Acupuncture Works, LLC
Initial Health Status

General Information:
Date:__________
Patient Full Name: ____ Date of Birth: ____________
Address: ____
City: ______________ State: __ Zip: ___________ Email: ________________________________
Home Phone: ____________ Work Phone: __________ Employer: __________________________
Occupation: __________________ Emergency Contact: __________________________________

Email address: ____
Is it okay to contact you by email:_____

Primary Care Physician: ______________________________ Phone: ______________________
Date of Last Physical Exam:________________ By Whom:_________________________________

How did you hear about the clinic?____

Reason for Visit:
Please describe in detail why you are here and major health goal: ___________________________
____
____
____
____
____

Date of Onset: _____________ Sudden/Gradual Have you had this in the past? No ☐ Yes ☐

When ______________ Severity (1 – 10, 10 worse) _________________

What makes it better? ____

What makes it worse?____

Is the condition: Getting Worse ☐ Improving ☐ Constant ☐ Comes and Goes ☐

How often are your symptoms present? Constant ☐ Frequent ☐ Sporadic ☐

Are your symptoms preventing you from daily activity: All Activity ☐ Some Activity ☐
Not at All ☐

Have you seen a physician or other practitioner for this condition: No ☐ Yes ☐

Please describe what treatments you have taken for the above condition and the results (Surgery, Chiropractic, Medications, Injections, Herbal….): ______________________________________

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____

Family Medical History:

Please check any illness or condition that a family member may have had in the past.

AIDS ☐ Asthma ☐ Allergies ☐ Alcoholism ☐ Antibiotic use ☐
Arthritis ☐ Artificial Joint ☐ Bleeding Tendencies ☐ Blood Disorder ☐ Breast Lumps ☐ Cancer ☐ Chicken Pox ☐ Convulsions or Seizures ☐ Depression ☐ Diabetes ☐
Glaucoma ☐ Gonorrhea ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ HIV ☐
Jaundice Kidney Disease ☐ Lupus ☐ Meningitis ☐ Mononucleosis ☐ Multiple Sclerosis ☐ Measles ☐ Mental Illness ☐ Polio ☐ Rheumatic Fever ☐ Stroke ☐
Thyroid Disease ☐ Other:____

Personal Medical History:

Describe your overall health:____

Please check any illness or condition that you may have now or in the past.

AIDS ☐ Asthma ☐ Allergies ☐ Alcoholism ☐ Antibiotic use ☐
Arthritis ☐ Artificial Joint ☐ Bleeding Tendencies ☐ Blood Disorder ☐ Breast Lumps ☐ Cancer ☐ Chicken Pox ☐ Convulsions or Seizures ☐ Depression ☐ Diabetes ☐
Glaucoma ☐ Gonorrhea ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure ☐ HIV ☐
Jaundice Kidney Disease ☐ Lupus ☐ Meningitis ☐ Mononucleosis ☐ Multiple Sclerosis ☐ Measles ☐ Mental Illness ☐ Polio ☐ Rheumatic Fever ☐ Stroke ☐
Thyroid Disease ☐ Other:____

Please list any surgeries including date and physician: ____________________________________

____

____

____

Please list any other traumas, injuries … and the dates they occurred: ________________________

____

____

____

Prescription Medications and Supplements:

Please list current medications, supplements, and herbs that you are taking including dose and frequency: ____

____

____

____

Do you have any history of or currently experience any of the following:

HEAD: Headaches ☐ What area______________________________ Frequency:___________
Dizziness ☐ Memory Loss ☐ Confusion ☐ Loss of Balance ☐
Other:____

SKIN: Dry ☐ Itchy ☐ Moist/Clammy ☐ Burning ☐ Change in moles/lumps (cysts) ☐
Boils ☐ Acne ☐ Rashes ☐ Hives ☐ Hair Loss/thinning ☐ Dry Scalp ☐
Skin Puffy/edema ☐ Where? ____
List all scars from accidents or surgeries____
Other: ____

