apricot grove

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender:_____ Marital status: S M D W

Phone numbers (please indicate cell,home,etc.): _____

Email:_____ Would you like to receive Apricot Grove email newsletter? Y N

Address:_____

Emergency contact info: name:_____ relation:_____ phone:_____

Physician contact info:_____

Do we have permission to contact your physician or your other healthcare providers? Y N

How did you hear about us? _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. What is the primary reason for your visit? _____

2. Please identify the health concerns that have brought you to Apricot Grove in order of importance below:

Condition	**Past Treatment**
a. _____	_____
How does this condition affect you? _____	
b. _____	_____
How does this condition affect you? _____	
c. _____	_____
How does this condition affect you? _____	
d. _____	_____
How does this condition affect you? _____	

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

5. Are you on a blood thinner? Y N

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? _____

7. Do you have any infectious diseases? Y N If yes, please identify: _____

8. Do you have a pacemaker? Y N

9. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

10. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____

When was this reading taken? _____

11. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio Tetanus Rubella/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

13. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

14. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Anxiety/Nervousness Stress/Mental Tension Depression

15. **Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems: _____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs Rheumatic Fever Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

21. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge

24. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?): _____

25. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

27. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

28. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there **anything else** we should know? _____

_____

29. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. Spiritual practice: _____

d. How many hours per night do you sleep? _____ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: _____Employer: _____ Hours/Week: _____

Do you enjoy work? Y/N Why/Why not? _____

g. Nicotine/Alcohol/Caffeine Use: _____

h. Have you experienced any major traumas? Y N Explain: _____

_____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: _____Reading habits: _____

k. Interests and hobbies: _____

Patient Name (print)_____

Patient Signature_____**Date**_____

Informed Consent to Receive Chinese Medical Treatment

I understand that the treatment I receive at Apricot Grove is performed by a State licensed, Board certified acupuncturist. I understand the the practices used at Apricot Grove meet the standards for ensuring sterility set by the Centers for Disease Control and Prevention (CDC) and conform to the guidelines for the Clean Needle Technique (CNT) established for acupuncturists by the National Commission for the certification of Acupuncturists and Oriental Medicine (NCCAOM).

I understand that acupuncturists do not do Western medical (biomedical) diagnosis and that I will not receive such diagnosis at Apricot Grove.

I hereby authorize the practitioners at Apricot Grove to perform diagnosis and treatment according to the professional standards of Oriental Medicine and their own professional judgement. This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures. I understand that my treatment at Apricot Grove may include a variety of Chinese medical modalities such as acupuncture, moxibustion, cupping, electrical stimulation, acupressure based on chinese medical principles. I understand that I may receive a recommendation for dietary therapy from Apricot Grove and that such recommendation does not constitute a prescription for dietary therapy.

I understand that there are possible unforeseen risks attendant to the performance of these therapies. I have been informed that possible side effects of Chinese medical treatment are rare buy may include: transient bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensations of heat or cold, tingling or numbness, brief lightheadedness or fainting, broken needles, temporary worsening of some symptoms and risks of infection and pneumothorax. Moxibustion may cause burns. There may also be unknown side effects.

I understand that herbal remedies may be recommended to me to treat bodily dysfunction or diseases to modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include but are not limited to: changes in bowel movement, abdominal discomfort and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Apricot Grove Chinese Medicine and Acupuncture as soon as possible.*

I understand that no promises or guarantees can be made regarding the outcome of treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care at Apricot Grove. All my questions have been answered to my satisfaction.

I understand and agree that I am ultimately responsible for the balance on my account and that all fees are payable at the time that service is received. I set forth that all information provided is accurate to the best of my knowledge.

I **have/have not** (circle one) been examined by a licensed physician or other licensed health care provider with regard to my illness or injury and have provided information form this examination to the practitioners at Apricot Grove.

□ **I have read and understand my provided copy of the Apricot Grove Notice of Privacy Practices and agree to its terms.**

Patient Name (print)_____

Patient Signature_____ Date_____

FINANCIAL AGREEMENT

Please be respectful of the time set aside for your treatment. If you need to change or cancel an appointment, be sure to make up the missed appointment within a week so that the effects from the treatments are not interrupted.

- All scheduled appointments require a 24-hour cancellation notice.
- Cancellations may be made by phone, by email, or in person.
- Late cancellations are charged $50.
- Missed appointments are charged the full appointment rate

If you are 20 or more minutes late for acupuncture, your appointment will be cancelled and you will be charged for the reserved appointment time. If you are late for massage therapy, your treatment will simply be shortened, ending as per the original appointment time.

All fees are due at the time of service. Accepted forms of payment include: cash, Master Card, Visa, and Discovery. Personal checks are accepted.

- Returned Check Policy

All returned checks will be subject to an additional charge of $30.00.

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I understand the contents of this disclosure and agree to abide by these policies.

Patient Signature: _____ **Date:**_____

Credit card #: _____ **Expiration date:** _____

Card verification code: _____ **Billing zip code:** _____