Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F Marital status: S M D W

Address: _____ _____ _____
(street) (city/state) (zip code)

Phone Number: (cell)_____ (work/home)_____

Email: _____ Blood Type: _____

Primary Care Physician: _____ _____
(name) (phone number)

Emergency Contact: _____ _____
(name) (phone number)

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care?

_____

For what reason?

_____

2. Has your case been referred to an attorney? Y N

3. Please identify the health concerns that have brought you here in order of importance below:

Condition **Past Treatment**

a. _____ _____

How does this condition affect you? _____

b. _____ _____

How does this condition affect you? _____

4. If applicable, please list any foods, drugs, or medications you are sensitive or allergic to (please include reaction):

_____

Name: _____ Date: _____

5. Please list any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking:

_____

_____

_____

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. **Family History:** Check those applicable:	Father	Mother	Brother(s)	Sister(s)	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other severe illnesses with approximate date: _____

Name: _____ Date: _____

13. **Hospitalizations and Surgeries:**

What	Reason	When

14. **X-Rays/CAT Scans/MRI's/Special Studies:**

What	Reason	When

15. **Emotional** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Mood Swings Nervousness Stress Depression Anxiety Panic Attacks

Any diagnosed mental illness? _____

16. **Energy and Immunity** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

17. **Head, Eye, Ear, Nose, and Throat** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Impaired/Blurry Vision	Red/Dry Eyes	Poor Night Vision	Floaters in Vision
Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches/Migraines
Sinus Problems	Nose Bleeds	Frequent Sore Throats	Teeth Grinding
TMJ/Jaw Problems	Hay Fever		

18. **Respiratory** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Phlegm	Asthma
Tuberculosis	Shortness of Breath	Allergies	Chronic Bronchitis

Other Respiratory Problems: _____

Name: _____ Date: _____

19. **Cardiovascular** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Heart Disease Chest Pain/Pressure Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

Abnormal Bleeding Easy Bruising Low Blood Pressure Stroke Heart Attack

20. **Gastrointestinal** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Very Thirsty No Thirst Epigastric Pain

Passing Gas Heartburn Belching Gall Bladder Disease Liver Disease Hepatitis B or C

Hemorrhoids Abdominal Pain Constipation Diarrhea

Any abnormal color, blood, smell, consistency, mucus, frequency, quality or quantity? Y N

If yes please explain: _____

21. **Genito-Urinary Tract** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Any abnormal color, smell, urgency, blood, foam, cloudy, frequency, quality or quantity? Y N

If yes please explain: _____

22. **Female Reproductive/Breasts** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge/Dryness Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods Sexual Function/Pain

23. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 5. Birth Control Type: _____ 8. # of Abortions: _____

2. # of Days of Menses: _____ 6. # of Pregnancies: _____ 9. # of Child births: _____

3. Length of Cycle: _____ 7. # of Miscarriages: _____ 10. Age of Menopause: _____

4. Date of last PAP smear: _____ Any abnormalities? _____

24. **Male Reproductive** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Sexual Difficulties/Pain Prostate Problems Testicular Pain/Swelling Discharge

Name: _____ Date: _____

25. **Musculoskeletal** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where): _____

26. **Neurologic** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Night Sweats Feeling Hot or Cold

28. **Dermatologic** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Rash Itching Eczema Psoriasis Acne Cold sores Shingles

29. **Other** (please **circle** any that you experience now and **underline** any that you have experienced in the past):

Anemia Cancer Cold Hands/Feet Dry Skin Dry Hair Dry Mouth Dry Eyes

30. Any Chronic or Continuing Illnesses or Conditions? _____

31. Any Contagious Diseases? _____

32. Is there anything else we should know? _____

_____

33. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Are you vegetarian? Y N Do you eat fish? Y N Eggs? Y N Diary? Y N

Other dietary restrictions: _____

b. Exercise routine: _____

c. How is your sleep? _____ How many hours per night do you sleep? _____

Do you wake up often? Y N Do you have trouble falling asleep? Y N Do you wake feeling rested? Y N

Name: _____ Date: _____

d. Level of education completed: High School Bachelors Masters Doctorate Other

e. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine Use(what & how much): _____

Caffeine Use(what & how much): _____

Alcohol Use (how much):_____

Drug Use (what & how much): _____

h. Have you experienced any major traumas? Y N Explain as you feel comfortable: _____

_____

i. Approximately how many ounces of water do you drink per day? _____oz.

j. Television habits: _____ Reading habits: _____

k. Interests and hobbies: _____

_____

l. Energy Level: (circle a number 1-10) (low energy) 1 2 3 4 5 6 7 8 9 10 (high, all the energy you need & more)

m. What are your goals with our treatment? _____

_____

_____

n. What is it you would like to be able to do but are unable to do right now due to your chief complaint? (ie-exercise, activities, work, family, or specific movements): _____

_____

_____

_____ _____

Signature Date

Financial Policies

Service	Price
Acupuncture new patient 1 hour	$120
Acupuncture return patient 45mins	$100
Yoga private lesson 1 hour	$100

How it works…

- All payments are due at the time of service.
- We will gladly provide you with the necessary forms for you to bill your insurance so that your insurance company can reimburse you directly.
- Please be on time, if you are late that time will be deducted from your appointment and you will be charged the full amount.
- Most conditions require an average of 4-8 treatments, although some will respond within 2-4 visits and others may require a longer series. This depends on the severity, the chronicity of what we are working on, your ability to stick to the plan that you have been given and your body's overall health and ability to recover. Every individual is unique and will respond in a different timeline.
- We accept **CASH & CHECKS ONLY**.
- Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you may be charged the full appointment fee. Insurance will not pay for a missed appointment.
- A $25 fee will be charged for all returned checks.

Please indicate your understanding and acceptance of these policies by signing below.

_____
Signature

_____ _____
Printed Name Date

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or herbal medicine or vitamins/supplements by Tiffany Cruikshank, L.Ac., MAOM, E-RYT at Athlete's Point PLLC. I understand that acupuncturists practicing in the state of Washington are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.
Herbs/Vitamins & Supplements: I understand that herbal medicine as well as vitamins and supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call as soon as possible.*
Acupressure/Tui-Na: I understand that I may also be given acupressure, tui-na or other forms of bodywork as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment at any time if it is uncomfortable.
Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.
Yoga: I understand that yoga can include physical exercises, stretches, breathing practices and meditation to regulate the body's movement patterns & physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to the treatment. Symptoms can get worse before they get better but I acknowledge that I am responsible to reports all changes along the way. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop at any time.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____/_____/_____

Printed Name: _____

Privacy Policies / HIPAA Form

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment. I consent to the use or disclosure of my identifiable health information by Tiffany Cruikshank, L.Ac. for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Athlete's Point PLLC may be conditioned upon my consent as evidenced by my signature on this document. Athlete's Point PLLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

I understand that this information serves as:

1 A basis for planning my care and treatment.
2 A means of communication among the many healthcare professionals who contribute to my care.
3 A source of information for applying my diagnosis and surgical information to my bill.
4 A means by which a third-party payer can verify that services billed were actually provided.
5 A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

1 To object to the use of my health information for directory purposes.
2 To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
3 To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

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

_____

_____

_____

_____

Patient:

X_____ _____/_____/_____

Patient Signature or Legal Representative **Date**

_____

Printed name and relationship