SWEATING: Night Sweats ☐ Rarely Sweat ☐ Excessive Sweating ☐

CIRCULATION: Feelings of Hot ☐ Cold ☐ What area?______________________________
Cold Limbs ☐ Bruise Easily ☐ Other:____

BLOOD PRESSURE: Normal ☐ High ☐ Low ☐ Unsure ☐ Other:________________________

MUSCULOSKELETAL PAIN: Neck ☐ Shoulders ☐ Arms/Hands ☐ Elbow ☐
Fingers ☐ Hip ☐ Thighs ☐ Knee ☐ Calves ☐ Ankles ☐ Toes ☐ Upper Back ☐
Mid Back ☐ Low Back ☐ Leg cramps at night ☐ Weakness in legs/knees/ankles ☐
Weakness arms, hands, fingers ☐ Tingling or Numbness in Hands/Feet ☐
Muscle Spasms, cramps, twitches ☐ Bones sore/painful/weak ☐ Painful Joints ☐
Stiff all over ☐ Bursitis ☐ Other:____

NEUROLOGICAL: Tremors ☐ Numbness/tingling in limbs ☐ Muscle weakness ☐
Seizures ☐ Nerve Pain ☐ Shingles ☐ Paralysis ☐ Other:__________________________

EYES: Pain ☐ Dry ☐ Blurry Vision ☐ Dark circles under eyes ☐ Floaters ☐
Other: ____

EARS: Poor Hearing ☐ Earaches ☐ Discharge/Infections ☐ Ringing High/Low ☐
Other:____

NOSE: Frequent Nosebleeds ☐ Sinus Trouble ☐ Frequent Colds ☐ Constant Discharge ☐
Allergies ☐ Please list: ____
Other: ____

THROAT/MOUTH: Sore throat ☐ When/Frequency ___________________________________
Hoarseness ☐ Difficulty Swallowing ☐ Jaw Problems☐ Teeth Problems☐ Speech Problems☐
Bleeding/Swollen/Painful Gums ☐ Mouth/Tongue Sores ☐ Unusual Tastes ☐
Other: ____

CHEST: Hard to Breathe ☐ Wheezing ☐ Shortness of Breath ☐ Palpitations ☐
Mucus/rattling with breathing ☐ Pain or Pressure in Chest ☐
Persistent Cough ☐ How Long ______________ Coughing Blood ☐ How Long ____________
Coughing Phlegm ☐ How Long _________ Color and Consistency__________________________

APPETITE: Excessive Appetite ☐ Poor Appetite ☐ Appetite keep changing ☐
Feel tired after eating ☐ Feel tired, weak or irritable if a meal is missed ☐
Food Cravings ☐ What are they?____
Excessive Thirst ☐ Never Thirsty ☐

DIGESTION: Stomach gas ☐ Lower bowel gas/cramping ☐ Heartburn ☐ Belching ☐
Nausea ☐ Vomiting ☐ Stomach pains/cramp ☐ Bad Breath ☐ Weight Gain ☐
Weight Loss ☐ Abdominal Bloating ☐ Food Allergies ☐ __________________________
Other: ____

URINE: Difficulty ☐ Painful or Burning ☐ Blood in Urine ☐ Loss of Bladder Control ☐
Frequent Infections ☐ Frequent at Night ☐ Color: ___________________________________
Other:____

BOWELS: Diarrhea ☐ Constipation ☐ Alternating Diarrhea/Constipation ☐
Bloody Stools ☐ Black Stools ☐ Mucus in stools ☐ Hemorrhoids ☐ Lower Bowel gas ☐
Colon Problem ☐ Number of Bowel movements daily _____ Other: _____________________

