INVIGORATE
ACUPUNCTURE

Health History Questionnaire **Date ____/____/____**

Please help us provide you with a complete evaluation by taking the time to fill out this form. All of your answers will be held absolutely confidential.

Name: _____ Date of Birth____/____/____ Age:_____

Address: _____

Phones: (Home) _____ (Work) _____ (Cell)_____

E-Mail Address:_____ Ht: ___ Wt: Occupation:_____

Primary Care Provider: _____ Referred By:_____

Emergency Contact: _____ (Phone)_____

Have you been treated with acupuncture or Chinese Medicine before? ____ Yes ____ No

Do you have an electronic implant like a pacemaker or have any other condition that may contraindicate electro-stimulation treatment? ____ Yes ____ No

Women's Fertility History:

Age at which menses began: ____

Painful periods? ☐ Yes ☐ No How many days does the pain last?_____

How many days do you normally bleed? ___ How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy What color is the blood? ☐ Light red☐ Bright red ☐ Dark red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Do you have PMS? ☐ Yes ☐ No Do you get premenstrual back pain? ☐ Yes ☐ No

Does your face break out before or during your period? ☐ Yes ☐ No

Do your breasts become tender premenstrually? ☐ Yes ☐ No

Do your bowel movements become loose at the beginning of your period? ☐ Yes ☐ No

Do you bleed or spot between your periods? ☐ Yes ☐ No

Are your menstrual cycles spaced irregularly? ☐ Yes ☐ No

How many days are there from one period to the next? _____

What was the date of your last menes? _____

How many pregnancies have you had? _____When? _____

How many children do you have? _____ Ages? _____

How many abortions have you had? _____ When? _____

How many miscarriages have you had?_____ When?_____

How many times has a D & C been performed? _____ When? _____

Have you ever had an abnormal papsmear? ☐ Yes ☐ No Date of last papsmear: _____

Have you ever had a cervical biopsy, operation,or cauterization? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with a chlamydial infection? ☐ Yes ☐ No

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Have you ever had pelvic inflammatory Disease? ☐ Yes ☐ No Were you treated for it? ☐ Yes ☐ No

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

Have you ever been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

_____

Please list all current or occasional drugs and supplements:
***Current*: _____**
_____
_____
_____
***Occasional*:_____**
_____
Please list drug allergies:

Please list other allergies (foods, animal dander, et cetera):
Please list significant surgeries and dental work:
Please list major injuries and accidents:

How physically active are you each day? Inactive Slightly Active Moderately Active Very Active

What are the activities you do to remain active?_____

On a daily basis, how much of the following do you intake?

Coffee____ Soda_____ Alcohol_____ Cigarettes_____

PLEASE CHECK ANY HISTORICALLY SIGNIFICANT OR RECENT SYMPTOMS

GENERAL

- ❑ Aversion to Cold (not improved with warmth)
- ❑ Fear of Cold (improved with warmth)
- ❑ Chilliness of specific areas of the body: _____
- ❑ Fever
- ❑ Morning Hot Flashes
- ❑ Afternoon Hot Flashes
- ❑ Hot Hands and Feet
- ❑ Fever and Chills
- ❑ Alternating Fever and Chills
- ❑ Frequent Sweating
- ❑ Night Sweating
- ❑ Profuse Sweating
- ❑ Scant Sweating
- ❑ Generalized Pain
- ❑ Heavy, Tired Body
- ❑ Paralysis or Numbness
- ❑ Tremors or Twitching
- ❑ Generalized Itching
- ❑ Jaundice
- ❑ Edema
- ❑ Unusual Weight Gain or Weight Loss
- ❑ Fatigue
- ❑ Drowsiness after Eating
- ❑ Afternoon Fatigue
- ❑ Bruising easily
- ❑ Loss of Consciousness
- ❑ Skin Diseases

HEAD AND BODY

- ❑ Headache
- ❑ Migraines
- ❑ Heavy Head Sensation
- ❑ Unusual Sensations in the Head
- ❑ Dizziness or Vertigo
- ❑ Dizziness with Standing
- ❑ Fine, Thin Hair
- ❑ Excessive Hair Loss
- ❑ Premature Graying
- ❑ Hot Flashes in the Head
- ❑ Facial Pain
- ❑ Facial Numbness or Tic
- ❑ Facial Swelling
- ❑ Deviated Mouth & Eyes
- ❑ Pain of the Four Limbs
- ❑ Numbness of the Limbs
- ❑ Weak Limbs
- ❑ Cold Limbs
- ❑ Joint Pain
- ❑ Inhibited Stretching
- ❑ Inability to Turn Neck
- ❑ Finger Numbness
- ❑ Hand Tremors
- ❑ Pale, Discolored, Thick, or Deformed Fingernails
- ❑ Edema (swelling) of the Lower Limbs
- ❑ Inflammation of the Lower Limbs
- ❑ Varicosities of the Lower Limbs
- ❑ Foot Pain
- ❑ Foot or Leg Tremors

