ACUPUNCTURE PLUS

Health History Questionnaire

Information for your Acupuncturist
Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
*****All information is strictly confidential*****

Your General Information (Please print)

Date: ____ /____ /_____ Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Cell Phone: (_____) _____ - _____

Home Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____

Email: _____

Age: _____ Date of Birth: _____ /_____ /_____ Place of Birth: _____

Occupation: _____ Guardian (if under 18): _____

Gender: ☐ Male ☐ Female Height: _____' _____" Weight: _____lbs

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Insurance Name: _____ Provider Phone #: _____

ID #: _____ Group #: _____

Have you done acupuncture before? ☐ Yes ☐ No (If yes, about how many times? _____)

How did you hear about our office? Referral by: _____

☐ Google ☐ Facebook ☐ Yelp ☐ Other: _____

Your purpose and goal for visiting me today:

1. _____

2. _____

3. _____

Conditions you want to improve

	Severe	Moderate	Slight	
1	☐	☐	☐	
2	☐	☐	☐	
3	☐	☐	☐	
4	☐	☐	☐	
5	☐	☐	☐	
6	☐	☐	☐	
7	☐	☐	☐	

Other conditions you want to improve: _____

How do these conditions impair your daily activities? _____

_____

Other physicians or therapists you are seeing:

Dr. _____ For _____

Dr. _____ For _____

Dr. _____ For _____

Medications you are taking:

Medications: _____ Prescribed by: _____ For: _____

Medications: _____ Prescribed by: _____ For: _____

Medications: _____ Prescribed by: _____ For: _____

Medications: _____ Prescribed by: _____ For: _____

Medications: _____ Prescribed by: _____ For: _____

Supplements (if any vitamins, herbs, minerals, etc.):

_____

_____

Please check the following that pertain to you:

Energy level:	☐ High	☐ Medium	☐ Low	
Appetite:	☐ High	☐ Normal	☐ Low	
Stress level:	☐ High	☐ Medium	☐ Low	
Sleep:	☐ Good	☐ OK	☐ Poor	
Bowel Movement	☐ Normal	☐ Loose	☐ Diarrhea	☐ Constipation
Emotion:	☐ Anxiety	☐ Anger	☐ Fear	☐ Sadness
	☐ Worry	☐ Other: _____		

Urination: Frequency: _____ Color: _____ Other: _____

Recent tests: (Please attach test results)

☐ Physical	☐ Cholesterol	☐ Prostate	☐ Blood (which?)	☐ HIV/STD
☐ Pap Smear	☐ Mammography	☐ Other: _____		

Your Medical History

How was your childhood health? _____

Hospital Visits / Stays: _____

Check any conditions you have had in the past:

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Polio	☐ Stroke	☐ Vein Control	☐ Thyroid Control
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Meningitis	☐ Bleeding Tendency
☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous Disorder
☐ Epilepsy	☐ HIV	☐ Heart Disease	☐ Mononucleosis
☐ Paralysis	☐ Cancer	☐ Migraines	☐ High Blood Pressure
☐ Mumps	☐ High Fever	☐ Hepatitis	☐ Multiple Sclerosis
☐ Other heart illnesses		☐ Other liver illnesses	☐ Other kidney illnesses
☐ Other spleen illnesses		☐ Other lung illnesses	☐ Other stomach illnesses

