Patient Information & Health History Questionnaire **Robin Arnold, MS, AP, Dipl. Ac**(NCCAOM®)

Name:_____Date:_____

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

Phones: Cell:_____; Other (indicate Home/Work): _____

Email:_____

Would you like to receive health newsletters from this office? ____Yes ____No

Occupation: _____ Referred by: _____

Sex: ___Male ____Female Birthdate:_____ Age: _____ Dominant Hand: ___L ___R

Emergency Contact:_____ Phone:_____ Relationship:_____

Have you ever had acupuncture before?_____ if yes, When? _____

Date of Last Physical Exam by Medical Doctor _____ Date of Last Blood/Lab Work_____

Are you currently under the care of an M.D. for any medical condition?_____

Please describe condition(s) for which treatment is sought:

Chief complaint:_____

Date of onset of symptoms:_____ Severity of symptoms1-10 (1 mild/ 10 severe) _____ _

Have you seen your physician about this condition?_____ other treatments_____

Secondary complaint: _____

Date of onset of symptoms:_____ Severity of symptoms1-10 (1 mild/ 10 severe) _____ __

Have you seen your physician about this condition?_____ other treatments_____

Additional complaint (if any): _____

Date of onset of symptoms:_____ Severity of symptoms1-10 (1 mild/ 10 severe) _____ _

Have you seen your physician about this condition?_____ other treatments_____

Please indicate if any of the following apply to you:

Hemophiliac:	___Yes ___No	Epilepsy:	___Yes ___No	Pacemaker:	___Yes ___No
Anticoagulant use:	___Yes ___No	Heart Condition:	___Yes ___No	Vegetarian:	___Yes ___No
Lung Condition:	___Yes ___No	Diabetes:	___Yes ___No	Stroke:	___Yes ___No
Hepatitis:	___Yes ___No	HIV/AIDS:	___Yes ___No	Cancer:	___Yes ___No

Are you pregnant/ is there a chance that you are pregnant? ___Yes ___No
*Note: you must advise if and when you are pregnant.

*Note: you must advise if there is any change in your medical conditions.

Please list the medications and supplements you are currently taking:

Drug/Supplement Reason for Taking For How Long Dose Frequency

_____

_____

_____

_____

_____

_____

_____

_____

Lifestyle:

Exercise: please check what applies:
____Mostly Sedentary (little to no activity) _____Mild Exercise (housework, gardening, etc.)
____Occasional vigorous exercise (under 4x/week for 30 mins. each)
____Regular vigorous exercise (over 4x/week for 30 mins. each/ hard manual labor)
____Extreme exercise (professional athlete, serious amateur athlete, 6-7x/week over 45 minutes each session)

Diet/Intake:
# of meals eaten in average day _____ Estimated glasses of water per day_____
Coffee cups per day: _____ Tea cups/glasses per day: _____ Soda cans/glasses per day: _____
Food Cravings or excesses (i.e. sugar, cheese): _____
How often do you eat vegetables: _____
Alcohol type/amount per week: _____Tobacco per week: _____

Would you like to improve your health with nutritional guidance? _____
Are you willing to implement changes? _____

How do you feel about the following areas of your life in the past month?

Self: ____Great ___Good ___Fair ___Poor ___N/A Comments: _____

Family: ____Great ___Good ___Fair ___Poor ___N/A Comments:_____

Significant Other: ___Great ___Good ___Fair ___Poor ___N/A Comments:_____

Work: ____Great ____Good ____Fair ____Poor ____N/A Comments:_____

How would you rate your current stress level? ___Extreme ___Very High ___High ___Moderate ___Low
Does this fluctuate? ____Yes ____No Why?_____

How would you rate your current energy level? ___Very High ___High ___Moderate ___Low ____Very Low
Does this fluctuate? ____Yes ____No Why?_____

Other Symptoms:

*****Please Circle/ indicate if you regularly experience any of the following:***

Head & Neck: Dizziness Fainting Stiff Neck Headache Migraine Enlarged Lymph Nodes

Other or explanation:_____

Eyes & Ears: Blurred Vision Red/Burning/Itching Eyes Spots/Floaters Dry Eyes Excess Tearing Poor Night Vision Vertigo Ear ache Decreased Hearing Ringing in Ears Chronic Ear Infection

Other or explanation:_____

Respiratory/Nose: Cough Coughing up Blood Cough with Phlegm Difficulty Breathing Bronchitis Wheezing/Asthma Allergies Frequent Colds Chronic Sinus Infection Nasal Congestion Nosebleeds

Other or explanation:_____

Genital/Urinary: Pain/Itching of Genitalia Frequent Urination Urgent or Unable to Hold Urination Bedwetting Painful/Burning Urination Excessive or Scant Urination Blood in Urine Kidney Stone Increased or Decreased Libido

Other or explanation: _____

Cardiovascular: Heart Palpitations Chest Pain/Tightness Poor Circulation Varicose Veins Irregular heartbeat Swelling of Feet/Ankles

Other or explanation: _____

Gastrointestinal: Nausea Vomiting Gas Hiccups Bloating Bad Breath Acid Reflux/Heartburn Rectal pain/itchiness Constipation or Hard Stool Loose Stool IBS/Alternating Constipation/Diarrhea Hemorrhoids Intestinal Pain/Cramping Laxative Use Blood in Stool Mucous in Stool Black Stool