UROGENITAL

- ❑ Erectile Dysfunction
- ❑ Premature Ejaculation
- ❑ Inability to Ejaculate
- ❑ Pain, Itching, or Discomfort of the genitalia
- ❑ Pain with Urination
- ❑ Profuse Urination
- ❑ Frequent Urination
- ❑ Frequent Urination at Night
- ❑ Dribbling Urination
- ❑ Bedwetting
- ❑ Incontinence
- ❑ Difficult Urination
- ❑ Bloody Urine
- ❑ Cloudy Urine
- ❑ Soft, Loose Stools
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloody Stools
- ❑ Anal Itching
- ❑ Rectal Prolapse
- ❑ Anal Fissures
- ❑ Hemorrhoids

MOUTH

- ❑ Unusual Taste in the Mouth (i.e. bitter)
- ❑ Bad Breath
- ❑ Excessive Saliva
- ❑ Mouth Sores
- ❑ Cracked Dry Lips
- ❑ Lip Tremors Tongue Disorders

- ❑ Loose Teeth or Toothache
- ❑ Extensive Dental Decay
- ❑ Grinding of the Teeth
- ❑ Painful, Swollen, or Bleeding Gums
- ❑ Poor Appetite
- ❑ Excessive Hunger
- ❑ Hiccup
- ❑ Belching
- ❑ Acid Regurgitation
- ❑ Nausea
- ❑ Vomiting

CHEST, RIB-SIDE, STOMACH, AND ABDOMEN

- ❑ Chest Pain
- ❑ Chest Tightness
- ❑ Cough
- ❑ Coughing of Blood
- ❑ Rapid, Labored, Hasty Breathing
- ❑ Wheezing
- ❑ Shortness of Breath when Speaking
- ❑ Rapid Beating of the Heart
- ❑ Pain Along the Sides of the Trunk
- ❑ Difficulty Swallowing
- ❑ Frequent Yawning
- ❑ Stomach Pain
- ❑ Pain in the Area of the Navel
- ❑ Abdominal Fullness
- ❑ Abdominal Swelling (ascites)
- ❑ Lower Abdominal Pain

THIRST AND INTAKE OF BEVERAGES

- ❑ Always thirsty
- ❑ Dry Mouth
- ❑ Lack of Thirst
- ❑ Thirst Unquenched by Drinking
- ❑ Liking for Cold Drinks
- ❑ Liking for Warm Drinks

EYES, EARS, NOSE, AND THROAT

- ❑ Eye Pain
- ❑ Itchy or Dry Eyes
- ❑ Red Eyes
- ❑ Frequent Tearing
- ❑ Sensitivity to Light
- ❑ Frequent Floaters in the Visual Field
- ❑ Night Blindness
- ❑ Sty
- ❑ Ear Ringing
- ❑ Itchy or Painful Ears
- ❑ Hearing Impairment
- ❑ Nosebleed
- ❑ Dry Nose
- ❑ Runny Nose
- ❑ Nasal Congestion
- ❑ Loss of Sense of Smell
- ❑ Sore, Swollen Throat
- ❑ Itchy or Dry Throat
- ❑ Hoarse Voice
- ❑ Loss of Voice
- ❑ Sensation of a Mass Stuck in the Throat Without Eating

SLEEP

- ❑ Insomnia
- ❑ Difficulty Falling Asleep
- ❑ Easily Being Awakened
- ❑ Waking Too Early
- ❑ Profuse Dreaming
- ❑ Excessive Sleep
- ❑ Apnea

WOMEN

- ❑ Age of First Menses _____
- ❑ Menopause: Age_____
- ❑ Duration Between Menses_____
- ❑ Duration of Menstrual Flow _____
- ❑ Irregular menses
- ❑ Clotted Menstrual Blood
- ❑ Pain with Menses
- ❑ PMS
- ❑ Vaginal Discharge
- ❑ Pregnancies_____
- ❑ Births _____
- ❑ Miscarriages _____
- ❑ Abortions _____

MENTAL-EMOTIONAL

- ❑ Panic Attacks
- ❑ Agitation
- ❑ Poor Memory
- ❑ Impaired Speech
- ❑ Depression
- ❑ Easy Anger
- ❑ Anxiety
- ❑ Obsessive Thoughts
- ❑ Persistent Sorrow
- ❑ Frequently Fearful
- ❑ Easily Startled

Additional Personal Medical History: Abuse Survivor Eczema Neurological Diseases AIDS/HIV Emphysema Alcoholism Enlarged Thyroid Pneumonia Fungal Infections Polio

Blood Clots Rheumatic Fever Cancer Gout Cardiovascular Disease Hepatitis Seizures Herpes STD's High Blood Pressure Stroke Kidney Stones TB **Concussions Considered/Attempted Suicide Ulcers COPD Valley Fever Diabetes**

HIPPA NOTICE
PRIVACY DISCLOSURE AND POLICIES

As a patient at this clinic, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which your information is secured confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This notice describes the 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.

