Acupuncture Health History Questionnaire

First Name ______________________________ Last Name _____________________________ MI _____
Address ____
City________________________ State____________ ZIP_______________________________________
Phone Numbers (Home)________________________(Cell) _____________________________________
Is it 0.K. to contact you at work? 0 Yes O No Work# ____
E-mail Address__________________________________SS#_____________________________________
Birth date________________________ Age _______Occupation ________________________________
Marital Status O Single O Married O Separated O Divorced O Widowed
Spouses Name_________________________________ Phone Number(s)__________________________
Children's Names and ages____
Emergency contact name______________________________Relationship________________________
Phone Number(s) ___________________Favorite hobbies and interests __________________________
Have you had acupuncture previously? □ Yes □ No If yes, where? ___________________________
Please list your three main complaints today: ____
____

Do you experience any of the following? (Please check all that apply)

□ Floaters in vision
□ Dry eyes
□ Tinnitus/Ringing in ears
□ Bitter/metallic taste in mouth
□ Dry mouth
□ Cracked lips or sores
□ Heart palpitations
□ Acid re flux/heartburn
□ Pain/discomfort with eating
□ Constipation
□ Diarrhea
□ Cramping with menstruation
□ Clotted menstrual blood
□ Bloating
□ Profuse sweating
□ Night sweats
□ Chills
□ Cold hands/feet
□ Mood swings
□ Difficulty falling asleep
□ Difficulty staying asleep
□ Vivid dreams
□ Frequent feeling of thirst
□ Increased stress
□ Worry/anxiety
□ Depression

SLEEP

How many hours do you sleep? ______________ Do you feel rested upon waking? □ Yes □ No
Other sleep symptoms: ____

MENSTRUATION

Date of last period:________________ How many days is your period? _______________________
Do you have any of the following? (please check all that apply)

□ Bright red blood
□ Dark red blood
□ Brown blood
□ Clotted
□ Scanty
□ Heavy
□ Light
□ Painful
□ Spotting

Acupuncture Health History Questionnaire and Cancellation Policy

ACUPUNCTURE CONSENT TO TREATMENT

-I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture. These procedures may include the insertion of small, sterile, single-use, disposable needles through the skin and into the body at specific points, the use of a small electrical current on pre-inserted needles (electro-acupuncture), a deep-tissue massage technique (Gua Sha) performed with a hand held tool made of plastic or ceramic, the use of glass or plastic cups that have been slightly heated and placed on the skin (cupping), and bleeding techniques with the use of a small lancet alone or in conjunction with cupping.
-I understand that acupuncture is generally a safe method of treatment, but that there has been documented adverse effects including, but not limited to, bruising, dizziness/fainting, nausea, and numbness or tingling near the needling site following treatment. In rare cases there is the possible risk of infection at the insertion site, pnuemothorax, scarring, or spontaneous miscarriage. I understand that Knewtson Health Group uses clean-needle standards and safety procedures to reduce the risk of any possible adverse effects.
-I understand it is my responsibility to inform Knewtson Health Group staff performing acupuncture of any changes to my health, including pregnancy, use of anti-coagulant drugs, bleeding disorders, blood borne diseases such as HIV or hepatitis, cancer/malignancies, metal implants, or pacemaker placement prior to treatment.
-I understand that acupuncture is an elective service done in conjunction with chiropractic care and may not be covered by insurance. I understand that if my insurance does not cover treatment that I am required to pay for this service by cash, check, or credit card prior to receiving acupuncture treatment. I understand I may independently submit charges I directly pay for acupuncture care to my insurance carrier for reimbursement.
-By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and have been told the risks and benefits of acupuncture treatment.

Cancellations:

Cancellations must be made 24 hours in advance or you will be charged for the full price of your session.

In some cases acupuncture session charges are billed to your insurance
(MVA, W/C and PI). Please keep in mind that all cancellation fees are billed directly to the patient and *are not* submitted to insurance. We strongly advise you to call your insurance company to verify your eligibility and coverage. PLEASE REMEMBER most acupuncture sessions are not covered by insurance.

I have read the Knewtson Health Group office policy regarding fees for acupuncture-cupping therapy and understand that all fees are due upon receipt and before your next service is provided.

I acknowledge the cancellation policy and will adhere to this policy.

Name: ___________________________________ Date: ____________________________

Signature: ____