NUTRITION: How many meals a day do you eat _____ When is the biggest meal ___________
Do you eat breakfast? Yes ☐ No ☐ Sometimes ☐
Do you eat fresh fruit and vegetables at least twice per day? Yes ☐ No ☐ Sometimes ☐
Are you vegan or vegetarian? ☐ Explain ____
Do you eat when you are not hungry? Yes ☐ No ☐ Sometimes ☐
Do you eat until you feel full ? Yes ☐ No ☐ Sometimes ☐
Do you "crash" diet? Yes ☐ No ☐ Sometimes ☐
Have you ever fasted? Yes ☐ No ☐ Type:____
How many glasses of water do you drink a day? _____________
How do you like your liquids? Hot ☐ Ice Cold ☐ Room Temperature ☐

SLEEP: Restful ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ # Hrs of sleep ______
Excess dreaming/nightmares ☐ Other: ____

EMOTIONAL: Depression ☐ Anxiety ☐ Worry ☐ Suicidal ☐ Easily Angered ☐
Easily irritated ☐ Frequent crying ☐ Mood swings ☐ How is your stress level?
None/Low ☐ Moderate ☐ Severe ☐ Cause ____
How do you feel you are handling your stress? ____
Are you being treated for emotional/psychological problems Yes ☐ No ☐ _________________
Do you have a group of family or friends for emotional support Yes ☐ No ☐ Unsure ☐
In general what is your day to day mood (ex: happy , stressed, overwhelmed…) _______________

Are you currently in a satisfying:
Marriage/Partnership Yes ☐ No ☐ Unsure ☐
Career/School Yes ☐ No ☐ Unsure ☐
Have you set goals for yourself? Yes ☐ No ☐ Unsure ☐
Do you have a sense of being fulfilled in life or being on your "path"? Yes ☐ No ☐ Unsure ☐
Other: ____

ENERGY LEVEL: High ☐ (Time of Day) ___________ Low ☐ (Time of Day)____________
Other: ____

LIFESTYLE/HABITS:
Alcohol Consumption: Yes ☐ No ☐ How many times per week:_________
Coffee/ Sodas: Yes ☐ No ☐ Type: _____________ How Often: _______________________
Exercise: Yes ☐ No ☐ Sometimes ☐: Type:____
How often: ____
Recreational Drug Use: Now ☐ Past ☐ Type: _______________ How often: _____________
Tobacco Use: Yes ☐ No ☐ Type: ________ How Often: ________ How Long: _____________
Meditate/Pray Yes ☐ No ☐ Sometimes ☐ How Often:______________________________
What activity do you do to relax/unwind (ex: exercise, yoga, music, shopping…) ____________
____

MALES
Impotence ☐ Low Sex Drive ☐ Lack of Sex drive ☐ Pain/Itching in genitalia ☐
Genital lesions/discharge ☐ Numbness/Cold in genitalia ☐ Weak Urinary System ☐
Premature Ejaculations ☐ Other: ____

FEMALES

MENSTRUAL HISTORY:
Age first period started: ____
How many days does the period last:_________ How many days between your periods:_________
If irregular, please explain frequency:____
What is the color of the flow? Dark Red ☐ Purple ☐ Bright Red ☐ Brown ☐ Pink ☐
If varies please explain:____
Clots with the period? None ☐ Few ☐ Many ☐ Cramps: None ☐ Moderate ☐ Severe ☐
If yes at what point in the period do the cramps start? Before ☐ During ☐ After ☐
What helps the pain? ____
What worsens the pain? ____
Nausea or Vomiting with ☐ or before ☐ period
Diarrhea or loose stool with ☐ or before ☐ period
Bleeding or discharge between periods, please describe:___________________________________
Premenstrual symptoms: None ☐ Moderate ☐ Severe ☐ Describe symptoms:_____________
____

GYNECOLOGICAL HISTORY:
Have you had or currently have any disease or surgery on the following: Breast ☐ Uterus ☐
Cervix ☐ Tubes ☐ Ovaries ☐ Abnormal Pap Smears ☐ Genital Warts ☐
Menopausal Symptoms ☐ List:____
Pain during sex ☐ Genital warts ☐ Frequent Vaginal Infections ☐ Pelvic Infections ☐
Infertility Yes ☐ No ☐ Unsure ☐ If yes, list length of time _______________, methods or procedures used to try to conceive along with dates: __________________________________
Other: ____

