Miranda R. Taylor, M.TCM., EAMP, L. Ac., High Point Health, dba Gesundheit Acupuncture and Herbs PLLC
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Health History Questionnaire

Date: ___/___/___

Patient's Name (Last, First, M.I.)	****DOB** (mm/dd/yyyy) **Sex**(M/F/O)	**Patient Status**: Single ☐ Married ☐ Other ☐ **Employed** ☐ **Student**: F-Time ☐ P-Time ☐	
Patient's Address (No. Street)	**Relation to Insured**	**Patient's Employer**	
City **State**	**Zip Code**	**Home/Cell Phone** (10 digit)	**Work/Cell/Other Phone**
Insured's Name (Last, First, M.I.)	****DOB** (mm/dd/yyyy) **Sex**(M/F/O)	**Insured's Employer:**	
Insured's Address (No. Street)	**Phone** (10 digit)	**Who** Referred You?	
City **State**	**Zip Code**	Tried acupuncture before? Y N When? With whom? For what reason?	
Patient's e-mail address:			

Insurance Company (I will copy your card front & back**) or Auto Ins. adjuster name & phone:**

Auto Accident? Y N **U.S. State** **Injury Date** **Injury Claim Number**

Are you presently being treated for a medical condition? Please describe. _____

What health issue(s) do you want treated? When did issue(s) begin? Have you been given a diagnosis? If so, what? Please describe as fully as possible, on separate sheet - if needed - for all your health concerns. _____

What treatments have you tried already? What were the results? _____

To what extent does this problem interfere with your daily activities?

How severe is (are) your problem(s) right now? (Please mark the scale below):

No problem Moderate Worst Imaginable

What's the most severe level you have endured within the last week? (Please mark the scale below):

No problem Moderate Worst Imaginable

Your Past Medical History (please indicate with **date(s)** on the line:

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____

Surgeries (type and date), Other Significant Trauma (auto accidents, falls, etc. and date):

_____

_____

Significant Dental Work (type and date): _____

_____

Birth History (prolonged labor, forceps delivery, caesarian section, etc, when YOU were born):

_____

(How) Do You Take Care Of Your Spirit? _____

Family Medical History (other family members besides yourself):

☐ High Blood Pressure	☐ Alcoholism	☐ *Cancer:*	☐ Allergies (other family):
☐ Heart Disease	☐ Seizures	*Who? What kind?* _____	
☐ Arteriosclerosis	☐ Asthma	☐ Stroke	☐ Diabetes

Occupational Stress (chemical, physical, psychological, etc.): _____

_____

Do you exercise regularly? Y or N Please describe: _____

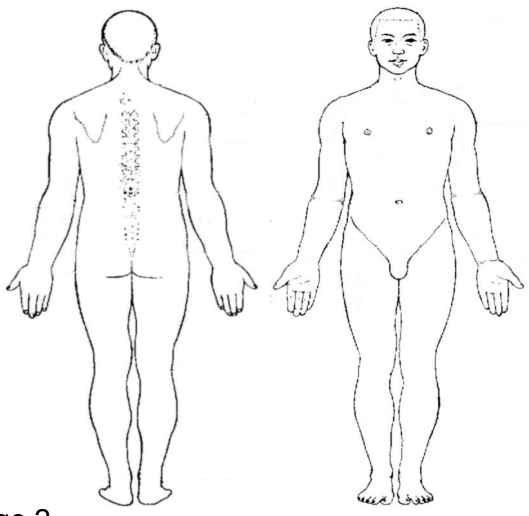
_____

Please list any other problems you would like to discuss: _____

How do you feel about the following areas in your life? Please circle appropriate description and indicate any problems you may be experiencing.

Partner or significant other:	great good fair poor bad	_____
Family:	great good fair poor bad	_____
Diet:	great good fair poor bad	_____
Sex:	great good fair poor bad	_____
Self:	great good fair poor bad	_____
Work:	great good fair poor bad	_____

Please indicate Painful or Distressed Areas on diagram of body below:



What are Your Treatment Goals?

- ☐ Temporary relief of symptoms, such as pain control.
- ☐ Eliminate root or cause of problem, if possible.
- ☐ Lessen/eliminate habits which contribute(d) to condition.
- ☐ Maintenance care (to keep in good health).

