

## NEW PATIENT HEALTH HISTORY

Please answer the following questions as thoroughly as possible. This will help us to better address your main symptoms while allowing us to create a more in-depth personalized treatment plan. If the question does not apply to you, please write "none" or "NA" in the field provided.

**Date of Birth:**

**Last Name:**

**First Name:**

**Address :**

**City:**

**State :**

**Zip Code:**

**Country :**

**Emergency Contact:**

**Emergency Contact Phone Number:**

**How did you hear about us?**

**Have you had any emotional trauma or thoughts of suicide?**  Yes  No **If yes, please describe.**

**Do you feel safe at home?**  Yes  No **If no, please describe.**

**Please list your most important health concerns. Include how long the issue has been going on.**

## GENERAL HEALTH

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Do you have a pacemaker?  Yes  No

Have you ever had acupuncture?  Yes  No

Have you ever had massage therapy?  Yes  No

**WOMEN:** Are you, or is there any chance, that you are pregnant?  Yes  No

If you are pregnant, please include: 1) Your due date and 2) General information about how your pregnancy is going so far:

Do you have any known communicable diseases at this time?

None  Hepatitis A, B, C, D or E  HIV  MRSA  TB  Other

Please list any communicable disease not listed above.

Height:

Weight:

Preferred weight:

Typical bedtime:

Hours of sleep per night:

## MEDICATIONS, DIETARY SUPPLEMENTS & HERBS

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Please list any ALLERGIES. If none, please say none.

Please list all PRESCRIPTION MEDICATIONS and over-the-counter DRUGS. Please include dose, how often, when you began, and reason for taking.

Please list all vitamins, herbs, and supplements. Please include dose, how often, when you began, and reason for taking.

Are you currently or have you taken antibiotics in the last 2 months?  Yes  No

If yes, please describe:

## MEDICAL HISTORY

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**Please list all major traumas/accidents.** Please include surgeries, breaks/fractures, potentially fatal bites/stings, cuts requiring stitches, scars longer than 1/2 inch, root canals/fillings/tooth extractions/etc, episiotomy or severe tearing, epidural or other spinal procedure, dislocated joints (including spinal vertebra), head trauma, car/bike/pedestrian accident, etc. If no major traumas, state "none".

**Please list any major illnesses or diseases, including those that you may have had in childhood.** Please include any cancer, kidney disease, tuberculosis, alcoholism or other drug addiction, diabetes, epilepsy, stroke, obesity, reproductive problems, sexually transmitted diseases, heart disease, arthritis, anemia, cholesterol, blood pressure, mental illness, blood disorders and problems with sense organs.

**Please include any recent tests (and results) that you've had in the last year.**

## FAMILY HISTORY

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**Mother - current age, health problems:**

**Father - current age, health problems**

**Siblings - current age, health problems:**

## REVIEW OF SYMPTOMS

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Smoker?  Yes  No

If yes, how many per day and how many years have you smoked?

**Respiration:** Circle all that apply.

Allergies	Cough	Feels like something is stuck in throat
Asthma	Deep, shallow, unusual breathing	Frequent colds
Chest tightness	Emphysema	Phlegm, sputum
Chronic bouts of bronchitis		

**Headaches:** Circle all that apply.

Back of the head	Sinus related
Brow area, near the bridge of the nose	Stuffy through the whole head
Forehead area	Temples, at the outer part of the eye
Sides of the head	Top of the head

**Eyes:** Circle all that apply.

Bloodshot, red	Floaters	Light sensitive
Blurry vision	Glasses, contacts	Night blindness
Cataracts	Glaucoma	Painful
Dry, gritty	Itchy	Swollen, puffy tender

**Nose:** Circle all that apply.

Clear, runny discharge	Chronic sinusitis	Frequent nosebleeds
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**Ears:** Circle all that apply.

Buildup of ear wax	Hearing loss
Constant ringing	Low buzz, cicada sounds
Ear pain	Ringing, high pitched
Frequent ear infections	Swelling

**Mouth, throat, teeth :** Circle all that apply.

Abscesses	Discoloration on teeth	Sore throat
Bad breath	Gum disease (periodontitis)	Tonsils removed
Canker sores, ulcers	Grinding teeth	
Cavities	Snoring	

**Skin:** Circle all that apply.

Acne	Dry, often have to apply lotion	Poor wound healing
Boils	Hives	Rashes
Bruise easily	Itching	Recent new moles or marks
Cancers	Lumps	Warts

**Hair:** Circle all that apply.

Changing from curly to straight or vice versa	Dry	Premature gray
	Falling out in clumps	Thinning
	Oily	Dandruff

**Nails:** Circle all that apply.

Clubbing	Ridges, pitting	Thin, brittle
Discoloration	Separating from nail beds	White Spots
Fungus	Spoon nails	

**Blood and Cardiovascular:** Circle all that apply.

Anemia	Heart disease	Rheumatic fever
Blood clots/throm/emboli	High blood pressure	Shortness of breath
Chest pain	Irregular heartbeat	Stroke
Easy/frequent bruising	Low blood pressure	Swelling hands/feet
Fainting	Palpitations	Varicose veins

Do you give blood?  Yes  No If yes, how often?

