Misty Mountain Acupuncture – Health History

Valerie S. Wilson, EAMP, LAc • 145 E. Third St., North Bend 98045 • 425.985.6494
www.MistyMountainAcupuncture.com

Name_____ Today's Date _____

Phone (primary)_____ OK to leave messages? Y or N Text? Y or N

Emergency Contact Name _____ Emergency Contact Phone _____

Address_____ City_____ State_____ Zip_____

Email Address_____(Appointment reminders go to your email)

Age_____ Date of Birth_____ Height_____Weight _____

Marital/Partnership Status_____ Referred by_____

Occupation _____Employer Name & Address_____

Insurance

Policyholder's Name_____ Relationship _____ Policy Holder birth date_____

Employer_____ Insurance Company_____ Group # _____

Physician Information

Family Physician_____ Phone _____

Main Problem(s) _____

_____

How long ago did this problem begin (be specific)? _____

_____

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

_____

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

_____

What kinds of treatment therapies have you tried? _____

_____

Past Medical History (please include date):

Cancer _____ Stroke _____ Diabetes_____

Autoimmune Disease _____ Heart Disease _____ Venereal Disease _____

High Blood Pressure_____ Hepatitis _____ Thyroid Disease _____

Seizures _____ Other_____

Surgeries and/or Hospitalizations (type and date)

_____

_____

Significant Trauma (falls, injuries, auto accidents, etc)

_____

_____

Significant Dental Work

_____

_____

Allergies (drug, food, chemical, etc.)

_____

_____

Family Medical History (check)

☐Diabetes ☐Cancer ☐High Blood Pressure ☐Heart Disease ☐Stroke ☐ Seizures ☐Asthma ☐Allergies

☐Other_____

Medicines taken with the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement	Reason for Taking It
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Occupational Stress (physical, chemical, emotional, etc)

_____

Do you have a regular exercise program? If yes, please describe: _____

_____

Have you ever been on a **restricted diet**? ☐Yes ☐No If yes, what kind? _____

_____

Please describe your **average daily meals**:

Morning _____

Afternoon _____

Evening _____

Snacks _____

☐ Smoke: number of cigarettes per day _____ ☐ Alcohol: number of drinks per day _____

☐ Caffeinated coffee/tea/cola cups per day _____ ☐ Recreational drugs: describe _____

Please check any you have had in the last three months

General

- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweats easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar smells or tastes
- ☐ Strong thirst (hot or cold)
- ☐ Thirst with no desire to drink
- ☐ Sudden energy drop: What time of day?____
- ☐ Poor sleep
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain
- ☐ Weight loss

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair and skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Other skin or hair problem

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficult breathing lying down
- ☐ Production of phlegm: Color?_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Other lung problems
- ☐ Date of last cold or flu_____

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches – where and when?_____ _____
- ☐ Other head or neck problems _____ _____

Cardiovascular

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands and feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Chest pain
- ☐ Fainting
- ☐ Phlebitis
- ☐ Difficulty breathing
- ☐ Other heart or blood vessel problems_____ _____

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems_____ _____

Genito-urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Other genital or urinary problems _____ _____
- ☐ Do you wake up to urinate? _____
- ☐ How often? _____
- ☐ Particular color to your urine? If so, what color? _____

Pregnancy and Gynecology

Number of pregnancies _____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age of first menses_____
Days between menses _____
Duration _____
First day of last menses _____
☐ Unusual character (heavy or light)
☐ Painful periods
☐ Vaginal discharge
What color?
☐ Changes in body/mood
prior to menstruation
☐ Clots
☐ Vaginal sores
☐ Irregular periods
☐ Last Pap _____
☐ Breast lumps
Are you sexually active?_____
Birth control? ☐ Yes ☐ No ☐ N/A
What type and for how long?
_____

Musculoskeletal

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

Neuropsychological

☐ Seizures
☐ Areas of numbness
☐ Concussion
☐ Bad temper
☐ Dizziness
☐ Lack of coordination
☐ Depression
☐ Easily susceptible to stress
☐ Loss of balance
☐ Poor memory
☐ Anxiety
☐ Other neurological or
Psychological problems
_____
_____

