

# Pathways Acupuncture

## NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

733 E. Eighth St, Ste 107, Traverse City, MI 49686 (231) 633-2929

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: \_\_\_\_\_  
Phone number: \_\_\_\_\_  
Referred by: \_\_\_\_\_

Please check this box if you would like to receive Pathways Acupuncture free quarterly email newsletter with current information on the effectiveness of Acupuncture and Traditional Chinese Medicine and on current research being done in this field. The newsletter will also include other health information I think is valuable for my patients. Email: \_\_\_\_\_

Are you currently under the care of a health care practitioner (MD, ND, etc.)? Yes \_\_\_ No \_\_\_  
If yes, please give name and location \_\_\_\_\_

Have you been treated by acupuncture and Chinese medicine before? Yes \_\_\_\_\_ No \_\_\_\_\_

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

### 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? \_\_\_\_\_  
\_\_\_\_\_

**Past medical history** (Please include dates): \_\_\_\_\_  
\_\_\_\_\_

**Significant Illnesses:** Cancer Diabetes Hepatitis High Blood Pressure Seizures  
Heart Disease Rheumatic Fever Thyroid Disease Venereal Diseases Other

**Surgeries:** \_\_\_\_\_  
\_\_\_\_\_

**Significant Trauma** (auto accidents, falls, etc.): \_\_\_\_\_  
\_\_\_\_\_

**Birth History** (prolonged delivery, forceps delivery, etc.): \_\_\_\_\_



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**Please check if you have had** (in the last three months):

**General**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Poor Appetite                          | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue            |
| <input type="checkbox"/> Fevers                                 | <input type="checkbox"/> Chills        | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Sweat Easily                           | <input type="checkbox"/> Tremors       | <input type="checkbox"/> Cravings           |
| <input type="checkbox"/> Localized Weakness                     | <input type="checkbox"/> Poor Balance  | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Bleed or Bruise Easily                 | <input type="checkbox"/> Weight Loss   | <input type="checkbox"/> Weight Gain        |
| <input type="checkbox"/> Peculiar Tastes or Smells              |  |   |
| <input type="checkbox"/> Strong Thirst (cold or hot drinks)     |  |   |
| <input type="checkbox"/> Sudden Energy Drop (What time of day)? |  |   |

**Skin and Hair**

- |   |                                       |                                       |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes                         | <input type="checkbox"/> Ulcerations  | <input type="checkbox"/> Hives        |
| <input type="checkbox"/> Itching                        | <input type="checkbox"/> Eczema       | <input type="checkbox"/> Pimples      |
| <input type="checkbox"/> Dandruff                       | <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair or skin texture |                                       |                                       |
- Any hair or skin problems?

**Head, Eyes, Ears, Nose, and Throat**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Concussions     | <input type="checkbox"/> Migraines               |
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Eye Strain      | <input type="checkbox"/> Eye Pain                |
| <input type="checkbox"/> Poor Vision     | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness         |
| <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Blurry Vision   | <input type="checkbox"/> Earaches                |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing    | <input type="checkbox"/> Spots in Front of Eyes  |
| <input type="checkbox"/> Sinus Problems  | <input type="checkbox"/> Nose Bleeds     | <input type="checkbox"/> Recurrent Sore Throats  |
| <input type="checkbox"/> Grinding Teeth  | <input type="checkbox"/> Facial Pain     | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Teeth Problems  | <input type="checkbox"/> Jaw clicks      |  |
- Headaches (Where and when?)
- Any other head or neck problems?

**Cardiovascular**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Chest Pain              |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Fainting                |
| <input type="checkbox"/> Cold Hands or Feet  | <input type="checkbox"/> Swelling of Hands  | <input type="checkbox"/> Swelling of Feet        |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Phlebitis          | <input type="checkbox"/> Difficulty in Breathing |
- Any other heart or blood vessel problems?

**Respiratory**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cough                                   | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Bronchitis                              | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Pain With a Deep Breath |
| <input type="checkbox"/> Difficulty in Breathing When Lying Down |   |  |
| <input type="checkbox"/> Production of Phlegm (What color?)      |   |  |
- Any other lung problems?