**Gastrointestinal:** Circle all that apply.

Abdominal pain, cramps	High appetite	Pain after eating
Bad breath, gas or stool	Hungry even after eating	Reflux, GERD, heartburn
Eating disorder	Low appetite	Ulcers
Gas, bloating, indigestion	Nausea	Vomiting

**Food SENSITIVITIES (please include TRUE ALLERGIES at the top of the form):**

**Liver, gallbladder, pancreas:** Circle all that apply.

Diabetes  
Hepatitis

High blood sugar  
Liver disease

Low blood sugar  
Gallstones

**Urination:** Circle all that apply.

Bed wetting  
Frequent  
Incomplete

Incontinence  
Painful  
Urgent

Waking to pee in the night  
Weak stream

**Elimination:**

Abnormal colored stool (green, white, clay colored, etc.) please include details in box below.

Alternating constipation and diarrhea  
Bowel movements feel incomplete  
Coffee colored stool  
Constipation  
Diarrhea  
Difficult, slow bowel movements  
Floating stool  
Hemorrhoids  
IBS, colitis, Crohns

Liquid diarrhea upon waking  
Loose stool  
Mucus in stool  
Pencil thin stool  
Polyps, fissures, prolapse  
Sticky stool (hard to wipe)  
Stool like pebbles  
Undigested food in stool

**Kidney/Bladder:** Circle all that apply.

Cysts  
IC, cystitis

Kidney disease  
Kidney stones  
Pain mid back

Urinary tract infections  
Frequent bladder infections

**Immune:** Circle all that apply.

Candidiasis/yeast infections  
HIV/AIDS  
Chronic fatigue syndrome

Prolonged recovery from illness  
Complete lack of colds/flu -never sick  
Swollen lymph nodes  
Frequent colds

Mononucleosis  
MRSA  
Chronic infections  
Epstein Barr Virus

**Cancer ?**  Yes  No **If yes, please specify.**

**Any other immune issues?**

**Mental-emotional:** Circle all that apply.

Addictions	Disturbing dreams	Overly sympathetic
Agitation	Dull mind	Overly talkative
Angry outbursts, bad temper, explosive	Easily confused	Panic attacks
Anxiety, excitable	Easily disappointed	Poor self confidence
Apathetic	Easily frightened	Poor self esteem
Bored	Emotional eating	Restless
Clingy	Frustrated easily	Sad
Constant worrying	Grief, unresolved	Scared of the dark
Decreased motivation	Hoarding	Shy
Depression, deep and dark	Insomnia	Stage fright
Depression, grieving	Joylessness, hopelessness	Suicide thoughts
Depression, quiet rage	Manic depressive	Suicide, attempted
Difficulty decision making	Monkey mind/overly busy mind	Want to fix others problems
Difficulty falling asleep	Nervous	Withdrawn socially
	Obsessive compulsive	

**Endocrine/Energy:** Circle all that apply.

Abdomen, cold	Difficulty rising from bed in the morning	Hypoglycemia
Addisons disease	Easily overheated/chilled	Hypothyroid
Cold feeling all over	Lethargy, desire to sleep a lot	Night sweating
Cushings syndrome	Gestational diabetes	Pituitary disorder
Diabetes Mellitus Type I	Significant unintended weight loss	Spontaneous sweating
Diabetes Mellitus Type II	Hot feeling all over	Weakness after sex
Easily weak, dizzy	Hyperthyroid	Weight gain

**Neurological:** Circle all that apply.

Concussion, history of	Loss of balance, coordination issues	Double vision
Difficulty swallowing	Numbness in extremities	Facial ticks
Dizziness	Stuttering, speech problems	Paralysis
Muscle twitches	Stroke history	

**Male Reproductive: (women, please skip to next section)**

Blunt trauma to groin	High libido	Penile pain
Erectile difficulty	Inability to conceive	Penile sores
Feeling of coldness in genitalia	Lack of responsiveness/sensitivity	Protate deisease
Feeling of numbness in genitalia	Low libido	Rashes, skin issue in groin
Frequent (daily) bicycle riding	Pain after sex	Swollen testes
Hernia	Penile discharge	Premature ejaculation
		Testicular pain

Other male reproductive comments?

Men are done here, the rest of the form is for females. Please proceed to Acupuncture Informed Consent to Treat.

## FEMALE REPRODUCTIVE

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Age of first menses?

Average # of days of bleeding?

Average length of cycle (from first day of bleeding (Day 1) until the day before bleeding starts again).

