Wolf Creek Acupuncture

150 Catherine Lane Suite I
Grass Valley, CA 95945

Registration and Health History Questionnaire

Patient Information

Date:_____
Name:_____
Age:_____ Birth date:_____

Occupation:_____
□ Full time □ Part time □ Unemployed □ Retired

Primary Physician: _____
Physician's Phone Number:_____
Date of Last Visit: _____

What is Your Blood Type: □ O □ A □ B □ AB

Contact Information

Address:_____
City State Zip:_____
Home Phone:_____
Work Phone:_____
Cell Phone: _____
Email:_____

Emergency Contact
Name:_____
Relationship:_____
Phone Number:_____
Alternate Phone Number:_____

Health History

Have you ever had acupuncture treatment? When and for what reason?

_____

_____

Are you currently being treated for a medical condition? Please describe:

_____

_____

Briefly describe any long-term (chronic) pain:

_____

_____

What are your primary concerns for coming in for treatment? _____

_____

_____

What treatments have you used for relief of these issues?_____

Please describe the type of foods you eat regularly

Breakfast:_____

Morning Snack:_____

Lunch:_____

Afternoon Snack:_____

Dinner:_____

Evening Snack:_____

Do you exercise regularly? □ Yes □ No

What type of exercise do you do? _____

_____

Do you have any other health concerns?

_____

_____

FAMILY HISTORY (Complete for each family member by placing an X in the appropriate box:)

	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Blood disorder/anemia							
Diabetes							
Cancer or tumors							
Seizures							
High Blood Pressure							
Kidney or bladder disorder							
Stomach or intestinal disorder							
Drug abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/ Mental Illness							
Other- explain:							
Age of Death							

MAJOR HOSPITALIZATIONS (If you have ever been hospitalized for any serious medical illness or operation, write in your most recent hospitalizations below.)

Year	Operation or Illness	Name of Hospital	City and State

PREVIOUS PREGNANCIES:
Total Pregnancies_____Living_____Ectopic_____Miscarriages_____Induced Abortions_____

MEDICINES (Mark an X in the box next to any of the following your are now taking

□aspirin	□diet pills	□tranquilizers	□pain reliever:_____
□arthritis	□sleeping pills	□diabetes	□other:_____
□oral contraceptives	□laxatives	□anti-depressants	_____
□blood pressure	□cold/flu	□antacids	_____
□blood thinners	□allergy	□cholesterol	_____

Vitamins (please list)_____

Herbs (please list)_____

DRUG ALLERGIES:_____

HABITS (Please check any of the habits listed below which apply to you now or in the past.)

Coffee yes□ no□ cups per day/week_____ age started_____ age quit_____
Tobacco yes□ no□ # cigarettes per day_____ age started_____ age quit_____
Marijuana yes□ no□ use per day/week_____ age started_____ age quit_____
Alcohol yes□ no□ use per day/week_____ age started_____ age quit_____
Crack/Cocaine yes□ no□ use per day/week_____ age started_____ age quit_____
Heroin yes□ no□ use per day/week_____ age started_____ age quit_____
Other_____ age started_____ age quit_____

(Please check any conditions that you are presently experiencing and any that reoccur)

GENERAL
- ☐ Poor appetite
- ☐ Excessive appetite
- ☐ Insomnia
- ☐ Fatigue
- ☐ Fevers
- ☐ Night Sweats
- ☐ Sweat easily
- ☐ Chills
- ☐ Localized weakness
- ☐ Poor Coordination
- ☐ Change in Appetite
- ☐ Strong Thirst
- ☐ Other_____

SKIN and HAIR
- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dryness
- ☐ Tumors/Lumps
- ☐ Hair Loss
- ☐ Other:_____

HEAD and NECK
- ☐ Dizziness
- ☐ Fainting
- ☐ Neck Stiffness
- ☐ Enlarged lymph glands
- ☐ Headaches
- ☐ Concussions
- ☐ Other:_____

EARS
- ☐ Infection
- ☐ Ringing
- ☐ Decreased hearing
- ☐ Other_____

EYES
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Spots
- ☐ Cataracts
- ☐ Eye Inflammation
- ☐ Other:_____

NOSE, THROAT, and MOUTH
- ☐ Nose Bleeds
- ☐ Sinus infections
- ☐ Allergies/hay fever
- ☐ Recurring sore throats
- ☐ Grinding teeth
- ☐ Difficulty swallowing
- ☐ Bad breath

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Blood clots
- ☐ Palpitations
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Cold hands/feet
- ☐ Swelling hands/feet
- ☐ Other:_____

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Frequent colds
- ☐ Chronic OPD
- ☐ Pneumonia
- ☐ Cough
- ☐ Coughing Blood
- ☐ Production of phlegm
- ☐ Other:_____

GASTRO-INTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Belching
- ☐ Blood in stools
- ☐ Tarry/black stools
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Gas
- ☐ Other_____

GENITO-URINARY
- ☐ Kidney stones
- ☐ Pain during urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Difficulty urinating
- ☐ Other:_____