CONTRACEPTIVE HISTORY:
Are you currently using birth control Yes ☐ No ☐ Type________________________________
Prior methods of birth control: Birth Control Pill ☐ Type __________ Foam ☐ IUD ☐
Diaphragm ☐ Sponge ☐ Condom ☐ Cap ☐ Withdraw ☐ Rhythm ☐
List any problems with past methods:____

PREGNANCY HISTORY:

Type	***Number***	***Dates***
Live Birth	__________	____________________________________
Caesareans	__________	____________________________________
Miscarriage	__________	____________________________________
Stillbirths	__________	_____________________________________
Ectopic (tubal)	__________	_____________________________________

Problems during pregnancy (toxemia, depression, diabetes, birth defects, preterm labor…)

____

Have you ever had an acupuncture treatment? When and for what reason?__________________

____

Any concerns about acupuncture/herbal medicine or afraid of needles? ____________________

____

I certify that the above information is complete and accurate to the best of my knowledge.

____________________________________ ___________________________

Patient Signature *Date*

Informed Consent and Disclosure

I hereby request and consent to acupuncture treatment and other procedures within the scope of the practice of acupuncture, and/or herbal supplement recommendations for me (or legal charge) provided by Deborah Farley.

I have read the information below and understand the possible risks involved and that I have had an opportunity to discuss these risks with the acupuncturist or clinic office staff named below, and that I understand that the results are not guaranteed.

- Acupuncture is a safe and effective method of treatment. Slight bleeding that is typically resolved when pressing dry cotton to the area, may occur. There may also be some slight bruising. The risk of infection is small when using sterile needles. It is the practice of this clinic to use pre-packaged, sterile, one-time-use only needles as required by law.
- Acupressure/TuiNa involves rubbing, kneading, pressing and stroking...of an area that may result in muscle soreness at the massage site that may last up to several days.
- Indirect Moxibustion requires the burning of an herbal material at a site near the skin or acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of contact and burns exist.
- Cupping involves localized suction produced by heating a small glass cup. There is a possibility of bruising from the suction as well as slight burning or blistering from the heat involved in the procedure.
- Gu sha involves scraping over a small area by using a smooth edge instrument. There is a possibility of local bruising at the site Gu sha is performed.
- Tapping, Plum Blossom, Bleeding, Pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment may occur. Only single use needles are used in this procedure.
- Electrical Stimulation / TENS uses microcurrent electricity to stimulate acupuncture points. A mild tingling of electricity may be felt.

Payment and Cancellation Agreement
I understand that payment is expected at the time of visit and I agree to make full payment at the time of my appointment.

I understand that when I schedule an appointment, I am agreeing to pay for the time set aside, as well as any treatment that I may receive during that designated time. I agree to provide this office with at least 24 hours notice when cancelling an appointment. I understand that if I cancel an appointment without a 24 hours notice, that I may be required to pay a charge which may include the cost of the appointment.

______________________________ ______________________
Patient Signature *Date*

______________________________ ______________________
Practitioner Signature *Date*

Patient Consent Use & Disclosure of Protected Health Information

Our **Notice of Privacy Practices** contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If our Notice changes, you may obtain a revised copy by contacting the clinic.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. Acupuncture Clinic of Richmond is not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Acupuncture Clinic of Richmond has a Notice of Privacy Practices and the patient may review this Notice
- Deborah Farley reserves the right to change the Notice of Privacy Policies
- Patient has the right to restrict use of their information, but the Practice is not required to agree to restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Deborah Farley may condition treatment upon the execution of this Consent.

I have received, read and understand the **Notice of Privacy Practices** and I authorize and consent to the use and disclosure of protected health information in manner described.

______________________________ ______________________
Patient Signature *Date*

______________________________ ______________________
Practitioner Signature *Date*