VITALITY ACUPUNCTURE

32 Market Place
Big Sky, MT 59716
(406)-595-4722
vitalitymontana@gmail.com

HEALTH HISTORY QUESTIONNAIRE

Name: DOB: Age: Height: Weight:

Address: City: State: Zip:

Email: Phone: Cell:

Emergency Contact: Phone:

Occupation: Marital Status

Have you ever tried acupuncture before: **YES** **NO** Are you sensitive to needles? **YES** **NO**

Who may we thank for referring you?_____

Recent Health Care Providers: (Name, Date, Service provided)_____

Insurance Provider: _____Policy #_____

WHAT IS YOUR MAIN CONCERN?_____

_____

When did you first notice symptoms?_____

How does this affect your daily activities?_____

Do you have a western medical diagnosis?_____

Hospitalizations/Surgeries/Accidents?_____

Allergies:_____

FAMILY HEALTH HISTORY

Family Member	*Age*	*Disease/Illnesses*	*Deceased Y/N*

PERSONAL HEALTH HISTORY

Please list all medicines, herbs and supplements that you are currently taking or have taken in the past month. Include dosages and frequency. Attach a separate sheet of paper if necessary:

GENERAL

Please check all that apply below

___ Poor Appetite ___ Weight Gain ___ Weight Loss ___ Cravings
___ Insomnia ___ Night sweats ___ Disturbed Sleep ___ Poor Balance
___ Sudden energy drop ___ Fever ___ Chills ___ Tremors
___ Strong thirst ___ Sweating easily ___ Bleeding ___ Bruising

SKIN & HAIR

___ Rashes ___ Eczema ___ Psoriasis ___ Hives
___ Itching ___ Ulcerations ___ Pimples ___ Recent moles
___ Hair loss ___ Dandruff ___ Changes in hair texture

HEAD, EYES, EARS, NOSE & THROAT

___ Dizziness ___ Concussion ___ Migraines ___ Glasses
___ Spots in front of eyes ___ Eye pain ___ Poor vision ___ Cataracts
___ Photophobia ___ Night blindness ___ Color blindness ___ Blurry vision
___ Eye strain ___ Ringing in ears ___ Ear aches ___ Ear discharge
___ Poor hearing ___ Headaches ___ Sinus problems ___ TMJ
___ Nose bleeds ___ Recurrent sore throat ___ Grinding teeth ___ Teeth problems
___ Facial pain ___ Jaw clicks ___ Bleeding gums ___ Dry lips
___ Sores on lips or tongue

CARDIOVASCULAR

___ High blood pressure ___ Low blood pressure ___ Dizziness ___ Chest pain
___ Fainting ___ Irregular heart beat ___ Chest tightness ___ Palpitations
___ Blood clots ___ Phlebitis ___ Stroke ___ Swelling of hands
___ Swelling of feet ___ Cold hands/feet ___ Difficulty breathing

RESPIRATORY

___ Cough ___ Asthma ___ Bronchitis ___ Emphysema
___ COPD ___ Shortness of breath ___ Excessive phlegm ___ Frequent colds
___ Flu ___ History of smoking ___ Coughing up blood

GASTROINTESTINAL

___ Nausea ___ Vomiting ___ Diarrhea ___ Parasites
___ Belching ___ Rectal pain ___ Constipation ___ Gas/bloating
___ Acid reflux ___ Bad breath ___ Hemorrhoids ___ Indigestion
___ Black stools ___ Abdominal cramps ___ Blood in stools ___ Crohn's
___ Colitis ___ Diverticulitis ___ History of polyps ___ IBS
___ Chronic laxative use ___ Tender abdomen ___ Sudden change in bowel movements

GENITOURINARY

___ Pain on urination ___ Incontinence ___ Sores on genitals ___ Decreased flow
___ Urinary infections ___ Blood in urine ___ Kidney stones ___ Impotence
___ Low to no sex drive ___ Wake at night to urinate ___ Vaginal/Penile discharge

MUSCULOSKELETAL

___ Neck pain ___ Back pain ___ Hand/wrist pain ___ Knee pain
___ Shoulder pain ___ Muscle pain ___ Muscle weakness ___ Sciatica
___ Hip pain ___ Foot/ankle pain ___ Arthritis ___ Tinnitus
___ Migraines ___ Numbness/tingling ___ Varicose veins ___ Jaw pain

NEUROPSYCHOLOGICAL

___ Seizure	___ Poor memory	___ Anxiety	___ Depression
___ Bad temper	___ Loss of balance	___ Concussion	___ Mood swings

OTHER ILLNESSES & BLOODBORNE PATHOGENS

___ HIV positive	___ Rheumatic fever	___ Eating disorder	___ Jaundice
___ AIDS	___ Mononucleosis	___ Diabetes	___ Epstein-Barr
___ Hepatitis	___ Underweight	___ Overweight	___ Hypoglycemia

