# CONFIDENTIAL MEDICAL HISTORY

This information is essential in helping to make an accurate diagnosis and provide you with the most effective treatment possible. Please fill out this form completely and as accurately as you can. Attach a separate page or use the back of this form if needed.

Name:_____ Date_____

Birth date:_____ Height____Weight____ Blood pressure_____ Date of last physical_____

Describe your main complaint:_____

_____

What has been diagnosed? (by a physician):_____

_____

Are you currently being treated by a physician? Yes___ No___ If yes, for what?_____

_____

Any problems/ complications with <u>your</u> birth? Please check: Premature☐ overdue☐ c-section☐ prolonged labor jaundice other (please specify):_____

**<u>Vaccination History</u>**: Any negative reactions that you remember?_____

_____ Any unusual vaccinations?_____

**<u>Surgeries & Injuries</u>**: List any surgeries (even minor surgeries) or injuries. Please only list major injuries **<u>or</u>** ones that have had a lasting impact. (use the back of this form if necessary):

**Childhood**

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

**Adolescence**

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

**Adulthood**

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Age:_____ Surgery or injury:_____

Do you have any scars (even minor ones) from any of the above? Please list: _____

_____

_____

CONFIDENTIAL MEDICAL HISTORY CONTINUED

Name:_____ Date_____

**Please place a check by any of the following that are part of your medical history**:

___pregnancy (#____ ) ___pace maker ___HIV+ ___hepatitis (type____ )
___herpes (type____ ) ___bruise easily ___seizures ___cancer (type_____ )

**Family History**

Has any member of your immediate family had any of these conditions? (place letter by all that apply)

a. asthma
b. cancer
c. diabetes
d. seizures
e. heart disease
f. high blood pressure
g. stroke
h. alcoholism
i. high cholesterol
j. neurological disorders
k. psychological disorders
l. orthopedic disorders
m. food allergies (dairy, wheat, etc)
n. thyroid disease
o. other (please specify): _____

mother_____
father_____
brother_____
sister_____
maternal grandmother_____
maternal grandfather_____
paternal grandmother_____
paternal grandfather_____
aunt _____
uncle _____

**Medications/ Supplements/ Herbs/ Vitamins/ Minerals**

Please list any medications, supplements, herbs, vitamins or minerals you are currently taking:

_____
_____
_____
_____
_____

Is there anything else that is significant in your health history?_____
_____
_____

Name:_____ Date:_____

SYMPTOM/ CONDITION LIST

**Circle** any problem, symptom or disease that *bothers you now*. **Underline** anything that *bothered you in the past*, (***regardless of how long ago it was***). Please be as accurate as possible.

**Skin**: eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

**Heart and vascular**: fast pulse (over 100 beats/ min.) slow pulse (under 60 beats/ min.) palpitation irregular pulse feeling of pressure in your chest shortness of breath chest pain pericarditis dizziness migraine headache with nausea cold hands/ cold feet Raynaud's disease flushed face anemia high or low blood pressure cold sweats red face varicose veins stroke deep vein thrombosis feel dizzy or faint when standing up quickly or standing for a long time

**Gastrointestinal**: constipation diarrhea no appetite stomach pain indigestion heartburn gas belching ulcer gastritis lack of stomach acid hemorrhoids ileocecal valve spasm peritonitis pancreatitis appendicitis irritable bowel polyps GI tumors food allergy/ sensitivity

**Respiratory**: asthma bronchitis emphysema chronic cough wheezing pneumonia lung abscess environmental allergies (pollen, dander, grass, etc)

**Hormone Imbalance**: low thyroid over active thyroid diabetes hypoglycemia

other hormone imbalances:_____

**Male**: impotency premature ejaculation prostate gland problem vasectomy infertility low libido incomplete urination/ dribbling undescended testicle(s)

**Female**: heavy/ light/ irregular periods cramping PMS emotional reactions cysts fibroids endometriosis miscarriage menopause symptoms tubal ligation infertility low libido frequent bladder infections

**Neurological**: tremors ticks twitching Bell's Palsy paralysis numbness tingling burning pain

**Autoimmune & inflammatory conditions**: Hashimoto's disease (thyroid) rheumatism colitis systemic lupus erythematosus Crohn's disease alopecia (baldness) cellulitis atopic dermatitis neurodermatitis vulvitis low immunity

**Effects of focal infections**: rheumatic disease rheumatic fever skin disease streptococci infections staphylococci infections

**Connective tissue**: arthritis myofascial pain syndrome fibromyalgia tendonitis plantar fasciitis

**Ear nose & throat**: deafness tinnitus (ringing in the ear) itchy ear ear pain ear infections sore throat sinus headaches yellow mucus stuff nose post nasal drip dry throat itchy throat swollen glands constant sinus congestion streptococci throat infections easily catch colds

**Oral disease**: bleeding gums periodontitis dental abscess mumps toothaches without cavities TMJ stomatitis (inflammation of the mouth) loose teeth

**Other**: insomnia exhaustion psychosomatic disorder constant slight fever kidney stones emotional problems (angry, irritable, depressed, anxious, etc.) difficult concentrating on a task car/ sea/ air sickness no appetite for breakfast moody in morning easily jet lagged never sweat unusual sweating (palms, soles, elsewhere) trouble adjusting to temperature change gall stones

