Patient Health History Questionnaire

Mei-jen Sun Stokesbary, L.Ac., C.S.S.Ac.
808-640-9090 ~ mstokesbary@hotmail.com

Date: _____

Last Name: _____ First Name: _____ Birthdate: _____

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

Phone: Home- _____ Other- _____ Age: _____

Cell-_____ Email-_____

Family Physician: _____ Referred by: _____

In Emergency, Notify: _____ Phone: _____

Have you been treated by acupuncture or Oriental medicine before? Yes No

Please list the primary reasons for your visit. Date of Onset:

1. _____ _____

2. _____ _____

3. _____ _____

What, if any, medical diagnosis have you been given for your symptoms? _____

_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

Surgeries: _____

_____

Significant Trauma (accidents, etc): _____

_____

Allergies**:** _____

What are your goals for receiving acupuncture? Check all that apply:

- ☐ stress relief
- ☐ reduction in symptoms or pain: To what percentage? _____%
- ☐ complete disappearance of symptoms or pain
- ☐ no expectation for improvement: Why? _____
- ☐ greater flexibility
- ☐ better posture
- ☐ illness prevention

Please check any of the following symptoms that you have experienced in the last three months:

General

- ☐ poor appetite
- ☐ cravings
- ☐ strong thirst
- ☐ poor sleeping
- ☐ weight gain
- ☐ weight loss
- ☐ sweat easily
- ☐ fever/chills
- ☐ low energy
- ☐ bruise easily
- ☐ dizziness

Neuropsychological:

- ☐ areas of numbness
- ☐ seizures
- ☐ bad temper
- ☐ lack of coordination
- ☐ poor memory
- ☐ loss of balance
- ☐ dizziness
- ☐ depression
- ☐ anxiety
- ☐ confusion

Respiratory:

- ☐ difficulty breathing
- ☐ coughing blood
- ☐ bronchitis
- ☐ cough
- ☐ difficulty in breathing when lying down
- ☐ pain with a deep breath
- ☐ asthma
- ☐ phlegm

Cardiovascular:

- ☐ blood clots
- ☐ high blood pressure
- ☐ cold hands or feet
- ☐ swelling of hands/feet
- ☐ chest pain
- ☐ palpitations
- ☐ fainting

Skin and Hair:

- ☐ rashes
- ☐ loss of hair
- ☐ itching
- ☐ eczema

Gastrointestinal:

- ☐ constipation
- ☐ hemorrhoids
- ☐ black stools
- ☐ rectal pain
- ☐ diarrhea
- ☐ nausea
- ☐ bad breath
- ☐ abdominal pain or cramps
- ☐ vomiting
- ☐ gas
- ☐ belching
- ☐ indigestion/heartburn

Head, eyes, ears, nose & throat:

- ☐ poor vision
- ☐ eye strain/pain
- ☐ ringing in ears
- ☐ poor hearing
- ☐ nose bleeds
- ☐ mouth sores
- ☐ earaches
- ☐ teeth problems
- ☐ sinus problems
- ☐ headaches
- ☐ grinding teeth

Pregnancy and Gynecology:

- ☐ clots
- ☐ vaginal discharge
- ☐ vaginal sores
- ☐ irregular periods
- ☐ painful periods
- ☐ breast lumps
- ____number of pregnancies
- ____number of births
- ____number of miscarriages

Musculoskeletal:

- ☐ neck pain
- ☐ back pain
- ☐ hand/wrist pain
- ☐ muscle pains
- ☐ hip pain
- ☐ muscle weakness
- ☐ shoulder pain
- ☐ knee pain
- ☐ foot/ankle pain

Genito-Urinary:

- ☐ pain on urination
- ☐ decrease in flow
- ☐ unable to hold urine
- ☐ blood in urine
- ☐ kidney stones
- ☐ urgency to urinate
- ☐ frequent urination
- ☐ wake up to urinate

Consent to Treatment Form

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Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that direct moxibustion is commonly used with the Seitai Shinpo treatment. This involves burning the herb Artemisia Vulgaris on acupuncture points on the skin. The application of moxibustion may become uncomfortable as it produces a heat sensation and could leave a small blister or scab on the surface of the skin. As with any part of treatment, if it becomes too uncomfortable I am free to notify the practitioner. With particular skin types there is a risk of scarring from its use, however shiunko oil will be administered directly on the skin to minimize scarring.

Chinese Herbs: I understand that substances from the Oriental Materia Medica 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 pain or 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 my practitioner as soon as possible.

Cupping/Gua Sha: I understand that the techniques of cupping or gua sha may produce a redness of the skin which may persist for 3-4 days, and may result in slight bruising or tenderness. The red discoloration is a sign of increased blood circulation.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture or similar techniques administered with acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Healing Reaction: I understand that in the natural healing system of acupuncture, the rebalancing of energy may result in a temporary worsening of symptoms, commonly referred to as a Healing Reaction, which may include symptoms such as dizziness, nausea, loss of appetite, slight fever, heavy head, and fatigue. The best treatment for this reaction is rest, and commonly the symptoms go away in a few days. I agree to contact my acupuncturist if my condition worsens.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____

Privacy Policy

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I understand that as part of my healthcare, Rainbow Bridge Acupuncture originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment. This information may be used to consult with other Seitai Shinpo practitioners anonymously only for educational purposes and to ensure appropriate diagnosis and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that Rainbow Bridge Acupuncture is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that Rainbow Bridge Acupuncture has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

_____

_____

I have read and understand my rights regarding privacy of information and under which conditions this information is shared with others so that I may receive therapy and claims be made on my behalf (only for insurance purposes).

Signature: _____ **Date:** _____

Print Name: _____

A copy of your patient rights is available upon request.