D'Arcy Wellness Center

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HEALTH HISTORY INTAKE FORM

Date _____

Name _____ **Date of Birth** _____

Phone _____ **Preferred Pronouns** _____

Email _____ **Referred by** _____

Address _____ **Physican** _____

_____ **Physican Phone #** _____

Emergency Contact _____ **Insurance Company** _____

Emergency Contact Phone # _____ **Member ID** _____

Please answer the questions below.

Have you received acupuncture before? ☐ **Yes** ☐ **No**

Main problem(s) you would like us to help you with:

_____

How long ago did this problem begin? Please be specific.

_____

To what extent does this problem interfere with your daily activities, such as work, sleep, etc.?

_____

Have you been given a diagnosis for this problem? If so, what?

_____

What kinds of treatment(s) have you tried?

_____

Past Medical History

Significant Illnesses
Please check all that apply. (Include date)

- [ ] Cancer
- [ ] Diabetes
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Heart Disease
- [ ] Rheumatic Fever
- [ ] Thyroid Disease
- [ ] Seizures
- [ ] STI's
- [ ] COVID-19
- [ ] Other:

Surgeries and/or Significant Traumas (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods)

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)

Occupational stress (chemical, physical, psychological, etc.)

Do you have a regular exercise program? If yes, please describe.

Have you ever been on a restricted diet? If yes, what kind?

How much water do you drink per day?

Do you smoke? If yes, how much?

How much caffeinated coffee, tea, or soda do you drink per week?

Please describe any use of drugs for non-medical purposes.

Please check any of the following you've had (in the last three months).

General

- [ ] General
- [ ] Poor sleeping
- [ ] Night Sweats
- [ ] Fevers
- [ ] Chills
- [ ] Weight loss
- [ ] Change in appetite
- [ ] Bleed or bruise easily
- [ ] Strong thirst (hot or cold drinks)
- [ ] Cravings
- [ ] Weight gain
- [ ] Peculiar tastes or smells
- [ ] Fatigue
- [ ] Sudden energy drop (what time of day?)
- [ ] Sweat easily

Skin & Hair

- [ ] Rashes
- [ ] Itching
- [ ] Dandruff
- [ ] Change in hair or skin texture
- [ ] Ulcerations
- [ ] Eczema
- [ ] Loss of hair
- [ ] Any other hair or skin problems
- [ ] Hives
- [ ] Pimples
- [ ] Recent moles

Head, Eyes, Ears, Nose, and Throat

- [ ] Dizziness
- [ ] Glasses
- [ ] Poor vision
- [ ] Cataracts
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Grinding teeth
- [ ] Teeth problems
- [ ] Any other head or neck problems?
- [ ] Concussions
- [ ] Eye strain
- [ ] Night blindness
- [ ] Blurry vision
- [ ] Poor hearing
- [ ] Nose bleeds
- [ ] Facial pain
- [ ] Jaw clicks
- [ ] Migraines
- [ ] Eye pain
- [ ] Color blindness
- [ ] Earaches
- [ ] Spots in front of eyes
- [ ] Recurrent sore throats
- [ ] Sores on lips or tongue
- [ ] Headaches (where, when?)

Cardiovascular

- [ ] High blood pressure
- [ ] Irregular heartbeat
- [ ] Cold hands and feet
- [ ] Blood clots
- [ ] Other:
- [ ] Low blood pressure
- [ ] Swelling of hands
- [ ] Phlebitis
- [ ] Difficulty in breathing
- [ ] Chest pain
- [ ] Fainting
- [ ] Swelling of feet

Respiratory

- [ ] Cough
- [ ] Bronchitis
- [ ] Difficulty in breathing when lying down
- [ ] Other:
- [ ] Coughing blood
- [ ] Pneumonia
- [ ] Production of phlegm; what color?
- [ ] Asthma
- [ ] Pain with a deep breath

Gastrointestinal

- [ ] Nausea
- [ ] Constipation
- [ ] Black Stools
- [ ] Bad breath
- [ ] Abdominal pain or cramps
- [ ] Vomiting
- [ ] Gas
- [ ] Blood in stools
- [ ] Rectal pain
- [ ] Chronic Laxative Use
- [ ] Diarrhea
- [ ] Belching
- [ ] Indigestion
- [ ] Hemorrhoids
- [ ] Poor appetite

Genito-Urinary

- [ ] Pain upon urination
- [ ] Unable to hold urine
- [ ] Blood in Urine
- [ ] Urgency to urinate
- [ ] Urgency to urinate
- [ ] Impotence
- [ ] Kidney stones
- [ ] Decrease in urine flow
- [ ] Blood in urine
- [ ] Sores on genitals

Do you wake up to urinate? How often?