Safeguards in place 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.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc.. It is our preference to discuss your health in the office setting only to protect you privacy and ensure that important information is kept in your chart.

Consultations

We consult with other healthcare practitioners and clinical specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, in person, by fax, or email are confidential, and names are not used unless necessary and consent is provided from you either verbally or in writing. In administering your health care, we may gather and maintain information that may include these examples of non-public personal information:

· From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.

· From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information)

Records Release

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax, and are accompanied by a Confidential Patient Information Cover Sheet if faxed.

Definition and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearing house in the normal course of business, and 2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. This information may reside in any medium: tape, paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have Invigorate Acupuncture, PLLC maintain my records confidentially in accordance with the law. I agree to inform Invigorate Acupuncture, PLLC if I need any special arrangements pertaining to this issue

Signature:	**Date:**
Printed name:	

Informed Consent to Receive Treatment

By Signing below, I do hereby request and voluntarily consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist, Kate Campos or other licensed acupuncturists who are now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist.

I understand that methods of treatment may include, but are not limited to, acupuncture, cupping, electrical stimulation, tui-na (chinese massage), chinese herbal medicine, nutritional counseling and lifestyle coaching.

Acupuncture: This is a safe treatment involving the insertion of fine, sterile, single-use needles through the skin. Treatments can occasionally produce a mild, temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a bruise at the acupuncture site. Other possible risks include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report any dizziness or lightheadedness to the licensed acupuncturist that occurs during or after a treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience and discomforts related to the use of any herbs I am prescribed, I understand that I should stop taking the herbs and inform my licensed acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage of administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking a medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Moxa or TDP lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by a heated glass cup or a pumped cup. There is the possibility of local non-painful bruising from this suction. Vary rarely a slight burn or blister may appear due to heat.

Gua-Sha: Gua Sha is a light scraping on the skin in a area using a smooth edged instrument. This often results in bruising of the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Electro-Acupuncture: A mild electric micro-current similar to a TENS unit may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during the treatment. Occasionally a mild achiness or soreness will be felt in the areas treated. I understand that I must inform my practitioner if am am using a pacemaker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or discomfort, as well as any area where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment, during or after the massage.

I understand that the clinical and administrative staff may review my patient records and lab records, but all my records will be kept confidential and will not be released without my written consent. 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 conditions and for future conditions for which I seek treatment.

Patients who are pregnant, have a pacemaker or heart condition, have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician, as Invigorate Acupuncture, PLLC is not a primary care physician.

I have 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 consent and permission for treatment.

Patient name:	Date:
Patient Signature:	Guardian Signature:

Notice and Authorization for Insurance Billing

I _____ (print name) do hereby give full permission and authorize Invigorate Acupuncture, PLLC, to bill my insurance for services rendered by Kate Campos, LAc. I also agree to have any checks or payment made by said insurance company to be payable and deliverable to:

Kate Campos LAc
6416 E. Tanque Verde, Suite B
Tucson, AZ 85715

As a courtesy, my insurance will be billed directly by Invigorate Acupuncture, PLLC. When possible, Invigorate Acupuncture, PLLC will call my insurance to verify my benefits, although benefits quoted by my insurance company are not a guarantee of payment. I am responsible for knowing the benefits my insurance policy covers. Payments will be due at the time of service for any non-covered services, deductibles or co-pays.

I understand if I do not have insurance coverage, I will receive a time of service discount. If I do have insurance that covers acupuncture treatment or other modalities, Invigorate Acupuncture, PLLC will bill my insurance for me at the full insurance fee rate. I understand a full fee rate for services rendered is available upon request. I will be required to pay my insurance policies stated copay or coinsurance fee if required by my insurance, and/or the difference of the full insurance reimbursement and cash based fees.

I understand the aforementioned office fees, insurance and billing policy. If my insurance is billed by this office, my billing statement will show "signature on file."

Please check one of the following:

____ I authorize Invigorate Acupuncture, PLLC to bill my insurance.

____ I choose not to have my insurance billed for me and will pay cash or credit card for my treatments at the time of service.

***Please note Invigorate Acupuncture, PLLC has a 24-hour appointment cancellation policy. Unless due to an emergency, any cancellations made with less than 24 hours notice prior to their scheduled appointment time will be charged a $30.00 fee.**

_____ _____

SIgnature **Date**