



HEALTH HISTORY FORM

NAME _____ DATE _____

ADDRESS _____ HOME PHONE _____

ALTERNATE PHONE _____

EMAIL _____

DATE OF BIRTH _____ M ___ F ___ MARITAL STATUS _____ NO. OF CHILDREN _____

OCCUPATION _____ HEIGHT _____ WEIGHT _____

EMPLOYER _____

REFERRED BY _____ SOCIAL SECURITY No. _____

Viola Huang-Beck, L.Ac.

M.S. TRADITIONAL CHINESE MEDICINE

*Acupuncture &
Herbal Medicine*



707.360.8176

info@huangbeckacupuncture.com

CHIEF COMPLAINT (PLEASE EXPLAIN THE NATURE OF YOUR HEALTH CONCERN AND WHAT YOU HOPE TO RECEIVE FROM TREATMENT)

1. _____

2. _____

3. _____

FAMILY HISTORY (CHECK ANY DISORDERS YOU OR YOUR FAMILY HAVE EXPERIENCED)

	YOU	FATHER	MOTHER	SIBLING	CHILDREN
ALLERGIES	<input type="checkbox"/>				
BLOOD DISORDER/ANEMIA	<input type="checkbox"/>				
CANCER/TUMORS	<input type="checkbox"/>				
DIABETES	<input type="checkbox"/>				
HEART DISORDER	<input type="checkbox"/>				
HIGH BLOOD PRESSURE	<input type="checkbox"/>				
SEIZURES	<input type="checkbox"/>				
STROKE	<input type="checkbox"/>				
OTHER	<input type="checkbox"/>				

PERSONAL HISTORY

► Hospitalizations / Medications

DATE	REASON/OUTCOME
_____	_____
_____	_____
_____	_____

PLEASE LIST ANY MEDICATIONS OR SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING

FOR WHAT CONDITIONS _____

PLEASE LIST ANY DRUG SENSITIVITIES YOU HAVE _____

DATE OF LAST PHYSICAL EXAMINATION _____

NAME AND ADDRESS OF PRIMARY CARE PRACTITIONER _____

► **Diet**

BREAKFAST _____

LUNCH _____

DINNER _____

CRAVINGS (SWEET, SALTY, BITTER, GREASY, SPICY) _____

HOW MANY CUPS A DAY DO YOU DRINK OF THE FOLLOWING?

WATER _____ SODA _____ COFFEE _____ TEA _____ ALCOHOL _____

DO YOU PERSPIRE DURING THE DAY? _____ DO YOU PERSPIRE AT NIGHT? _____

ARE YOU ALWAYS THIRSTY? _____

DO YOU PREFER HOT, ICED, OR ROOM TEMPERATURE DRINKS? (CIRCLE ONE)

LIST ANY KNOWN FOOD ALLERGIES _____

► **Exercise and energy**

WHAT KIND OF EXERCISE DO YOU ENGAGE IN? _____

HOW OFTEN? _____ HOW IS YOUR ENERGY LEVEL? (100% IS BEST WHAT IS YOURS PERCENTAGE?) _____

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|--|---|--|
| <input type="checkbox"/> PANIC ATTACKS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ANXIETY/NERVES |
| <input type="checkbox"/> FEAR | <input type="checkbox"/> DIFFICULTY CONCENTRATING | <input type="checkbox"/> POOR MEMORY |
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP | <input type="checkbox"/> RESTLESSNESS | <input type="checkbox"/> DISTURBED SLEEP |
| <input type="checkbox"/> WAKING UP AT _____ AM/PM | <input type="checkbox"/> RECENT DIVORCE OR MAJOR STRESS | |

HAVE YOU EVER TAKEN ANTIDEPRESSANTS? _____ WHAT KIND? _____

HAVE YOU EVER TAKEN SLEEPING PILLS? _____ WHAT KIND? _____

► **Gastrointestinal**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> BELCHING | <input type="checkbox"/> NAUSEA | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> BLOATING | <input type="checkbox"/> INDIGESTION | <input type="checkbox"/> ACID REFLUX |
| <input type="checkbox"/> HERNIA | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> ABDOMINAL PAIN |
| BOWEL MOVEMENTS: HOW OFTEN? _____ | <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> DIARRHEA |

► **Urinary** (CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> FREQUENT URINATION, HOW OFTEN? _____ | <input type="checkbox"/> INCONTINENCE |
| <input type="checkbox"/> BURNING SENSATION | <input type="checkbox"/> BLADDER INFECTION |