On the following page, please check any boxes of acute symptoms you have had in the past 2 weeks. Please also check long-term chronic conditions that you still have, and include dates, if requested:

Patient Name:_____ Date:_____

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema (swelling)
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches…
  *When:*_____

  Where: _____
- ☐ Facial pain
- ☐ Glasses
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

_____

Cardiovascular

- ☐ Arteriosclerosis/Stints
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other stomach or intestinal problems:*_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?
☐ Yes ☐ No

How often? _____
What color is your urine?

_____

*Other genital or urinary system problems?*_____

Pregnancy and Gynecology

of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Average Length of full cycle:
e.g. 23-34 days_____
Average Length of menses:
e.g 3-7 days_____
Last menses start date:

_____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  Year: _____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?
☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

Other pain / lack of movement?

_____

Neuropsychological

- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?
☐ Yes ☐ No

Patient Name: _____ Date: _____

Last Physical Date: _____ Doctor: _____ Results: _____

Are you now, or have you ever been, on a restricted diet? Please describe the diet and give the start/stop dates:

_____

_____

What medicines have you taken within the last 2 months? (include prescriptions, vitamins, over-the-counter drugs, herbs, etc.) Please attach longer lists: _____

_____

_____

What allergies do you have? What are your reactions to chemicals, foods, drugs, animals etc?

_____

Habits Please indicate below: None, Light, Moderate, or Heavy. Please circle or add comments:

	Excessive	Moderate	Minimal	None	
Alcohol:	☐	☐	☐	☐	
Coffee:	☐	☐	☐	☐	
Herbal or blackTea:	☐	☐	☐	☐	
Tobacco:	☐	☐	☐	☐	
Sleep:	☐	☐	☐	☐	
Appetite:	☐	☐	☐	☐	
Energy Level:	☐	☐	☐	☐	
Prescribed med's:	☐	☐	☐	☐	
Vitamins:	☐	☐	☐	☐	
Food Intake:	☐	☐	☐	☐	
Teeth problems:	☐	☐	☐	☐	
OTC/illegal/drugs:	☐	☐	☐	☐	
Salt Intake:	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	
Stress Level:	☐	☐	☐	☐	

FOOD Required: Your dietary intake, in detail. Everything you ate in the past 24 hours:

Morning: .....

Afternoon: .....

Evening: .....

Before bed: .....

Between meals: .....

Local person to call in case of an emergency? Name & Phone:_____

Sometimes other professionals can help me provide better care for you. If you would like me to consult with any of your other health care professionals, I will need to have you sign an agreement form before I consult with them. Would this be helpful?

Yes --- No If Yes: name of practitioner & contact info: _____

Informed Consent for East Asian Medicine Treatment

Purpose of treatment: The purpose of treatment is to resolve your complaint, i.e., the reason you are seeking treatment. “East Asian Medicine” is a health care service utilizing East Asian Medicine diagnosis and treatment to promote health and treat organic or functional disorders.

Nature of treatment: The scope of East Asian Medicine practice includes acupunctrue, electroacupuncture, moxibustion, acupressure, cupping, Gua Sha (dermal friction), infrared, sonopuncture (sound stimulation), laserpuncture, point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory; herbal, vitamin and nutritional supplements; breathing, relaxation and exercise techniques; Qi gong, East Asian massage and Tui na; and heat and cold therapies.

Benefits of treatment: Acupuncture and East Asian Medicine procedures have been used effectively to treat disease for hundreds of years. The world Health Organization lists over 40 conditions, which are effectively treated by acupuncture. These include muscular-skeletal injuries, digestive difficulties, respiratory diseases, women’s health issues, etc. This record does not allow a guarantee of any individual course of treatment.

Risks of treatment: East Asian Medicine procedures have been shown to be relatively safe. There are some uncommon but potential risks, which include discomfort during and after treatment; “needle sickness,” which includes dizziness or fainting, which may occur if the patient has not eaten; localized but minor bruising or swelling; minor burns from moxibustion, infection (rare with my use of disposable needles); broken needle; and temporary aggravation of symptoms that existed prior to treatment.

Please notify the acupuncturist if you have any adverse effect from treatment. Miranda will be glad to work with you to overcome any adverse effect.

Special situations: You should inform Miranda if you have a severe bleeding disorder or are wearing a pacemaker or other electronic medical device. In addition, some herbs and acupuncture points are contraindicated during pregnancy. Notify Miranda if you are pregnant, or if you might be pregnant.