MENTAL HEALTH

Is stress a major problem for you?	**YES**	**NO**
Do you feel depressed?	**YES**	**NO**
Do you panic when stressed?	**YES**	**NO**
Do you cry frequently?	**YES**	**NO**
Do you have problems with eating or appetite?	**YES**	**NO**
Have you ever attempted suicide?	**YES**	**NO**
Have you ever seriously thought about hurting yourself?	**YES**	**NO**
Do you experience alcohol or drug addiction or dependance?	**YES**	**NO**
Have you ever been to a counselor?	**YES**	**NO**
Would you like a referral for a counselor?	**YES**	**NO**

WOMEN'S HEALTH

Age at onset of menstruation: _____ Date of last menstruation: _____ Cycle occurs every ____ days

Number of pregnancies: _____ Number of live births: _____

Are you pregnant or breastfeeding?	**YES**	**NO**
D&C, hysterectomy, or Cesarean?	**YES**	**NO**
History of miscarriages or abortions?	**YES**	**NO**
Hot flashes or night sweating?	**YES**	**NO**
Heavy periods, irregularity, spotting, pain or discharge?	**YES**	**NO**
Menstrual tension, pain, bloating, irritability or PMS around cycle?	**YES**	**NO**
Breast tenderness, lumps, nipple discharge?	**YES**	**NO**

MEN'S HEALTH

Recent kidney, bladder or prostate infections?	**YES**	**NO**
Problems emptying your bladder completely?	**YES**	**NO**
Difficulty with erection or ejaculation?	**YES**	**NO**
Testicle pain or swelling?	**YES**	**NO**
BPH or chronic prostatitis?	**YES**	**NO**
Burning or discharge from penis?	**YES**	**NO**

LIFESTYLE

EXERCISE:

_____ Sedentary (no exercise)

_____ Mild (climb stairs, walk a few blocks, golf)

_____ Occasional vigorous exercise (workout, recreation, less than 4X/week for 30 minutes)

_____ Regular vigorous exercise (workout or recreation 4X/week or more for at least 30 minutes)

DIET:

Are you dieting?	**YES**	**NO**
If so, are you on a physician prescribed medical diet?	**YES**	**NO**

Number of meals you eat in an average day? _____

Please describe your daily diet (what is an average meal for you, do you avoid any foods?) _____

_____

_____

_____

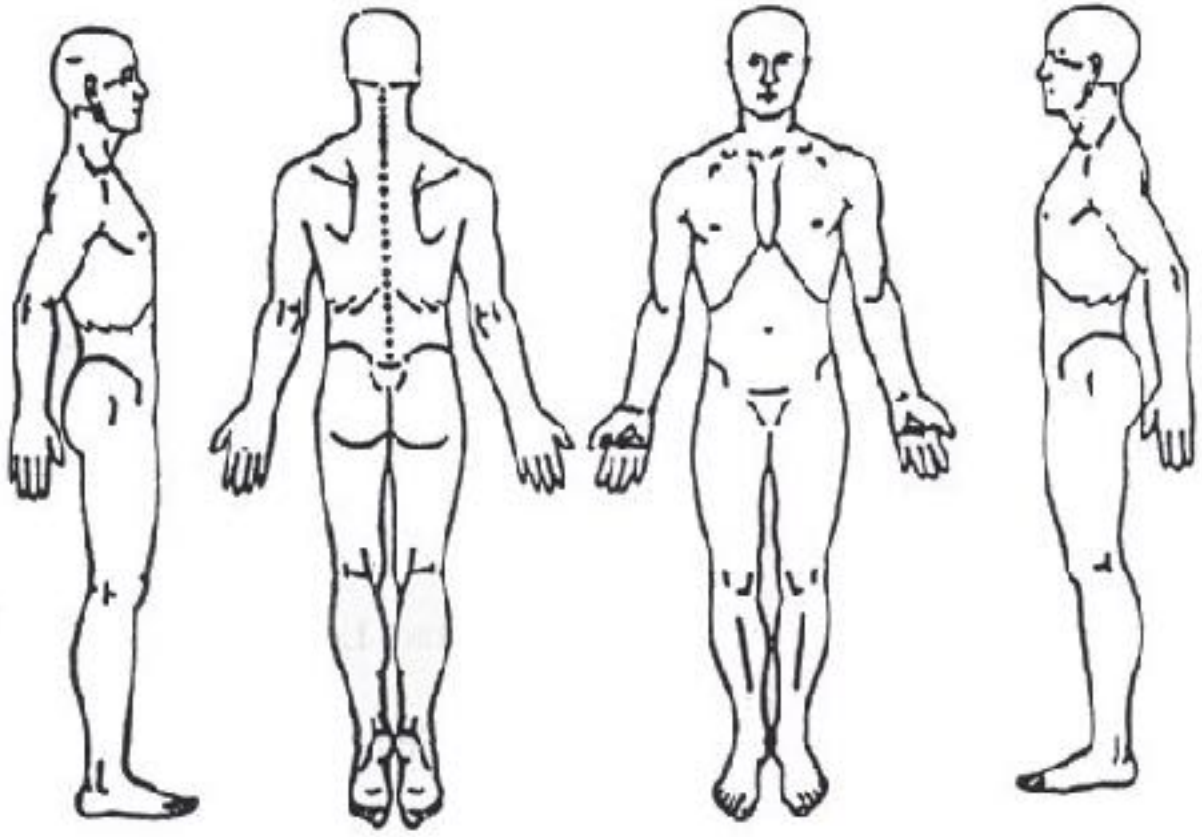
CAFFEINE: *Indicate # of cups/cans per day* _____ Coffee _____ Tea _____ Soda