Other or explanation:_____

Appetite/Thirst: Excessive Hunger Poor Appetite Hunger w/no desire to eat Specific Cravings Excessive Thirst Thirst w/no desire to drink No Thirst

Temperature of drinks most commonly desired: Very Cold Room Temp. Hot

Other or explanation: _____

Mouth & Throat: Bleeding Gums Recurrent Sore Throat Bitter Taste in Mouth Dry Mouth Tongue/Mouth Sores/Ulcers Difficulty Swallowing Lump in Throat Hoarseness or Loss of Voice

Other or explanation:_____

Skin: Hives/Rashes Acne Dry Skin Eczema/Psoriasis Itchy Skin Easily Bruised Brittle/Weak Nails Spontaneous Sweating Night Sweating

Other or explanation:_____

Muscles & Joints: Joint Swelling Joint Pain Joint Discoloration Location:_____ Body Ache/Stiffness General Weakness Numbness/Tingling _____ Heaviness of body/ limbs

Other or explanation:_____

Sleep: Sound/Restful Trouble Falling Asleep Awaken During the Night at (times)_____
Vivid Dreaming/Nightmares Difficulty Waking Up Wake Easily/Early

Other or explanation: _____

Emotions: Relaxed/Calm Sad/Grief/Depressed Fearful Anxious Angry/Frustrated Worry
Trouble with Decision Making Forgetful/Poor Memory Impatient Stressed Manic

Other or explanation: _____

General: Cold Hands/Feet Always Feel Hot Always Feel Cold Fever & Chills
Recent Unexplained Weight Changes Fatigue Edema

Other or explanation: _____

Women – Menses: Regular Irregular Menopause Date/Year of last period_____
Amenorrhea (absence of) Dysmenorrhea (painful periods) Excessive Flow Scanty Flow
Clots Mid-cycle Spotting Cramping PMS Vaginal Discharge
Oral Contraceptive Use Hysterectomy Endometriosis Fibroids

Other or explanation:_____

Pregnant: ____yes ____no _____maybe _____trying !!(advise if any changes)!!

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Please answer if you have pain:

Location of Pain:_____For How Long? _____

Any known cause? (i.e.: injury) _____

Quality of Pain: ___Dull ___Sharp ___Stabbing ___Sore ___Cramping ___Burning ___Constant
___Fixed ___Moves Does Pain Radiate?_____ Where_____

Level of Pain: (on a scale of 1 – 10: 1 = very low; 10 = unbearable) _____

What aggravates the pain? ___Ice ___ Heat ___ Rest ___Movement ___Pressure ___Moisture ___Massage ____Nothing

What helps the pain? ___Ice ___ Heat ___ Rest ___Movement ___Pressure ___Moisture ___Massage ____Nothing

When is the pain the worst? ___Morning___Afternoon___Evening

Informed Consent

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by Robin Arnold, AP, L.Ac., on me (or on the patient named below if a minor, or for whom I am legally responsible), and or other licensed acupuncturists who now, or in the future treat me while associated with or serving as back-up acupuncturist to Robin Arnold, AP, L.Ac.

I understand that there are minor risks associated with acupuncture treatment, including, but not limited to, slight bleeding and/or bruising of the skin, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that the risk of infection is negligible when using single use, disposable needles. 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 Oriental Medicine. Some herbs and acupuncture treatments are contraindicated during pregnancy. I will notify the clinic practitioners if I am or intend to become pregnant.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand that results are not guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise good judgment during the course of the procedure, based on the facts they know, and act in my best interest. I will keep the practitioners informed of my current medications, medical conditions, and understand that I am responsible for obtaining appropriate primary medical care, which is not provided by this clinic.

I have read the above consent, or have had it read to me. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

I understand that any services, consultation, advice, products or treatments that I receive from the acupuncturist are not a substitute or replacement for conventional western medical services or treatment. I currently have a relationship with a state licensed medical doctor (M.D. or D.O.), and understand I am to continue my Traditional Medical care.

Following your treatment: (1) occasionally, a person may feel light headed after an acupuncture treatment. If this happens to you, please sit for a while in the designated area. (2) Herbs or supplements prescribed for the patient are intended for his or her use only, and should not be used by those for whom they are not dispensed.

Financial policy: I understand that I am expected to pay for services at the time of treatment, and that this clinic does not bill insurance, but will provide me with a receipt to submit for reimbursement (if applicable) upon request.

Please sign and date below to indicate that you have read and understand this form.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Patient Representative (include relationship, or if minor)	Printed Name	Date

Robin Arnold, MS, AP, Dipl.Ac.(NCCAOM®);FL Lic AP 3450

381.026 Florida Patient's Bill of Rights and Responsibilities

SUMMARY OF THE FLORIDA PATIENT'S BILL OF
RIGHTS AND RESPONSIBILITIES

Florida law requires that your care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behaviors on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider, information concerning the diagnosis, planned course of treatment, alternatives, risk and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request; full information and necessary counseling on the availability of know financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider of health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to access any mode of treatment that is, in his or her own judgment and the judgment of his or her health care practitioner, in the best interest of the patient, including complimentary or alternative health care treatments, in accordance with the provisions s 456.41.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her, and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the healthcare provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments, and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for the following health care facility rules and regulations affecting patient care and conduct.

Patient Signature