

# North Peninsula Acupuncture

430 East Lauridsen Blvd., Port Angeles WA 98362 (360) 477 3948

## Health History Questionnaire

Date \_\_\_\_\_

Name: _____	Hm Phone _____	Wk/cell (circle one) Phone _____
Address: _____	City: _____	ST _____ ZIP: _____
Age: _____	Date of Birth _____	Height: _____ Weight: _____ Marital Status: _____ Gender _____
Employer: _____	Occupation _____	
Insurance Company: _____	Phone: _____	
Primary Physician: _____		
In Case of Emergency Notify: _____ Phone: _____		
<b>Have you been treated by acupuncture or Oriental Medicine before?</b> <input type="checkbox"/> yes <input type="checkbox"/> no		

How did you hear about us? \_\_\_\_\_

Email: \_\_\_\_\_

<b>Main problem(s) :</b> _____
When did this problem begin? _____
Average number of hours per day that you experience <b>Primary Symptoms:</b> _____ hours _____
Have you been given a diagnosis for this problem? If so, what? _____

**Do you faint easily?**  yes  no

**Do you have a bleeding disorder?**  yes  no

### Medical History:

Cancer  yes  no    Hepatitis  yes  no    HIV/Aids  yes  no    High Blood Pressure  yes  no

Heart Disease  yes  no    Rheumatic Fever  yes  no    Thyroid Disease  yes  no    Seizures  yes  no

Other: \_\_\_\_\_

**Health Care Providers Seen in Last Year:**  Medical Doctor  Chiropractor  Acupuncturist

Dentist  Naturopath  Nurse  Physical Therapist  Psychotherapist  Other \_\_\_\_\_

Please list the **Name** and daily **Dosage** of all the medications, herbs, and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

Surgeries/ significant dental work (type and date): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Significant Trauma (auto accidents, falls, etc) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Allergies (drug, chemical, food) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you follow dietary restrictions?  yes  no Please describe: \_\_\_\_\_

**General:**

- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (hot or cold)
- Thirst, no desire to drink
- Sudden energy drop-  
what time of day?\_\_\_\_\_
- Insomnia or other sleep  
problems
- Chills
- Tremors
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

**Skin and Hair**

- Rashes
- Itching
- Dandruff
- Ulcerations
- Eczema
- Loss of hair
- Hives
- Pimples
- Recent moles
- Other hair or skin problems:  
\_\_\_\_\_

**Head, Eyes, Ears, Nose & Throat**

- Dizziness
- Poor vision
- Cataracts
- Spots in front of eyes
- Dry eyes
- Eye strain
- Eye pain
- Color blindness
- Night blindness
- Blurry vision
- Earaches
- Ringing in ears
- Poor hearing
- Tooth problems
- Jaw clicks
- Pain when chewing
- Grinding teeth
- Sinus problems
- Nose bleeds
- Migraines
- Concussions
- 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 or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands/feet
- Chest pain
- Fainting
- Difficulty breathing

Other heart or blood  
vessel problems\_\_\_\_\_

**Respiratory**

- Cough
- Bronchitis
- Difficulty breathing when  
lying down
- Production of Phlegm  
what color? \_\_\_\_\_
- Coughing of blood
- Pneumonia
- Asthma
- Pain with breathing
- Other lung problems\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