Confidentiality of medical records: Your medical records are not released to anybody without your written consent. If data from this clinic are used in research, all identities and individual records are kept confidential.

Required consultations: Washington State law requires acupuncturists to receive a written diagnosis or to consult with a primary care provider (MD, DO, ND, PA, ARNP), before treating patients with any of the following potentially serious disorders: cardiac conditions, including uncontrolled hypertension; acute abdominal symptoms; acute, undiagnosed neurological changes; unexplained weight loss or gain in excess of 15% of body weight within three months; suspected fracture or dislocation; suspected systemic infection; any serious, undiagnosed hemorrhagic disorder, and acute respiratory distress without previous history or diagnosis. This consultation requires your authorization; if you refuse the authorization or do not provide a recent diagnosis from the physician, you will have to sign a waiver so that treatments may continue.

The First Consent Part

By signing below you request and consent to the performance of acupuncture and East Asian medicine treatments. You are free to withdraw your consent and stop treatment at any time.

You understand that your signature indicates that you have read and understand the preceding information and that you will ask Miranda if you have any question about it.

You release Gesundheit Acupuncture and Herbs pllc from any and all liability that may occur in connection with the treatments, except for the failure to perform the procedures with appropriate medical care.

Your signature also authorizes the release of any medical information necessary to process a claim for insurance benefit coverage. It does not authorize release of medical information for any other purpose.

Your signature also indicates your understanding that you are ultimately responsible for all financial obligations for treatments.

Patient/Guardian's Name (please print) _____

Patient/Guardian's Signature _____ Date signed _____

The Cancellation Policy Consent

Please contact Miranda at least 24 hours prior to your appointment to cancel or reschedule it. This may be done by phone to Miranda's voicemail at any hour. Miranda enforces a strict cancellation policy and you will be charged the full amount for your scheduled appointment time if canceling or rescheduling is less than 24 hours before your appointment. Thank you for your time and understanding.

I (please print name) _____, have read the cancellation policy and acknowledge that I will be charged the full amount and am responsible for payment of my scheduled appointment if I cancel for reschedule with less than 24 hours notice:

Patient/Guardian's Signature _____ Date signed _____

Qualifications: Miranda R. Taylor is licensed by the State of Washington to practice East Asian Medicine, including acupuncture and nutritional therapies. Her license number is AC 002224, first awarded in 2003. She was awarded a four-year Master's Degree in Acupuncture by the NW Institute of Acupuncture and *East Asian* (use of *Oriental* is now outdated language) Medicine (NIAOM). She served an internship at the Chengdu University of TCM Hospital, April-June, 2002, in China.

Patient Name: _____

INSURANCE VERIFICATION FORM—please fill out completely— Required if you expect your insurance plan to pay for your acupuncture therapy.

My office is set up for direct payment from insurance companies. This is done as a service to you. It is important that you understand that insurance policies are an arrangement between you and your insurance company. You are personally responsible for all charges incurred in my office. I expect payment in full when the services are rendered until your insurance coverage has been verified.

***Name of person** you spoke with at the insurance company _____

*Date called_____ Time called_____

*required because if the company does not pay, you can ask for recording of the call.

Does my insurance policy cover acupuncture performed by a licensed acupuncturist?

YES--------NO

Is Miranda R. Taylor in my health insurance network? YES-------NO

If no, what are the "out of network acupuncture benefits" for my plan?_____

Is my specific issue = _____ covered for acupuncture? YES--------NO

Is my_____ **pain issue** covered for acupuncture? YES------NO

Is this CPT (treatment) code covered? 99213? (evaluation/mgmt) YES——NO

97810? (acupuncture) YES--------NO

What is my annual acupuncture benefit limit? (*dollars)* $_____

What is my annual acupuncture benefit limit? *(numbers)* # of treatments covered _____

What is my deductible? $_____

Has it been met? YES--------NO

If NO, what is the amount remaining? $_____

Is there a co-pay? YES————NO If YES, how much? $_____

If I need to pay co-insurance, what percentage of what is billed will I need to pay?_____

Does acupuncture treatment have to be referred by my primary care physician? YES-NO

Who is my primary care physician?_____Phone:_____

Please bring your insurance card to your appointment: we copy front & back