_____

How many times per day do you urinate?

_____

Any particular color to your urine?

_____

Any other problem with your genital or urinary system?

_____

Musculoskeletal

- [ ] Neck pain
- [ ] Back pain
- [ ] Hand / wrist pains
- [ ] Any other joint or bone problems?
- [ ] Muscle pain
- [ ] Muscle weakness
- [ ] Shoulder pain
- [ ] Knee pain
- [ ] Foot / ankle pains
- [ ] Hip pain

Reproductive and Gynecologic

- ☐ # of pregnancies_____
- ☐ # of live births_____
- ☐ # of premature births _____
- ☐ # of miscarriages_____
- ☐ # of abortions_____
- ☐ Date of last period _____
- ☐ Vaginal discharge
- ☐ Breast lumps
- ☐ Menopause: age _____
- ☐ Irregular periods
- ☐ Menstrual pain
- ☐ Number of days period lasts _____
- ☐ Menstrual clots
- ☐ Unusual periods (heavy, light, etc.)
- ☐ Spotting or pain between periods
- ☐ Date of last pap _____
- ☐ Results _____

Number of days between periods

_____

Do you practice birth control? What type and for how long?

_____

Changes in body / psyche prior to period:

_____

Is there any chance that you are pregnant now?

_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Tremors
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Suicidal thoughts

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or attempted suicide? ☐ Yes ☐ No

Any other neurological or psychological concerns: _____

COMMENTS:

Please tell us of any other problems you would like to discuss.

Please list any herbs, vitamins, or nutritional supplements that you are taking.

INFORMED CONSENT

1. Acupuncture therapy consists of inserting sterile stainless-steel needles at various depths into the skin. Occasionally bruising may occur at the site of the insertion.

2. Acupuncture therapy can also consist of the use of heat through burning the herb Artemesia vulgaris. This herb is also known as moxa and the procedure is known as moxibustion. Although indirect moxibustion is used most often, moxa may also be used directly on the skin. This procedure may cause slight discomfort and leave a small blister on the skin, and occasionally a small scar.

3. In some cases, electrical stimulation of the needles may be indicated. This procedure involves the use of a small, battery-powered stimulator, attached to the end of the needles. A slight vibratory sensation may be felt with the use of this technique.

4. All Chinese herbal prescriptions used in this clinic are considered safe within the practice of Chinese Medicine. However, I understand that these herbs may produce unforeseen allergic reactions.

5. I understand I have the right to decline any treatment technique that I do not feel comfortable receiving.

6. I understand certain types of treatments are contraindicated in pregnant woman. If I become pregnant or suspect I am pregnant, I will notify staff before treatment.

7. I understand that acupuncture treatments may induce feelings of deep relaxation or lightheadedness. If these feelings occur, I will rest in the waiting room before driving.

8. I understand that a $50 fee will be charged if appointments are canceled without 24 hours notice. I understand that I will be charged the full price if I no show my appointment. I also certify that I have read this entire form and have discussed any questions.

9. I understand that if I am going through health insurance, I am responsible for the initial consultation payment of $100.00 as we do not bill out for consultations.

10. I understand that if my insurance denies a claim, I am responsible for out-of-pocket payment for treatment.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

Disclosure of Your Health Care Information

Without specific written authorization, we are permitted to use and disclose your health records for the purposes of treatment, payment and health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers of specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing an insurance company for services provided to you by our office. Health Care Operations include the business aspects of running our practice. For example, patient information may be used for quality assessment.

We may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence.

Your Health Information Rights

- **You have the right to request restrictions on certain uses and disclosures of your health information.**
- **You have the right to inspect and copy your health information.**
- **You have the right to request amendments be made by this office to your protected health information file.**
- **You have a right to receive an accounting of disclosures of your protected health information.**
- **You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.**

If you have questions about this notice or of you want more information, please contact us at: D'Arcy Wellness Clinic, 508-650-1921. This notice is effective as of 3/1/03. By way of my signature, I authorize D'Arcy Wellness Clinic with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Name _____ **Signature** _____ **Date** _____