retention
- ☐ Breast Swelling
- ☐ Food Cravings
- ☐ Headaches
- ☐ Migraines
- ☐ Breast Tenderness
- ☐ Irritability
- ☐ Anxiety
- ☐ Depression
- ☐
- ☐
- ☐

**Please answer the following questions about your menstruation. Select all that apply.**

**Your Menstrual Cycle Is Generally:**

**Color:** ☐ Normal ☐ Bright ☐ Red ☐ Pale ☐ Brown ☐ Rust ☐ Other

**Amount of Flow?** Select

**Pain / Cramps?** Select

**Clots?** Select

**Vomiting?** Select

**Nausea?** Select

**Other Comments:**

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## Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/ or substances from the Oriental Materia Medica by the licensed Acupuncturist, Cindi Fox Kemp, DOM, AP (FL), L.Ac., of the Acupuncture & Wellness Center.

**Acupuncture/Moxibustion**: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body?s physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Cupping:** I understand that if I receive cupping as part of therapy, there is a likelihood of bruising and/or discoloration on the body-area on which cupping is preformed. There may also be a slight probability of mild discomfort from this procedure. I understand that I may refuse this therapy.

**Chinese Herbs**: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction of diseases, to modify or prevent pain perception, and to normalize the body?s physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to : changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Acupuncture & Wellness Center immediately.

**Acupressure/ Tui-Na Massage**: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body?s physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture**: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

By entering my name below, I am indicating my intent to electronically sign this Consent to Treatment form and warrant that all of the information I have provided is true, complete, and accurate.

| | | |
|---|---|---|
| Please type your name in the spaces to electronically sign your form: | | |
| Please re-type your name in the spaces to confirm your electronic signature: | | |

Completed And Signed On:

Signature of parent or guardian if patient is a minor (under 18 years of age)

By entering my name below, I am indicating my intent to electronically sign this Consent to Treatment form and warrant that all of the information I have provided is true, complete, and accurate.

| | | |
|---|---|---|
| Please type your name in the spaces to electronically sign your form: | | |
| Please re-type your name in the spaces to confirm your electronic signature: | | |

Completed And Signed On:

## Notice of Privacy Practices for Protected Health Information

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!**

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

**Example of uses of your health information for treatment purposes:**
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

**Example of use of your health information for payment purposes:**
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

**Example of use of your information for health care operations:**
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

**Your health information rights:**

**The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:**

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office; Appeal a denial of access to your protected health information except in certain circumstances; Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office; File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care; communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office at (919) 859-2500 during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

**Our Responsibilities**
**The practice is required to:**

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and Accommodate your reasonable requests regarding methods to communicate health information with you.
- We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice.
- You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our “Notice” or by visiting our office and picking up a copy.

## Notice of Privacy Practices for Protected Health Information - Continued

**To Request Information or File a Complaint**

**If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office at (919) 859-2500.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services .

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

**Other Disclosures and Uses**

**Notification**
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

**Communication with Family**
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

**Food and Drug Administration (FDA)**
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

**Workers Compensation**
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

**Public Health**
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse & Neglect**
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

**Correctional Institutions**
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

**Law Enforcement**
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

**Health Oversight**
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

**Judicial/Administrative Proceedings**
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

**Other Uses**
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

**Website**
If we maintain a website that provides information about our entity, this Notice will be on the website.

By entering my name below, I am indicating my intent to electronically sign this form:

Please type your name in the spaces to electronically sign your form:

Please re-type your name in the spaces to confirm your electronic signature:

Completed And Signed On:

Relationship to patient (if other than patient):

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930 SE Cary Parkway, Ste. 104
Cary, NC 27518
(919) 859-2500


## Patient Questionnaire

Please complete this page to let us know how you would like to be contacted.

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation:

Name: Phone:

Name: Phone:

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: Phone:

Name: Phone:

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

Address:

City: State: AL Zip:

Please indicate if you want all correspondence from out office sent in a sealed envelope marked "CONFIDENTIAL":

Select

Please print the phone number where you would like to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

Phone:

Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

Select

24 hour Cancellation policy: If you need to cancel your initial or any future appointment, please give us 24 hours notice, or you will be charged full fees for the missed appointment.

| Type | Credit Card Number | Expiration | CCV |
|---|---|---|---|
| Select | | | |

By entering my name below, I am indicating my intent to electronically sign this form:

Please type your name in the spaces to electronically sign your form:

Please re-type your name in the spaces to confirm your electronic signature:

Completed And Signed On:

Relationship to patient (if other than patient):

Print Form