Cramping/pain during menses? If so, please rate on a scale of 1-10:

**Menstrual:** Circle all that apply.

Breast tenderness

Clots

Moodiness before hand

Bright red blood

Darkly colored blood

Tampon use

Brown blood

Excessive bleeding

Very little bleeding

**Ovaries, uterus, fallopian tubes, vagina:** Circle all that apply.

Endometriosis

Vaginal discharge

Vaginal odor

Ovarian cysts

Vaginal dryness

Yeast infections

Uterine prolapse

C-section?  Yes  No If yes, how long ago?

Hysterectomy?  Yes  No If yes, reason and type:

Fibroids?  Yes  No If yes, size? :

**Breasts:** Circle all that apply.

Discharge

Lumps

Fibrocystic breast discharge

Tenderness

**Sexual Health:** Circle all that apply.

High libido

Lack of responsiveness/sensation

Low libido

Pain after intercourse

Pain during intercourse

Sexually active

**Fertility & Pregnancy:** Circle all that apply.

Difficulty conceiving

In-vitro fertilization

Postpartum problems

Traumatic birth

Number of pregnancies?

Live births?  Yes  No How many?

Vaginal births?  Yes  No How many?

C-Sections?  Yes  No How many?

VBAC? (Vaginal Birth after C-section)  Yes  No How many?

Miscarriages?  Yes  No How many?

**Other female reproductive comments:**

**Menopause:** Circle all that apply.

Absent minded

Breast distention

Cold limbs

Cold pain at waist or knees

Dizziness

Emotional swings

Fatigue

Headaches

Hot flashes

Hot palms and soles of feet

Joint pain

Loose teeth

Night sweats

Restless sleep, insomnia

Thirst

Tinnitus

Vaginal dryness

Age at which menopause started?

**Other menopausal symptoms you experienced or are experiencing:**

## ACUPUNCTURE CONSENT TO TREAT

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I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturists at Golden West Acupuncture and Wellness or by licensed acupuncturists working on behalf of acupuncturists at Golden West Acupuncture and Wellness. I understand that methods of treatment may include, but are not limited to: Acupuncture, Chinese herbal medicine, electrical stimulation, cupping, Supplements, nutritional counseling, and Tui-Na (Chinese massage). I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs or supplements. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax), infections and other possible risks, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that Golden West Acupuncture and Wellness does not provide emergency services and that I should call 911 in the event of an emergency. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements are traditionally considered safe in the practice of Chinese Medicine, though some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

**Patient Signature:**

**Date:**

## GOLDEN WEST WELLNESS OFFICE POLICIES

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Welcome to the Golden West Acupuncture and Wellness. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

**FEES:** Payment is due at time of service. A \$20 service fee will be added to your account for each missed payment. The fees charged in this office are comparable to those charged by other healthcare providers in this areas, with similar qualifications. Please see our posted fee schedule. We accept cash, credit cards, and personal checks. Please note there is a \$50.00 charge for checks returned due to insufficient funds or declined credit cards.

**INSURANCE COVERAGE:** Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign the financial agreement below.

**CANCELLATIONS:** As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a \$45.00 fee for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations.

**FRAGRANCES AND SCENTS:** Please refrain from wearing fragrances, and/or clothing that has been washed in scented detergents and dried using scented fabric softeners when coming for treatments.

*Additionally, please silence your cell phones prior to entering the clinic.*

**Initials:**

**RELEASE OF INFORMATION:** Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

**Initials:**

**FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS:** I am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all "non covered" services and /or coinsurance/co-pays associated with my office visit. In addition I authorize insurance payment of medical benefits to Golden West Acupuncture and Wellness. By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

**Acknowledgement of Financial Agreement Signature:**

**Today's Date:**

## GOLDEN WEST WELLNESS PRIVACY PRACTICES

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The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices in the patient portal. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically. If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Your privacy is critical to us. An SOC2-certified and HIPAA compliant speech to text transcription software tool may be used to make writing our medical notes more efficient. This is an effort to spend more time focused on your care, and less time on the computer. The tool has audio access to the conversation during the treatment only. The transcript is not saved or recorded and is only used within the Electronic Health Record as our chart notes. Your medical information will stay private and only shared with those who you allow. Your initials below grant permission for use of this tool during our visit and future visits.

**I have received the Privacy Practices of Golden West Acupuncture and Wellness.**

Initials:

Today's Date:

**RELEASE OF INFORMATION:** I authorize Golden West Acupuncture, it's employees, and agents the release of information including but not limited to: appointment times, diagnosis, records; examination rendered to me, and claims information. I understand that information may be released as needed to my insurance company for payment of claims and as applicable by law. This release will remain in effect until terminated by me in writing. This information may be released to:

**Spouse:**  
(name)

**Children:**  
(names)

**Other:**  
(names)

**Do NOT release my information. Initials:**

**If unable to reach me you may:**

- Call my cell phone and leave a detailed message or request a return call.
- Call my home phone leave a detailed message or request a return call.
- Call my office phone leave a detailed message or request a return call.
- Email me with a detailed message or request a return call.

**Acknowledgement of Release of Information Signature:**

*This form is complete. Thank you for providing us with your information so that we can assist you in the best way possible.*