D'Arcy Wellness Clinic, 63 South Main Street, Natick, MA 01760

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Your Appointment has been scheduled for: ____________________________________

HEALTH HISTORY QUESTIONNAIRE

Please bring this with you to your appointment. For a complete medical evaluation please take the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential.* If you have any questions, please ask. Any additional information that you feel is relevant and not asked on this form please note it in the comments section at the end.

Date:			
Name:	Home phone:	Work/Cell phone:	
Street		Age	Date of birth:
City State: Zip:			Weight:
Email:			
Family Physician:	Phone #		Referred by:
Emergency Contact and Phone Number:			
Insurance Company:			

Have you been treated by acupuncture or Oriental medicine before? □ Yes □ No
Main problem(s) you would like us to help you with:
How long ago did this problem begin? Please be specific.
To what extent does this problem interfere with your daily activities, such as work, sleep?
Have you been given a diagnosis for this problem? If so, what?
What kinds of treatment(s) have you tried?

PAST MEDICAL HISTORY (Please include date)

Significant Illnesses *(Please circle all applicable)*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Sexually Transmitted Infections Other

Surgeries

Significant trauma (auto accidents, falls, etc.)

Allergies (drugs, chemicals, foods)

FAMILY MEDICAL HISTORY *(Please circle all applicable)*

Diabetes | Cancer | High Blood Pressure | Heart Disease | Stroke | Seizures

Asthma | Allergies | Other:

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)
Occupational stress (chemical, physical, psychological, etc.)
Do you have a regular exercise program? If yes, please describe.
Have you ever been on a restricted diet? If yes, what kind?
How much water do you drink per day?
Do you smoke? If yes, how much?
How much caffeinated coffee, tea, or soda do you drink per week?
Please describe any use of drugs for non-medical purposes.

Please check if you have had (in the last three months):

General	□ Weight loss	□ Weight gain
□ Poor sleeping	□ Change in appetite	□ Peculiar tastes or smells
□ Night Sweats	□ Bleed or bruise easily	□ Fatigue
□ Fevers	□ Strong thirst (hot or cold drinks)	□ Sudden energy drop (what time of day?)
□ Chills	□ Cravings	□ Sweat easily

Skin & Hair		
□ Rashes	□ Ulcerations	□ Hives
□ Itching	□ Eczema	□ Pimples
□ Dandruff	□ Loss of hair	□ Recent moles
□ Change in hair or skin texture	□ Any other hair or skin problems	

Head, eyes, ears, nose, and throat		
□ Dizziness	□ Concussions	□ Migraines
□ Glasses	□ Eye strain	□ Eye pain
□ Poor vision	□ Night blindness	□ Color blindness
□ Cataracts	□ Blurry vision	□ Earaches
□ Ringing in ears	□ Poor hearing	□ Spots in front of eyes
□ Sinus problems	□ Nose bleeds	□ Recurrent sore throats
□ Grinding teeth	□ Facial pain	□ Sores on lips or tongue
□ Teeth problems	□ Jaw clicks	□ Headaches (where, when?)
□ Any other head or neck problems?		

Cardiovascular

□ High blood pressure	□ Low blood pressure	□ Chest pain
□ Irregular heartbeat	□ Swelling of hands	□ Fainting
□ Cold hands and feet	□ Phlebitis	□ Swelling of feet
□ Blood clots	□ Difficulty in breathing	

□ Any other heart or blood vessel problems?

Respiratory

□ Cough	□ Coughing blood	□ Asthma
□ Bronchitis	□ Pneumonia	□ Pain with a deep breath
□ Difficulty in breathing when lying down	□ Production of phlegm; what color?	

□ Any other lung problems?

Gastrointestinal

□ Nausea	□ Vomiting	□ Diarrhea
□ Constipation	□ Gas	□ Belching
□ Black stools	□ Blood in stools	□ Indigestion
□ Bad breath	□ Rectal pain	□ Hemorrhoids
□ Abdominal pain or cramps	□ Chronic laxative use	□ Poor appetite

□ Any other problems with your stomach or intestines?