► **Gynecological**

ARE YOU STILL MENSTRUATING? HOW OFTEN ARE YOUR CYCLES? _____

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|---|--|---|
| <input type="checkbox"/> IRREGULAR MENSES | <input type="checkbox"/> HEAVY FLOW, WHAT DAY/S OF CYCLE _____ | |
| <input type="checkbox"/> HEAVY FLOW, WHAT DAY/S OF CYCLE _____ | <input type="checkbox"/> BLOOD CLOTS | |
| <input type="checkbox"/> PMS, WHAT SYMPTOMS _____ | | |
| <input type="checkbox"/> PAINFUL PERIODS, WHAT DAY OF CYCLE _____ | | |
| <input type="checkbox"/> UTERINE FIBROIDS OR CYSTS | <input type="checkbox"/> ENDOMETRIOSIS | <input type="checkbox"/> CYSTIC BREASTS |
| <input type="checkbox"/> PERIMENOPAUSAL, WHAT SYMPTOMS _____ | | |
| <input type="checkbox"/> MENOPAUSAL | DATE OF LAST MENSTRUAL PERIOD _____ | |

► **Muscular-skeletal**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> MUSCLE PAIN | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> BACK PAIN | <input type="checkbox"/> JOINT PAIN |
| <input type="checkbox"/> PAIN ELSEWHERE IN THE BODY, & IF SO, WHERE? _____ | |

► **Respiratory, ENT & Head**

DO YOU SMOKE? _____ HOW MANY TIMES A DAY? _____ FOR HOW MANY YEARS? _____

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|---|---|--|
| <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> BLEEDING GUMS | <input type="checkbox"/> DRY MOUTH | <input type="checkbox"/> RINGING IN EARS |
| <input type="checkbox"/> CLOGGED/POPPING EARS | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> MIGRAINE |

► **Cardiovascular**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|--|---|---|
| <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> IRREGULAR HEART BEAT | <input type="checkbox"/> POOR CIRCULATION |
| <input type="checkbox"/> COLD HANDS/FEET | <input type="checkbox"/> SWOLLEN HANDS/FEET | <input type="checkbox"/> VARICOSE VEINS |
| <input type="checkbox"/> SPIDER VEINS | <input type="checkbox"/> HEART MURMUR | |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> LOW BLOOD PRESSURE | |

► **Skin & Hair**

DO YOU HAVE OR HAVE YOU HAD? (CHECK ALL THAT APPLY)

- | | | |
|-----------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> DRY SKIN | <input type="checkbox"/> OILY SKIN | <input type="checkbox"/> ITCHING |
| <input type="checkbox"/> ACNE | <input type="checkbox"/> SKIN RASHES | <input type="checkbox"/> ECZEMA |
| <input type="checkbox"/> HIVES | <input type="checkbox"/> HAIR LOSS | |

WHAT TREATMENT HAVE YOU RECEIVED FOR THESE CONDITIONS? _____

WHAT IS YOUR SKIN CARE REGIMEN? _____

ARE THERE ANY OTHER HEALTH CONDITIONS I SHOULD BE INFORMED OF?

Thank you!

FOR OFFICE USE ONLY

Dx:

T:

P:

PTS:

RX

NOTES:

Patient Information and Informed Consent

Information About Chinese Medicine (CM) and Acupuncture

Please carefully read each section below, ask any questions, and initial each section to indicate your understanding of the information:

- _____ **Acupuncture** is a healing art that involves the stimulation of specific points on the body. It has the intended effect of normalizing body functions, modifying the perception of pain, and treating certain diseases or dysfunctions of the body. The stimulation may be produced by needles, heat, digital pressure, electric currents, or other means, but most frequently by needling. Location and depth of needle insertion is determined by the nature of the problem. Acupuncture is considered a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that lasts a few days.

- _____ Insertion of acupuncture needles may be accompanied by a brief painful sensation, and there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma (bruise) at the site of needling, or fainting. Momentary euphoria or lightheadedness may occur after treatment. Some very rare risks of acupuncture include fainting, spontaneous abortion, pneumothorax (a partially or fully-collapsed lung due to air in the chest cavity), and infection.

Some health conditions are contraindications to acupuncture treatment, or they require special precautions to be taken during treatment. These conditions include, but are not limited to: a history of a bleeding disorder, current anticoagulation therapy, diabetes, an implanted pacemaker or prosthetic heart valve, certain medications, and/or pregnancy. It is important that you notify your acupuncturist if any of these might apply to you, so that you can discuss any risks and ensure safe and effective acupuncture treatment.

- _____ **Moxibustion** is heat supplied, either directly or indirectly, by burning the herb *Folium Artemisiae Vulgaris* over a single acupuncture point or group of points. The area being treated may remain red and warm for several hours after treatment. In rare instances, a minor burn may occur at the site of moxibustion.

- _____ **Cupping** is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. Cupping may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks are not indications of complications or injury.

- _____ **Acupressure/Tui Na Massage** is used to modify or prevent the perception of pain and to normalize the body's physiologic functions. Possible side effects of this treatment include, but are not limited to, bruising, muscle soreness, and the possible aggravation of symptoms existing prior to treatment.

