JADE
Acupuncture
6905 N Fenwick Ave.
Portland, Or. 97217
503-417-1774

HEALTH HISTORY

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Referred by: _____ Occupation: _____

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Main complaint: (symptoms, diagnosis, duration, etc.)

Surgeries: (please include date of procedure)

Allergies: (chemical, environmental, food, drugs, etc.)

Medications: (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs:

Exercise: Days per week _____ Length of workout _____ Type of Activity _____

Diet: Meals per day _____ Snacks _____ Caffeinated drinks _____ Alcohol per week _____

What makes your condition <u>better</u>? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition <u>worse</u>? (Stress, fatigue, hunger, heat, certain foods, damp days, etc.)

Personal Medical History: Please circle any conditions or symptoms you are currently experiencing.

Arthritis	Liver/Gall Bladder Disease	Stroke	Heart Disease
High/Low Blood Pressure	Hypo/Hyperglycemia	Kidney Disease	Elevated Cholesterol
Cancer	Diabetes	Food Allergies/Intolerance	Diverticulitis/IBS
Ulcer	Seizures	Hepatitis	Raynaud's Disease
Chronic Fatigue	Anemia	Thyroid Imbalance	Respiratory Allergies
Alcoholism	Lyme Disease	Chronic Pain Condition	Impotence
Gastritis/Pancreatitis	Asthma	Infertility	Emphysema

Family Medical History: Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

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

Other _____

General: Please **circle** items listed below that you've had in the last ***3 months.***

Poor Appetite	Poor Sleeping	Fatigue	Fevers
Chills	Night Sweats	Sweats Easily	Tremors
Cravings	Localized Weakness	Poor Balance	Change in appetite
Bleed/Bruise easily	Weight loss/gain	Peculiar tastes/smells	Dental/gum problems
Muscle weakness/fatigue	Sudden energy drop	Strong thirst (hot or cold drinks)	

Skin and Hair:

Rashes	Ulcerations	Hives/Allergic Dermatitis	Itching
Eczema/Psoriasis	Dandruff	Loss of hair	Recent moles
Skin discoloration	Acne	Change in skin/hair texture	Face flushing
Dermatitis	Warts	Fungal Infection	Weak/ridged nails

Head, Eyes, Ears, Nose and Throat:

Dizziness	Difficulty swallowing	Migraines Glasses	
Eye Strain	Eye pain	Poor vision Night Blindness	
Color Blindness	Cataracts	Blurred vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes	Sinus problems
Nose bleeds	Recurrent sore throat/colds	Grinding teeth	Facial pain
Sores on lips/tongue	Dental problems	Jaw clicks/locks	Headaches

Cardiovascular:

Chest pain or pressure	Irregular heart beat	Palpitations at rest	Fainting
Cold hands/feet	Swelling of hands/feet	Blood clots Phlebitis	
Shortness of breath	Varicose/spider veins	Pressure in chest	High blood pressure
Low blood pressure	Spontaneous sweating	Dizziness	

Respiratory:

Cough/Wheezing	Coughing blood	Asthma	Bronchitis
Pneumonia	Pain with deep inhalation	Tight sensation in chest	Difficult inhale/exhale
Difficulty breathing when lying down		Production of phlegm... what color? _____	

Gastrointestinal:

Nausea	Vomiting	Diarrhea	Constipation
Gas	Belching	Black stools	Blood in stool
Indigestion	Bad breath	Rectal pain Hemorrhoids	
Bloating/Edema	Chronic laxative use	Loose stools (>2 per day)	Abdominal pain/cramps
Changes in appetite	Acid reflux/GERD	Hernia	Poor appetite
Excessive appetite	Significant thirst	IBS/Crohn's Disease	

Genito-Urinary:

Pain on urination	Frequent urination	Blood in urine	Urgent urination
Unable to hold urine	Kidney stones	Scanty flow Copious flow	
Impotence	Sores on genitals	Urinary tract infection	Burning urination
Premature ejaculation	Decreased libido	Prostatitis Dribbling after urination	
Nocturnal emission	Pain in testicles	Herpes	Infections
Excessive libido	Night urination: What time? _____ How often? _____		

Gynecological/Reproductive:

Difficult/Painful intercourse	Ovarian cysts	Age of first menses _____
Vaginal dryness	Endometriosis	Date of last menses _____
Vaginal sores	Uterine Fibroids	Date of last PAP/Pelvic _____
Vaginal discharge	Fibrocystic breast tissue	Number of pregnancies _____
Infertility	Polycystic Ovarian Disease	Number of ectopic pregnancies ____
Irregular menstruation	PMS	Number of live births _____
Painful menstruation	Number of miscarriages _____	Number of abortions _____

Do you practice birth control? _____ What type? _____ How long? _____

Musculoskeletal:

Neck pain	Shoulder pain	Hand/wrist pain	Carpal Tunnel
Knee pain	Sprains/Strains	Sciatica	Foot/ankle pain
Hip pain	Muscle pain	Muscle weakness	Tendonitis
Back pain Low___ Middle___ Upper___		Bursitis	Rotator Cuff

Soreness/weakness in lower body (back, knee, hip, ankle, foot) _____

Neuropsychological:

Seizures	Loss of balance	Vertigo/Dizziness	Areas of numbness
Lack of coordination	Poor memory	Concussion	Depression
Anxiety/Panic attacks	Bad temper/irritable	Easily susceptible to stress	Manic Depression
Nervousness	ADD/ADHD	Seasonal Affective Disorder	

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.*

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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.

_____
initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____
initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____
initia

_____
Patient's Name

_____
Patient's Signature

_____
Date Signed

JADE
Acupuncture

Acupuncture

Chinese Herbal Medicine

Insurance Billing / Time of Service Agreement

We are pleased to be able to bill your insurance for you. Many insurance plans in Oregon cover acupuncture. We are happy to check your benefits for you. *Please let us know as soon as possible if there is a change in your insurance carrier or coverage.* Following is our policy regarding payment. Please read, initial, and sign at the bottom.
We look forward to working with you.

Insurance Billing
If there are no insurance benefits for my acupuncture, or if my insurance claim is denied for any reason, I hereby agree to pay Jade Acupuncture the discounted rate of $95.00 per hour for acupuncture on the date service is rendered. I understand that this rate is only available to people without insurance benefits and is payable at time of service.

Payment records will be kept in receipt form only. No formal billing will take place; therefore, payment records will be minimal and will not be sufficient if claims are made in the future.

_____ Please initial that you understand and agree to this policy.

No Show and Late Cancellation Policy
Jade Acupuncture requires 24-hour notice if you are not able to keep your scheduled appointment. Otherwise, a $60.00 "no show" fee will be charged to your account.
*Please note that this fee is not payable by insurance, and is the responsibility of the patient.

_____ Please initial that you understand an agree to this policy.

Patient Name _____

Patient Signature _____ Date _____

Parent/Guardian Name _____

Parent/Guardian Signature _____ Date _____