MALE
- ☐ Pain of genitalia
- ☐ Itching of genitalia
- ☐ Genital lesions
- ☐ Penile discharge
- ☐ Impotence
- ☐ Weak urinary stream
- ☐ Lumps in testicles
- ☐ Other:_____

FEMALE
- ☐Frequent urinary infections
- ☐Frequent vaginal infections
- ☐ Pain of genitalia
- ☐ Itching of genitalia
- ☐ Genital lesions
- ☐ Genital discharge
- ☐ Abnormal Pap smear
- ☐ Irregular periods
- ☐ Painful periods
- ☐ PMS
- ☐ Abnormal bleeding
- ☐ Menopause
- ☐ Breast lumps
- ☐ Low abdominal pain
- ☐ Other:_____

NEUROLOGICAL
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness of limbs
- ☐ Tingling of limbs
- ☐ Concussion
- ☐ Pain
- ☐ Paralysis
- ☐ Other:_____

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ Irritability
- ☐ Manic behavior
- ☐ Other:_____

INFECTION SCREENING (check if positive)
- ☐ HIV
- ☐ TB
- ☐ Hepatitis
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Genital warts
- ☐ Herpes oral
- ☐ Herpes genital

Office Policies Form

Wolf Creek Acupuncture does **not** provide primary care medicine and is not a substitute for Western medicine. If you think you may have a serious infection, malignant growth, or an injury that won't heal or if you want someone to go over the details of your medical history with you, you need to see a primary care physician (MD and DO).

We can provide complimentary care for conditions, which require a physician's attention. Do **not** expect us to diagnose and treat really serious conditions that need immediate emergency care or require Western medical intervention.

Although we do our best to provide the utmost privacy, there are other people around who may be able to hear private information about you. **Auditory privacy is not guaranteed in either our reception area or our treatment room**. Please be aware of the need for quiet while in the clinic. Turn off your cell phones and electronic equipment prior to entering the clinic treatment area.

We request a 24-hour advanced notice to reschedule or cancel an appointment. **For any appointments that are rescheduled or canceled within 24 hour of the scheduled appointment, a $20 fee will be charged. All no shows without notice will be charged $40 with no exceptions. Fees will be waived for early cancellation for severe weather conditions,**

These Policies are subject to change. Any changes made will be posted at our front desk.

We accept the following forms of payment: cash, check, credit and debit cards. **Full payment is due at the time that services are rendered for "time of service discount" charges.** There will be a $20.00 fee charged for all returned checks, plus the face value of the check.

I have read, or have had read to me, the above policies. I have also had an opportunity to ask questions about their content and by signing below I am agreeing to the above-listed policies. I intend for these policies to be in effect during all of my present and future treatments at Wolf Creek Acupuncture.

Patient's name: _____ Signature: _____ Date: _____
(Please print)
Representative's name: _____ Signature: _____ Date: _____
(Please print if applicable)
Relationship to patient: _____

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150 Catherine Lane Suite I
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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and AccountabilityAct of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from designated third-party payers.**
- **Conduct normal health care operations**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information(available in the office in print form or online). I have reviewed such *Notice of Privacy Practices* prior to signing this consent, and acknowledge that I have studied the *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notices of Privacy Practices*.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ ____/____/_____ **Patient's Name Date of Birth**

_____ ____/____/_____ **Patient's Signature (or Guardian) Date**

QUADRUPLE VISUAL ANALOGUE SCALE

Please circle the number that best describes the question being asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example: *Headache* *Neck* *Low Back*

0 1 (2) 3 4 (5) 6 7 (8) 9 10

No Pain *Worst Possible Pain*

What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Possible Pain*

GENERAL PAIN INDEX QUESTIONNAIRE

We would like to know how much your pain ***presently*** prevents you from doing what you would normally do. Regarding each category, please indicate the ***overall*** impact your present pain has on your life, not just when the pain is at its worst. **Please circle the number which best describes how your typical level of pain affects these six categories of activities.**

1. **FAMILY/ AT-HOME RESPONSIBILITIES** SUCH AS YARD WORK, CHORES AROUND THE HOUSE OR DRIVING THE KIDS TO SCHOOL:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

2. **RECREATION** INCLUDING HOBBIES, SPORTS OR OTHER LEISURE ACTIVITIES:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

3. **SOCIAL ACTIVITIES** INCLUDING PARTIES, THEATER, CONCERTS, DINING-OUT AND ATTENDING OTHER SOCIAL FUNCTIONS:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

4. **EMPLOYMENT** INCLUDING VOLUNTEER WORK AND HOMEMAKING TASKS:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

5. **SELF-CARE** SUCH AS TAKING A SHOWER, DRIVING OR GETTING DRESSED:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

6. **LIFE-SUPPORT ACTIVITIES** SUCH AS EATING AND SLEEPING:

   0 1 2 3 4 5 6 7 8 9 10

   COMPLETELY ABLE TO FUNCTION — TOTALLY UNABLE TO FUNCTION

SCORE ____ [60]