

Pathways Acupuncture

HEALTH QUESTIONNAIRE

866 Webster Street, Traverse City, MI 49686 pathwavstc@charter.net www.PathwaysTC.com

Name: _____ Date: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Business Phone: _____
Age: _____ Sex: _____ Ht: _____ Wt: _____ Mobile Phone: _____
Marital Status: _____ Occupation: _____
Date of Birth: _____ Employer Name: _____
Place of Birth: _____ In Emergency notify: _____
Family Physician: _____ Emergency Contact Phone: _____

How did you hear about o g?

- Phone book: Yellow Book (big book)
 Phone book: Yellow Pages (small book)

- Internet: Where? _____
 Referred by: _____
 Advertisement: Where? _____

Are you currently seeing a health care practitioner (MD, ND, DC) for a current health concern? Yes _ No "a
If yes, please give name _____

Have you been treated by acupuncture and Chinese medicine before? Yes a "No "a

Have you had massage therapy or other body work before? Yes _ "No _ Last treatment: _____ aaaaaaaaaa _

Please sign me up for Pathways Acupuncture free quarterly email newsletter with current information on the effectiveness of acupuncture. Email: _____

Treatment Information:

Main problem (s) you would like help with: _____

How long ago did this problem begin? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

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

What kind of treatments have you tried? _____

Current & Past Medical History (Please give dates):

Significant Illnesses:

Cancer - Diabetes - Hepatitis - High Blood Pressure - Seizures - Heart Disease
High Cholesterol - Rheumatic Fever - Thyroid Disease - Venereal Disease - Other

Surgeries: _____

Significant Trauma (auto accidents, falls, broken bones, etc.): _____

Birth History (prolonged delivery, forceps delivery, etc.): _____

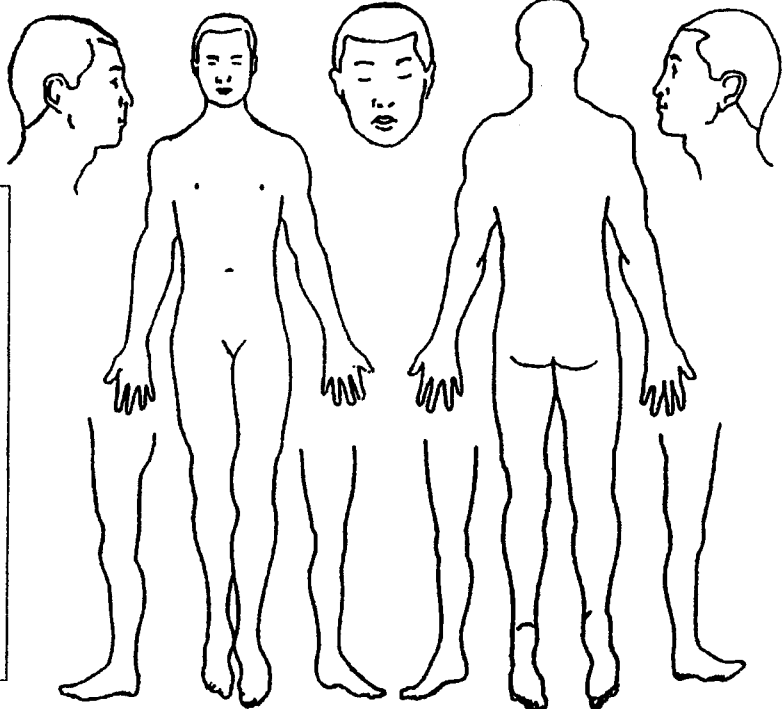
Allergies (drugs, chemicals, foods): _____

Family Medical History: Diabetes Cancer High Blood Pressure Heart Disease
Strokes Seizures Asthma Allergies Other

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

Indicate painful or distressed areas:

Symbols	
Pain/pressure	X
Swelling	()
Tension	+
Weakness	-
Pulsing	*
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑



Occupation: _____ Occupational stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? _____ Please describe: _____

Have you ever been on a restricted diet? _____ What kind? _____

Please describe your average daily diet:

Morning _____ Afternoon _____ Evening _____

Do you smoke? _____ How many packs of cigarettes do you smoke a day? _____

How much coffee, tea, or cola do you drink per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please check if you have had any of these symptoms in the last 3 months or if they have been significant health issue in the past:

General

- Poor Appetite
- Fatigue
- Fatigue after meals
- Sudden Energy drop
- Strong Thirst
- Tend to be HOT or COLD
- Change in Appetite
- Cravings
- Tremors
- Poor Balance
- Mouth Ulcers
- Hot Flashes
- Night sweats
- Chills
- Sweat easily
- Weight Gain
- Weight Loss
- Poor Sleep:
___ Can't fall asleep ___ Wake frequently
___ Wake hot ___ Wake early

Skin & Hair

- Rashes: where? _____
- Itching
- Dandruff
- Skin or hair problems
- Ulcerations
- Eczema
- Hives
- Pimples
- Recent Moles
- Loss of Hair
- Change in hair or skin texture

Head, Eyes, Nose, & Throat

- Dizziness
- Ringing in Ears
- Poor Hearing
- Teeth Problems
- Facial Pain
- TMJ/jaw
- Grinding teeth
- Earaches
- Glasses
- Poor Vision
- Eye Strain
- Blurry Vision
- Night Blindness
- Spots in front of eyes
- Cataracts
- Eye Pain
- Sores on Lips or Tongue
- Recurrent Sore Throats
- Nose bleeds
- Sinus Problems:
- Seasonal Allergies: Time of year _____
- Headaches or migraines: Please show on diagram. plus give time of day occur: _____
- Concussions