- _____ **Herbs and/or Nutritional Supplements** from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and/or to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are typically taken by mouth in a tea, pill, or powder; topically by rubbing into the skin; or applied internally.

- _____ Herbs are considered safe in the practice of CM, although some substances may be toxic in large doses. Some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. Most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin.

Due to possible interactions between herbs and Western medications, it is very important to report all prescribed and over-the-counter medications you are taking at the time of your visit.

_____ **Gua sha** means “scraping sha-bruises” and involves using a scraping tool intended to result in minor skin bruising. Some patients experience temporary indentation of their skin after gua sha treatment, and in some instances minor bleeding can occur. If any bleeding occurs, there is an associated risk of infection.

_____ **Infrared and TDP (Teding Diancibo Pu)** lamp therapy consists of warming the skin with a heat source mounted to an adjustable arm and positioned above the body. If the heat source comes into close proximity with or contacts the skin, there is the risk of a burn.

Consent for Chinese Medicine and Acupuncture Treatment

I understand the importance of communicating with all of my health care providers regarding my health status. I have provided my full medical history, current health status, all medications I am currently taking, and a description of my complaints. This information is complete and accurate, to the best of my knowledge.

Do you have an implanted pacemaker, defibrillator, or prosthetic heart valve? Yes No

Do you take steroid or anticoagulant medications? Yes No

Female patients: Are you pregnant? Yes No (If no, provide date of last menstrual period: _____)

The diagnosis given to me conforms to the principles of CM, and in no way purports to replace allopathic (Western) medical evaluation, diagnosis, or treatment.

No guarantees have been made concerning the use and effects of CM. I understand that, in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

I am not required to take recommended herbs or nutritional supplements, but if I do decide to take these substances, I must follow the directions for administration and dosage. I will immediately notify my practitioner of any unanticipated or unpleasant effects associated with herbs or nutritional supplements.

I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with CM treatment. I understand that I am free to withdraw my consent to treatment, and/or stop treatment at any time.

Patient Name:

Signature of Patient or person authorized to consent on behalf of the patient:

Date:

CANCELLATION AND NO SHOW POLICY

48 hours required for canceling or rescheduling appointments. If we receive less than 48 hours notice, and we cannot fill that time slot, you will be charged the full appointment fee. This policy also applies to missed appointments.

Please arrive 5 minutes before your appointment so that you can relax and change into loose fitting clothing if necessary. If you know you will be late, please call. We may be able to fit you in but your appointment may be shorter; if we're unable to, the missed appointment will be subject to the full cancellation fee.

Payment methods - We accept Cash, Check, and Credit Cards.

Returned checks - For Insufficient Funds: Pursuant to California Civil Code section 1719(a) you are liable for the full amount of the check plus a service charge of \$25 for the first bounced check and \$35.00 for each subsequent bounced check.

By agreeing to these terms, you understand that services rendered to you are your financial responsibility.

Signature: _____ **Date:** _____

OFFICE POLICIES

_____ **RELEASE OF INFORMATION**

You hereby authorize Kang Shou Acupuncture, Professional Corporation, having treated you, to release to government agencies, insurance carriers and all others who are financially liable for your care, all information to substantiate payments for your care and to permit representatives thereof to examine and make copies of all records related to such care and treatment.

_____ **HEALTH INSURANCE**

The provider agrees to supply a Superbill upon request. Under special circumstances the provider *may* agree to bill your insurance directly. In the case that the provider agrees to bill your insurance company directly, you authorize your insurance company to pay your benefits directly to the provider and understand that you are responsible for the required deductibles, copay/ coinsurance as stated by your health insurance contract.

_____ You understand that should your health insurance company send payment to you directly, you will forward the payment to this office within 5 business days. To avoid any additional cost and inconvenience, should your insurance company forward payments to you, you authorize this office to facilitate payment utilizing the credit card stored on file. Charges to this card will NOT occur unless checks from the Insurance Carrier are not endorsed and received within 5 days of receipt.

_____ I have received a copy of this office's **HIPPA Notice of Privacy Policies**.
By signing you acknowledge that you have read and understand the Privacy Policies.

⇒ **Signature:** _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment - Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment - We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations - We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law - Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization - Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect - We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings - We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients - We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies - We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care - We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight - If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement - We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions - We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health - If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety - We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research - PHI may only be disclosed after a special approval process or with your authorization.

Fundraising - We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission - We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization - Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to us.

- Right of Access to Inspect and Copy - You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- Right to Amend - If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- Right to an Accounting of Disclosures - You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions - You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- Right to Request Confidential Communication - You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- Breach Notification - If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
 - Right to a Copy of this Notice - You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this Notice is July 1, 2007.