Please make a check in the box that indicates the severity of your problem as it is now:

No problem	Annoying	Just managing	Uncomfortable	Worst imaginable

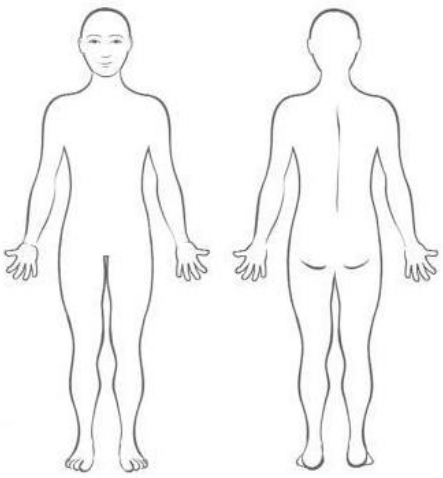
Please note the severity within the last week:

No problem	Annoying	Just managing	Uncomfortable	Worst imaginable

Comments (please mention any other problems you would like to discuss)

_____
_____
_____

Indicate painful or distressed area



Misty Mountain Acupuncture – Notice of Privacy

Valerie S. Wilson, EAMP, LAc • 145 E. Third St., North Bend 98045 • 425.985.6494
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Please review the information below carefully.

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA):
HIPPA is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. This act provides the patient rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health.

Our Responsibility:
We respect our legal obligation to keep health information that identifies you as private. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use it and disclose your health care information. We do not use your health information inside or outside our office without your written permission. In some limited cases, the law requires us to disclose your health care information without either a written or verbal consent.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Use and Disclose with Consent:
We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations in this office. Treatment can be stopped with refusal to sign the form. We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization.

Use and Disclosure without Consent:
In some limited situations, the law requires us to use and disclose your health information without your permission. These examples include:

- When state or federal law mandates certain health information be reported for a specific purpose.

- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims or suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
- Disclosures in response to subpoenas of orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.

Your Rights Regarding Your Health Information:
You have the following rights with respect to your protected health information, which you can exercise in writing to our office:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to the request restriction. If we do agree with the restriction, we must abide by it unless you agree I writing to remove it.
- The right to ask to communicate with you in confidential ways, such as contacting you at work rather than at home. Please provide a written request.
- The right to see or get photocopies of your health information. You may have to pay for photocopies in advance. We do charge a fee to release your records to an outside source other than a health care provider. Please complete our written records request for billing or medical records release.
- The right to receive an accounting disclosure of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice at your request.

You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Service in the event you feel your privacy rights have been violated.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

Signature_____ Date _____

EAST ASIAN MEDICINE INFORMED CONSENT TO TREAT & FINANCIAL POLICY

Misty Mountain Acupuncture • 145 E. Third St., North Bend, WA • 425-985-6494

Licensed in Washington State as Valerie S. Wilson, EAMP, LAc, #AC60643266

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese/Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above 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 within the scope of Chinese/Oriental medicine may include, but are not limited to, acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians, use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, moxibustion, acupressure, cupping; dermal friction technique; infra-red; sonopuncture; laserpuncture; point injection therapy (aquapuncture); dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; breathing, relaxation, and East Asian exercise techniques; qi gong; East Asian massage and Tui na, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and superficial heat and cold therapies. I understand that the herbs may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application 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, dizziness or fainting, and needle sickness. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (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 effect 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, I will notify the acupuncturist named below if I am taking any medication or supplements concurrently with Chinese herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify an acupuncturist member who is caring for me if I am or become pregnant. ***Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema must inform practitioners prior to any treatment.***

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups.

I understand that the acupuncturist may review my patient records and lab reports.

I agree to the release of any medical information my health insurance may need I order to process payment. I assign such benefits to be paid to the above named provider. In the event that my insurance coverage expires or denies payment, I understand that I am personally responsible for all fees incurred unless other arrangements have been made. I will provide my acupuncturist with at least 24 hours' notice if I need to cancel or reschedule an appointment and I understand that I will be charged the regular amount for my appointment broken with less than 24 hours' notice.

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

Signed_____ Date_____

Printed name_____