Hillcrest Community Acupuncture

1807 Robinson Ave. Suite 205 San Diego, CA 92103
619-298-2228 www.HillcrestACU.com

Health History Questionnaire and Registration

PATIENT INFORMATION	CONTACT INFORMATION
Date ______	Home phone ______
Name ______	Work phone ______
Address ______	Other/cell phone ______
City State Zip ______	Email ______
Age ______ Birth date ______	Have you had acupuncture before? ______
Occupation ______	Another person we may contact if needed:
Company name ______	Name ______
Primary physician ______	Relationship ______
Physician phone number ______	Home phone ______
How did you hear about us? ______	Work phone ______

HEALTH HISTORY

What are your health concerns/purpose of coming for treatment (ex. 'pain in left shoulder', insomnia', etc.)?

1- ______

2- ______

3- ______

Do you have difficulty falling asleep? ______
Staying asleep?______How many hours a night do you
Typically get? ______ Wake to urinate? ______
How many times/night? ______
How is your digestion? ______
How often do you have a bowel movement? ______
Well-formed? ______Loose? ______
Diarrhea? ______Constipation? ______
Gas and/or bloating? ______Acid reflux? ______
List serious illnesses, accidents or surgeries:

______

______

How often do you use caffeine/nicotine/alcohol?

______

______

Last medical exam? ______
Please list medications/supplement/herbs you are taking:

______

______

Check illnesses that have occurred in blood relatives.

□ Diabetes □ High blood pressure □ Stroke
□ Cancer □ Heart disease □ Kidney disease

Check symptoms you have or have had in the last year.

□ Depression
□ Difficulty in focusing
□ Dizziness
□ Easily startled
□ Excessive worry
□ Excessive anger
□ Excessive fear
□ Fatigue/tiredness
□ Headaches
□ Loss of sleep/poor sleep
□ Loss or gain of weight (circle)
□ Nervousness/irritability
□ Overwhelmed by life

Check conditions you have or have had in the past:

□ AIDS
□ Allergies
□ Anemia
□ Arthritis
□ Bleeding disorders
□ Breast lump
□ Cancer (what type?) ______
□ Diabetes
□ Hepatitis (what type?) ______

HEALTH HISTORY…..Continued

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- ☐ Tremors
- ☐ Cramps
- ☐ Swollen joints

Pain, weakness, numbness in:

- ☐ Arms or hands (circle)
- ☐ Legs
- ☐ Back
- ☐ Hips
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders
- ☐ Other ________________________

EYES/EAR/NOSE/THROAT/RESPIRATORY

- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Ear ache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

GENITO/URINARY

- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure (circle)
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat (circle)
- ☐ Swelling of ankles

GASTROINTESTINAL

- ☐ Belching, gas or bloating (circle)
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

FOR WOMEN ONLY

- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant? ____________________________

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature ____ Date ______________________________________

Hillcrest Community Acupuncture
1807 Robinson Ave. Suite 205 San Diego, CA 92103
619-298-2228 www.HillcrestACU.com

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I understand that acupuncture involves the insertion of pre-sterilized, disposable needles through the skin at specific points and that additional therapies (such as herbal therapy, Asian nutrition therapy, acupressure, gua sha, electrical stimulation to the skin, and TDP heat lamp) may be suggested to support the treatment process. All therapies will be fully explained before administration. Side effects such as local bruising, needle sickness, broken needles, pain at site of insertion, infection, pneumothorax, spontaneous miscarriage, and allergic reaction (with herbs) are rare, but possible. If I agree to take herbal medicine, I understand that I must follow all administration and dosage instructions. I understand that my practitioner is providing dietary guidance based on Asian medicine principles of nutrition and is not a licensed dietician. During the course of treatment, I agree to inform my practitioner of all health and medication changes, especially possible pregnancy. I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will go immediately to the hospital if I experience a medical emergency. Physician care is recommended. I consent to receive the therapies listed above, understand the risks and understand that I may refuse any treatment at any time. I understand that the practice of Acupuncture and Oriental medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment. I understand that acupuncture is conducted in a group setting at *Hillcrest Community Acupuncture*. I understand that my conversations in the group room may be overheard by others sitting nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone, by e-mail, or by scheduling an appointment to talk privately. I understand that *Hillcrest Community Acupuncture* may record medical and other information concerning my treatment. I understand that *Hillcrest Community Acupuncture* abides by federal regulations regarding patient privacy as defined under 45 CFR 164.528. I know that I can ask for more information regarding this procedure. I permit a copy of this authorization to be used in place of the original. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal Law.

Patient's Signature ____ Date __________________

Patient's Printed Name ____

CONSENT TO TREAT A MINOR CHILD I authorize *Hillcrest Community Acupuncture* to administer Acupuncture and Oriental Medicine as deemed necessary to ____________________ who is my ______________________________ (relationship).

Adult's Signature ____ Date __________________

Hillcrest Community Acupuncture
1807 Robinson Ave. Suite 205 San Diego, CA 92103
619-228-2228 www.HillcrestACU.com

Financial Policy

Hillcrest Community Acupuncture makes every attempt to make alternative health care, as acupuncture and Chinese medicine, available to as many people as possible, at the most affordable rates.

In respect for our intention to offer high quality health care at affordable prices, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be charged the regular fee for that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding,

Hillcrest Community Acupuncture Staff

Signature ______________________________________ Date __________________________

Printed Name ______________________________________