Genito-Urinary

□ Pain upon urination	□ Unable to hold urine	□ Blood in Urine
□ Urgency to urinate	□ Impotence	□ Kidney stones
□ Decrease in urine flow	□ Blood in urine	□ Sores on genitals

□ Do you wake up to urinate? How often __________

□ How many times per day do you urinate? __________

□ Any particular color to your urine? __________

□ Any other problem with your genital or urinary system?

Musculoskeletal

□ Neck pain	□ Muscle pain	□ Knee pain
□ Back pain	□ Muscle weakness	□ Foot / ankle pains
□ Hand / wrist pains	□ Shoulder pain	□ Hip pain

□ Any other joint or bone problems?

Reproductive and gynecologic

# of pregnancies _____	□ Vaginal discharge	□ Menstrual clots
# of live births _____	□ Breast lumps	□ Unusual periods (heavy, light, etc.)
# of premature births _____	□ Menopause: age _____	
# of miscarriages _____	□ Irregular periods	□ Spotting or pain between periods
# of abortions _____	□ Menstrual pain	Date of last pap _____ Results _____
Date of last period ___________	Number of days period lasts _____	

Number of days between periods Age of 1st menses _____
Changes in body / psyche prior to period:

Do you practice birth control?........ What type and for how long?

Is there any chance that you are pregnant now?

Neuropsychological

□ Seizures	□ Lack of coordination	□ Loss of balance
□ Areas of numbness	□ Depression	□ Poor memory
□ Concussion	□ Easily susceptible to stress	□ Anxiety
□ Bad temper	□ Tremors	

Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

COMMENTS:
Please tell us of any other problems you would like to discuss.

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Please list any herbs, vitamins or nutritional supplements that you may be taking.

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INFORMED CONSENT

1. Acupuncture therapy consists of inserting sterile stainless steel needles a various depths into the skin. Occasionally bruising may occur at the site of the insertion.

2. Acupuncture therapy can also consist of the use of heat through burning the herb Artesema vulgaris. This herb is also known as moxa and the procedure is known as moxibustion. Although indirect moxibustion is used most often, moxa may also be used directly on the skin. This procedure may cause slight discomfort and leave a small blister on the skin, and occasionally a small scar.

3. In some cases, electrical stimulation of the needles may be indicated. This procedure involves the use of a small, battery-powered stimulator, attached to the end of the needles. A slight vibratory sensation may be felt with the use of this technique.

4. All Chinese herbal prescriptions used in this clinic are considered safe within the practice of Chinese Medicine. However, I understand that these herbs may produce unforeseen allergic reactions.

5. I understand I have the right to decline any treatment technique that I do not feel comfortable receiving.

6. I understand certain types of treatments are contraindicated in pregnant woman. If I become pregnant or suspect I am pregnant, I will notify staff before treatment.

7. I understand that acupuncture treatments may induce feelings of deep relaxation or lightheadedness. If these feelings occur, I will rest in the waiting room before driving.

8. I understand that a $25 fee will be charged if appointments are canceled without 24 hours notice. I also certify that I have read this entire form and have discussed any questions.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT.

Disclosure of Your Health Care Information

Without specific written authorization, we are permitted to use and disclose your health records for the purposes of treatment, payment and health care operations. Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers of specialists involved in the continuation of your care.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing an insurance company for services provided to you by our office. Health Care Operations include the business aspects of running our practice. For example, patient information may be used for quality assessment.

W e may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to inspect and copy your health information.
- You have the right to request amendments be made by this office to your protected health information file.
- You have a right to receive an accounting of disclosures of your protected health information.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

If you have questions about this notice or of you want more information, please contact: D'Arcy Wellness Clinic, 508-650-1921. This notice is effective as of 3/1/03. By way of my signature, I authorize D'Arcy Wellness Clinic with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Name:______________________________ Signature:_______________________________ Date: ____________