**Gastrointestinal**

- |                                 |                                   |                                   |
|---------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
|---------------------------------|-----------------------------------|-----------------------------------|

- Constipation
- Black Stools
- Bad Breath
- Abdominal Pain or Cramps
- Chronic Laxative Use
- Any other problems with your stomach or intestines?
- Gas
- Blood in Stools
- Rectal Pain
- Belching
- Indigestion
- Hemorrhoids

**Genito-Urinary**

- Pain When Urinating
- Urgency to Urinate
- Decrease in Flow
- Do you wake up to urinate?                      How often?
- Any particular color of your urine?
- Any other problems with your genital or urinary system?
- Frequent Urination
- Unable to Hold Urine
- Impotency
- Blood in Urine
- Kidney Stones
- Sores on Genitals

**Pregnancy and Gynecology**

- \_\_ Number of Pregnancies
- \_\_ Miscarriages
- \_\_ Period Between Menses
- Unusual Character (Heavy or Light)
- Painful Periods
- Vaginal Discharge
- Changes in Body/Psyche Prior to Menstruation
- Do you use birth control?                      What type and for how long?
- \_\_ Number of Births
- \_\_ Abortions
- \_\_ Duration
- Clots
- Vaginal Sores
- \_\_ Premature Births
- \_\_ Age at First Menses
- \_\_ First Date of Last Menses
- Irregular periods
- Last PAP
- Breast Lumps

**Musculoskeletal**

- Neck Pain
- Back Pain
- Hand/Wrist Pains
- Any other joint or bone problems?
- Muscle Pains
- Muscle Weakness
- Shoulder Pain
- Knee Pain
- Foot/Ankle Pains
- Hip Pain

**Neuropsychological**

- Seizures
- Areas of Numbness
- Concussion
- Bad Temper
- Have you ever been treated for emotional problems?
- Any other neurological or psychological problems?
- Dizziness
- Lack of Coordination
- Depression
- Easily Susceptible to Stress
- Loss of Balance
- Poor Memory
- Anxiety

**Comments**

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

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# Pathways Acupuncture

## Informed Consent for Treatment

I, \_\_\_\_\_, hereby authorize Jennifer S. Payne, Dipl Ac, MAcOM, CMT to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

**Herbal Prescriptions:** May be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally or externally as a wash or paste. **Herbal formulas may include shell, mineral, and animal materials.**

**\*\*\* If you do not want animal-based products used in your formula, please notify your practitioner at every visit when herbs are prescribed.**

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

**Cupping:** cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Mild bruising may result and can be helpful in the purpose of increasing local blood circulation.

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

**Electrical Acupuncture:** use of electrical device to produce electrical stimulation on the acupuncture needles.

**Moxa:** direct or indirect burning on an acupuncture point using a stick, string, or ball moxa to relieve symptoms and treat the cause.

**Massage:** Chinese Tuina and/or Western style massage

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

**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.

**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.

**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 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.

\_\_\_\_\_  
Signature of Patient, Patient Representative, or Guardian

\_\_\_\_\_  
Date

**Pathways Acupuncture**  
**Jennifer Payne, Dipl Ac, MAcOM , CMT**  
733 E. Eighth Street, Ste 107, Traverse City, MI 49686  
Phone (231) 633-2929

PATHWAYS ACUPUNCTURE  
FINANCIAL POLICY  
FOR  
INDIVIDUAL PRIVATE OFFICE TREATMENTS

**Fees and Payment:**

Initial Visit	(1 ½ hours)	\$80.00
Subsequent Visits	(1 - 1 ¼ hours)	\$60.00

Herbs vary in price and are not included in the treatment fee.  
Payment is in full, by cash or check, at the time of service.

**Cancellation  
Policy:**

Please give me 24 hours notice for cancellations. Appointments repeatedly cancelled with less than 24 hours notice and appointments repeatedly missed without notification will be charged the regular treatment fee for that visit. Please pay for the missed visit at or before your next appointment.

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.

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Signature of Patient

Date