Cardiovascular

- High Blood Pressure
- High Cholesterol
- Irregular Heart Beat
- Any other heart or blood vessel problems? _____
- Chest Pain
- Low Blood Pressure
- Dizziness
- Fainting
- Strokes
- Difficulty in Breathing
- Blood Clots
- Swelling or Feet
- Cold Hands or Feet
- Swelling of Hands
- *** Do you have a PACEMAKER, DEFIBULATOR or have SEIZURES? Yes No *****

Respiratory

- Cough
- Coughing Blood or Mucus
- Pain With Deep Breath
- COPD/Emphysema
- Bronchitis
- Pneumonia
- Any other lung problems? _____
- Mucus in back of throat
- Asthma
- Difficulty Breathing Lying Down

Gastrointestinal

- Diarrhea
- Constipation
- # of Bowel mvmts per day: _____
- Black Stools
- Blood in Stools
- Indigestion
- Nausea
- Vomiting
- Bad Breath
- Gas: odor/no odor
- Any other problems with your stomach or intestines? _____
- Hemorrhoids
- Abdominal Pain or Cramps
- Rectal Pain
- Chronic Laxative Use
- Gallbladder issues

Genito-Urinary

- Pain When Urinating
- Urgency to Urinate
- Decreased Flow
- Frequent Urination
- Wake to urinate? How many times per night _____
- Unable to Hold Urine
- Blood in Urine
- Frequent UTI's
- Kidney Stones
- Any other problems with your genital or urinary system? _____
- Sores on Genitals
- Erectile Dysfunction
- Low Libido
- Color of Urine: _____

Pregnancy & Gynecology

*****Are you pregnant or trying to conceive?*** Yes No**

- _____ Number of Pregnancies
- _____ Miscarriages
- _____ Age at First Menses
- _____ First Day of Last Menses
- _____ # of Days Between Periods
- _____ # of days Period Lasts
- Clots: size - qtr/nickel/dime
- _____ Number of Births
- _____ Abortions
- Painful Periods
- Excessive Blood Flow
- Light Blood Flow
- Changes in Body / Psyche Prior to Menses
- Breast Tenderness/Distention Prior to Menses
- _____ Number of Premature Births
- Last PAP Date: _____
- Unusual Color: _____
- Vaginal Sores
- Vaginal Discharge
- Use Birth Control

Musculoskeletal

- Neck Pain
- Back Pain
- Shoulder Pain
- Hand/Wrist Pain
- Osteoporosis
- General Achiness
- Muscle Pain
- Muscle Weakness
- Areas of Numbness
- Peripheral Neuropathy
- Foot/Ankle Pain
- Hip Pain
- Leg Pain
- Knee Pain
- Fibromyalgia
- Any other joint or bone problem? _____

Neuropsychology

- Depression
- Bad Temper
- Lack of Coordination
- PTSD
- Anxiety
- Have you ever been treated for emotional problems? _____
- Bi-Polar
- Cutting
- Obsessive Compulsive
- Personality Disorder
- Easily Susceptible to Stress
- Concussion
- Any other neurological or psychological problems? _____
- Suicidal
- Poor Memory
- Seizures
- Dizziness
- Loss of Balance

Comments - Please tell us any other problems you would like to discuss: _____

Informed Consent for Treatment – Pathways Acupuncture

I, _____ (print name), hereby authorize Jennifer S. Payne, Dipl Ac, MAcOM, CMT to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special sterilized needles through the skin into the underlying tissues at specific points on the surface of the body.

Heating Lamp, or Pad: Produces heat on the acupuncture points, meridians, and different areas of the body.

I recognize the potential benefits and risks of these procedures as described below:

Potential Benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to the prevention or elimination of the presenting health problem, as well as strengthening the overall body.

Potential risks: discomfort, pain, infection, and blistering at the site of the procedure; temporary discoloration of skin; nausea, loose bowel movements, abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment. Treatment may also result in unforeseen consequences.

Consent: With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Jennifer Payne, Dipl Ac, MAcOM, CMT, regarding cure or improvement of my condition.

Liability: I hereby release Jennifer S. Payne from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and to discontinue participation in the procedures at any time.

Confidentiality/Records: I understand that a record will be kept of my health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself if it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three years, but no more than eight years after the date of my last treatment.

Cancellation Policy: I request 24 hours notice for cancellations.

Payment: Please have payment ready before your acupuncture session begins and hand it to the acupuncturist at the start of your session when she arrives to insert the needles. We provide payment envelopes in a basket in our entry room, which you may use if you like. We accept cash or check. We do not accept credit card payments. **We allow for one missed appointment free of charge. After that, you will be charged a missed appointment fee of \$15.00 for each missed appointment, which must be paid at the time of your next appointment.

Your Privacy: To protect your privacy please indicate where we may leave a voice mail message or answering machine message for you if need be:

Home Phone number Business Phone Number Mobile Phone Number

Please sign and return this form. By signing, you understand and accept the above policies and terms of business. Thank you for allowing me to work with you to improve your health.

Signature of Patient

Date