**Before noon time**: no energy feel spacey scattered mind long shower or bath makes you feel dizzy energetic all evening, but hate to wake up early in the morning

**Medication and Drugs**: Birth control tobacco caffeine alcohol marijuana stimulants

**Not listed above**: _____

_____

 

ACCOUNT INFORMATION

First name: _____ Last name: _____ Name you go by: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone: Mobile: _____ Home: _____ Work: _____

What is your primary contact number? Mobile: Yes / No Home: Yes / No Work: Yes / No

Is it okay to leave private information at these numbers? Mobile: Yes / No Home: Yes/ No Work: Yes / No

Sex: Male Female Birth date: _____ Student: Yes / No, If 'yes': full or part-time

Occupation: _____ Employer:_____

E-mail address: _____ Marital Status (circle) M S W D P (legally partnered)

**Your email address is required for our records. We use it to send appoint confirmations and reminders, and to inform you of important information such as changes in office policy, clinic hours, etc.**

Please note: **YOUR E-MAIL AND CONTACT INFORMATION IS PRIVATE AND PROTECTED BY LAW, WE DO NOT SELL IT TO THIRD PARTIES.**

Would you like to be notified about upcoming events or special offers that Green Willow Acupuncture is associated with via e-mail?

Yes / No

Person who will be responsible for payment on this account: _____

Contact info for responsible party, (if different from patient's info above):

First name: _____ Last name:_____ Relationship to patient: _____

Address: _____City: _____ State: ___ Zip: _____

Telephone: Day: _____ Evening:_____ Mobile:_____

Emergency contact name: _____ Phone: _____ Relation: _____

Is your condition due to an accident? Yes / No If Yes, Date of accident?_____

What kind of accident was it? (please circle): automobile accident / work related accident / other_____

Do you have an open or ongoing insurance claim related to this accident? Yes / No

How did you hear about us? Word of mouth / phone book / drive, walk, ride by / the Source / on the web / other _____

If you heard about us from a friend or as a referral from someone, please give us their name so we can thank them:

_____

Have you had or are you currently having acupuncture? Yes / No If yes, with whom and when?_____

_____

# OFFICE POLICIES

We want you to know that your health is our primary concern and providing effective, affordable treatment is our mission. By implementing and maintaining these policies it allows us to focus our attention on that mission. It is with this in mind that we are constantly striving to find ways to better serve you. Thank you for choosing Bend Community Acupuncture.

**General**:
Please be on time for your appointment. That means that you have arrived at the clinic and are ready to begin treatment at your scheduled time. Wear comfortable, loose fitting clothing or bring it to change into BEFORE your appointment time. ***Please do not wear perfumes, fragrances or any other strong scents***.

**Noise policy**:
Out of courtesy to other patients please keep noise levels down and speak in a "library voice" while in the office. Cell phone conversations are prohibited in the clinic. Please silence your phone prior to entering. *Auditory privacy is not guaranteed in our reception area.*

**Cancellation policy:**
We require a 24-hour notice to cancel an appointment. Clients who miss more than one appointment without giving 24 hours notice will be charged for the missed appointment. Call and let us know if you are going to be late**.** Clients who are more than 10 minutes late will have to re-schedule their appointments, and will be charged for a missed appointment. Unfortunately, we cannot guarantee that latecomers will receive adequate time for their treatment.

**Snow cancellation policy**:
Appointments cannot be cancelled with less than a 24hr notice due to snowfall unless the Bend Unified School District is on a "Snow Delay" or is closed due to excess snowfall.

**Our payment policies:**
We accept the following forms of payment: cash, check, credit, and debit cards. Full payment is due at the time services are rendered, unless prior arrangements have been made. Please understand that you the client or other responsible party, are liable for all charges and balances on your account. There will be a $30.00 fee charged for all returned checks, plus the face value of the check.

These Policies are subject to change. Any changes made will be posted at our front desk and/ or on our website.

I have read, or have had read to me, the above policies. I have also had an opportunity to ask questions about their content and by signing below I am agreeing to the above listed policies.

Patient's name: _____ Signature: _____ Date: _____
(Please print)

Representative's name: _____ Signature: _____ Date: _____
(Please print)

Relationship to patient: _____

# PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please request the **NOTICE OF PRIVACY PRACTICES** from your practitioner.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this office.

_____

Signature of patient or representative Date

_____

Print patient name

Green Willow Acupuncture 541-388-4999

# INFORMED CONSENT AGREEMENT

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 the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, oriental massage (Tui-Na), oriental herbal medicine, and nutritional counseling. 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 be 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.

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. Bruising and/or blistering are common side effects of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking or applying 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been informed about the risks and benefits of acupuncture and other procedures, and have had the 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.

Acupuncturist: Rob Mills, L.Ac., MTCM and Emden Griffin, L.Ac., MAOM

Patient's name: _____ Signature: _____ Date: _____
(Please print)

Representative's name: _____ Signature: _____ Date:_____
(Please print)

Relationship to patient: _____