<p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Black stools</li> <li><input type="checkbox"/> Bad breath</li> <li><input type="checkbox"/> Abdominal pain or cramping</li> <li><input type="checkbox"/> Chronic laxative use</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Gas</li> <li><input type="checkbox"/> Blood in stools Rectal pain</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Belching</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Hemorrhoids</li> </ul> <p>Other stomach or intestinal problems _____</p> <p><b>Genito-Urinary:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain with urination</li> <li><input type="checkbox"/> Urgency to urine</li> <li><input type="checkbox"/> Decrease in flow</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Unable to hold urine</li> <li><input type="checkbox"/> Impotency</li> <li><input type="checkbox"/> Kidney stones</li> <li><input type="checkbox"/> Sores on genitals</li> <li><input type="checkbox"/> Other genital or urinary problems _____</li> </ul> <p>Do you wake up to urinate? _____ If so, how often? _____ Color of urine? _____</p>	<p><b>Pregnancy and Gynecology:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Number of pregnancies _____</li> <li><input type="checkbox"/> Number of births _____</li> <li><input type="checkbox"/> Premature births _____</li> <li><input type="checkbox"/> Miscarriages _____</li> <li><input type="checkbox"/> Abortions _____</li> <li><input type="checkbox"/> Age at first menses _____</li> <li><input type="checkbox"/> Days between periods _____</li> <li><input type="checkbox"/> Duration of period _____</li> <li><input type="checkbox"/> Date of last period _____</li> <li><input type="checkbox"/> Usual character to flow (heavy or light)</li> <li><input type="checkbox"/> Painful periods</li> <li><input type="checkbox"/> Vaginal discharge</li> <li><input type="checkbox"/> Changes in body/psyche prior to period</li> <li><input type="checkbox"/> Clots</li> <li><input type="checkbox"/> Vaginal sores</li> <li><input type="checkbox"/> Irregular period</li> <li><input type="checkbox"/> Last PAP _____</li> <li><input type="checkbox"/> Breast lumps</li> <li><input type="checkbox"/> Do you practice birth control? _____</li> </ul> <p>What type, and for how long? _____</p>	<p><b>Musculo-skeletal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Neck pain</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Hand/wrist pain</li> <li><input type="checkbox"/> Muscle pain</li> <li><input type="checkbox"/> Shoulder pain</li> <li><input type="checkbox"/> Knee pain</li> <li><input type="checkbox"/> Muscle weakness</li> <li><input type="checkbox"/> Foot/ankle pain</li> <li><input type="checkbox"/> Hip pain</li> <li><input type="checkbox"/> Other types of muscle pain _____</li> </ul> <p><b>Neuropsychological</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Areas of numbness</li> <li><input type="checkbox"/> Concussion</li> <li><input type="checkbox"/> Bad temper</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Lack of coordination</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Easily susceptible to stress</li> <li><input type="checkbox"/> Loss of balance</li> <li><input type="checkbox"/> Poor memory</li> <li><input type="checkbox"/> Anxiety</li> </ul> <p>Other neurological or psychological problems _____</p>
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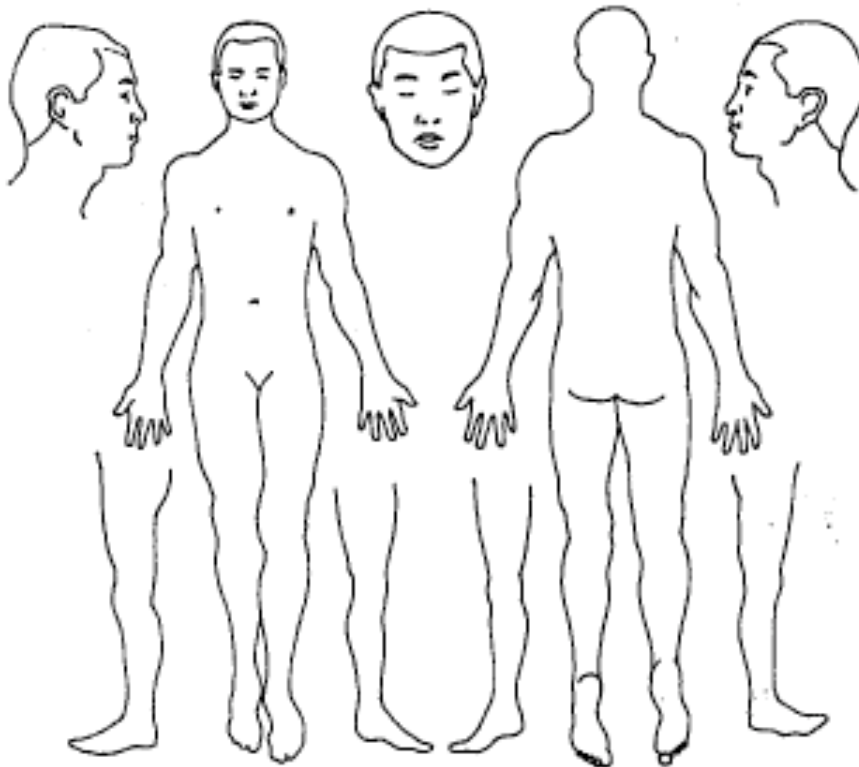
Please note the severity of your problem at this time:

\_\_\_\_\_

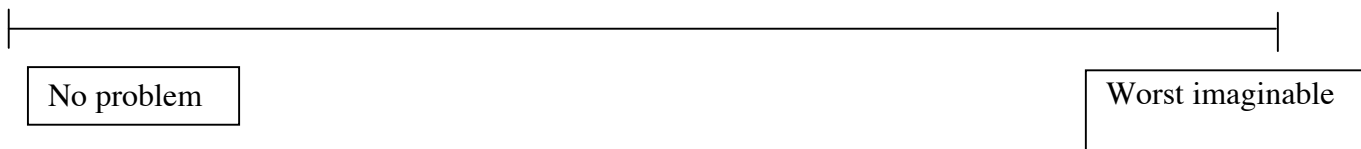
No problem

Worst imaginable

Please indicate painful or distressed areas:



Please note the greatest degree of severity of your problem within the past week:



Is there anything else we should know:

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## Consent for Traditional Oriental Medicine Therapeutic Methods

I, the undersigned, hereby authorize Steve Stigler L.Ac. and/or Ann Fritts L.Ac. to perform the following procedures:

**Acupuncture:** insertion of special sterilized needles through the skin into underlying tissues at specific points on the surface of the body.

**Cupping:** a technique to relieve symptoms in which cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other devices.

**Plumb Blossom or Seven Star Hammer:** a light tapping of an area of the body with a small sterile hammer, which has seven points.

**Gua Sha:** a rubbing on an area of the body with a blunt round instrument.

**Herbs:** may be given in the form of pills, powders, tinctures, pastes, plasters, or other forms such as raw herbs to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials. Note: over 98% of the herbs used are of botanical origin. Occasionally a condition calls for the use of animal products. Do you wish to be informed if this is the case?

Yes

No

I recognize the potential risks and benefits of these procedures as described below:

**Potential risks:** discomfort, pain, infection and blistering at the site of procedure, temporary discoloration of skin, nausea, loose bowel movements, abdominal cramping, and aggravation of symptoms existing prior to the treatment.

**Potential benefits:** drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem, and strengthening of the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Steve Stigler L.Ac. and Ann Fritts L.Ac. regarding cure or improvement of my condition.

I hereby release Steve Stigler L.Ac. and Ann Fritts L.Ac. from any and all liability, which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and discontinue participation any of these procedures at any time.

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Signature of Patient

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Date

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## Consent for Information Privacy, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Ann Fritts L.Ac. & Steve Stigler L.Ac. (hereafter noted as Ann & Steve) for the purposes of diagnosis, treatment, or to conduct health care operations. I understand that diagnosis or treatment of me by North Peninsula Acupuncture (hereafter noted as N.P.A.) may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. N.P.A is not required to agree to the restrictions that I may request. However, if /N.P.A. agree to a restriction that I request, the restriction is binding upon N.P.A.

I have the right to revoke this consent, in writing, at any time except to the extent that N.P.A. have taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review N.P.A.'s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of N.P.A.

Ann & Steve/N.P.A reserve/s 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 have read this document and agree to the information contained there within.

\_\_\_\_\_ I agree to pay for each treatment at the time of the visit, unless another agreement has been made with N.P.A.

\_\_\_\_\_ I understand that each appointment time has been reserved specifically for me. In the event of a missed appointment or an appointment cancelled with less than 24 hours, I will be charged in full for that appointment.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name and Relationship