Other: _____

Immunization: _____

Surgeries: _____

_____

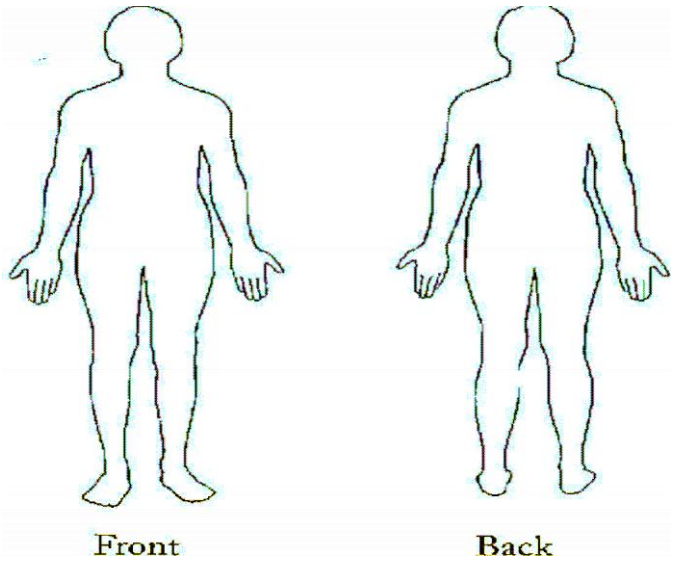
Your Family History

Family member	*Alive*	*Deceased*	*Present Health or Cause of Death*
Father	☐	☐	_____
Mother	☐	☐	_____
Spouse	☐	☐	_____
Children	☐	☐	_____
Brother	☐	☐	_____
Brother	☐	☐	_____
Sister	☐	☐	_____
Sister	☐	☐	_____

Where are you in the birth order? First Middle Last Only Other: _____

Patient Profile

Please clearly mark any areas with pain or scars: (Mark an X for *pain* or mark an O for *scars*):



Is the pain: Sharp Burning Aching Cramping Moving Fixed Other: _____

Do the following lessen the pain? Pressure Cold Heat Exercise Other: _____

Do the following worsen the pain? Pressure Cold Heat Other: _____

Women's Health

(Gentlemen, please go to the bottom of the page and sign it.)

Pregnant: ☐ Yes ☐ No

Age of first menstruation: _____ / Number of days of flow: _____

Cycle: every _____ days / Vaginal discharge: _____

Fertility challenge: _____

Irregular Period: _____ Fibroids: _____

Endometriosis: _____ Ovarian cysts: _____

Others: _____

Any of the following pre-menstrual syndromes:

☐ Vomiting	☐ Nausea	☐ Headaches
☐ Anxiety	☐ Food cravings	☐ Irritability
☐ Breast swelling	☐ Depressions	☐ Water retention
☐ Breast tenderness	☐ Migraines	

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain / cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Other							

Age of Menopause (if applicable): _____ Hot flashes: _____

Night sweats: _____ Dry skin: _____ Other: _____

X_____ **Date:** ____/____/____

Patient signature

Notification Form Regarding

Evaluation of Patient by a Physician

(Pursuant to the requirement of Section 6.11, Subsection
(b) through (d) V.A.C.S., article 4495b, governing the practice of acupuncture)

I _____ am notifying Acupuncture Plus of the following:

☐ Yes ☐ No I have been evaluated by a physician, dentist, or nurse practitioner for the condition being treated within six months before the acupuncture was performed.

I recognize I should be evaluated by a physician for the condition being treated by the acupuncturist.

OR

☐ Yes ☐ No I have received a referral from a chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 30 days or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician.

It is my responsibility and choice to follow this advice.

X_____ **Date:** ____/____/____
Patient signature

Acupuncture Plus is not responsible for untrue statements made by patients.

Dear Acupuncture Plus's Client,

Many insurance companies are putting limitations and restrictions on coverage for acupuncture. Please know we will do our best to inform you of acupuncture coverage for your specific plan but these quotes are only estimates of coverage until we file your claim.

I understand that this office will bill my insurance company as a courtesy to me, and if for any reason the insurance company does not pay or cover the services, that I will be directly responsible for no more than $125.00, a discounted price, per a basic acupuncture session (excluding herbal supplements and specialty treatments).

_____

Client's Name

_____ _____

Signature (or responsible party) Date

NOTE** If you have multiple health coverage plans, please include all health plans you may have actively covering you as to help us file your claims properly and timely.

List which plan is your primary and which one is your secondary coverage.

Primary_____

Secondary_____

ACUPUNCTURE PLUS

11851 Jollyville Road #102

Austin, TX 78759

Contact us by phone: (512) 453-5352

Email: acupunctureplus.austin@gmail.com

www.AcupuncturistAustin.com