TOBACCO: YES NO Type? _____ **# per day** _____ **# of years?** _____

ALCOHOL/DRUGS: Do you drink alcohol? **YES NO** How many drinks per week? _____

Do you use recreations drugs? If yes, what type and how often? _____

_____



Please mark painful or distressed areas on the chart above

PAIN	X = little	XX = moderate	XXX = severe
SWELLING	O = slight	OO = moderate	OOO = severe
WEAKNESS	W = slight	WW = moderate	WWW = severe
NUMBNESS	N = slight	NN = moderate	NNN - severe
SKIN ISSUES = S		**Temperature =** (**+** hot) (**-** cold)	

Please use the space below to list any other information that you think is important regarding your health history and general intake:

32 Market Place
Big Sky, MT 59716
(406)-595-4722

VITALITY ACUPUNCTURE CLINIC POLICIES

- I agree to provide at least 24 hours notice of a cancellation and accept the $40.00 fee for missed appointments.
- I acknowledge that there is a $35.00 processing fee for returned checks.

Initial:_____

Acknowledgement of the receipt of Vitality Acupuncture clinic policies

Vitality Acupuncture, LLC., provides each patient with a statement of clinic policies.

I have read, revised, understand and agree to the statement of the Office Policies for healthcare services at Vitality Acupuncture.

Acknowledgement of the receipt of Vitality Acupuncture Consent to Privacy Practices

_____ _____ _____
Name (printed) Signature Date

If you are a minor or you are being represented by another party

_____ _____ _____
Personal Representative (printed) Signature Date

Description of the authority action on behalf of the patient: _____

This form is required by our malpractice insurance company. Please read and sign. Thank you.

ACUPUNCTURE INFORMED CONSENT

Consent
I, _____ hereby authorize Valerie Schwankl, Licensed Acupuncturist, to perform acupuncture treatments on me (or on the patient named below, for whom I am legally responsible). This authority shall extend to remedying any unforeseen conditions or reactions to treatment procedures.

Scope of Practice
I understand that scope of practice includes, but is not limited to, the following:

- Using Oriental medical theory to assess, diagnose, and develop a plan to treat a patient in an attempt to improve overall body function and/or to relieve pain.
- Using treatment techniques that may include:
  - -Insertion of sterile acupuncture needles through the skin
  - -Acupuncture stimulation including, but not limited to electrical stimulation or the application of heat with moxabustion or heat lamps
  - -Cupping
  - -Dermal friction
  - -Acupressure
  - -Herbal therapies
  - -Dietary counseling based on traditional Chinese medical principles
  - -Breathing techniques or exercise according to Oriental medical principles

Risks and Possible Side Effects
I understand that there are possible side effects to my treatment that may include the following:

- Minor pain or soreness in the treatment area
- Transient bruising
- Infection
- Needle sickness (dizziness, nausea, fainting)
- Broken needles
- Sensations of heat, cold, tingling or numbness
- Skin irritation or slight bleeding at needle site
- Generalized fatigue
- Gastrointestinal disturbance from herbal remedies
- Minor burns from moxabustion (heat stimulation)
- Spontaneous miscarriage
- Pneumothorax

Treatment Outcomes
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. I understand that I may stop treatment at any time.

Western Biomedical Diagnosis
I understand that it is not within the scope of practice for acupuncturists to offer Western medical (biomedical) diagnosis, and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

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. If yes, I have informed the practitioner of the diagnosis.

I do / do not (*circle one*) have a pacemaker or bleeding disorder.

_____ _____
Patient (or Guardian) Signature Date

_____ _____
Witness Date

VITALITY ACUPUNCTURE

32 Market Place
Big Sky, MT 59716
(406)-595-4722

BEFORE YOUR FIRST APPOINTMENT

The following are guidelines for patients to follow to get the most out of their acupuncture sessions. If you have any questions, please do not hesitate to contact your practitioner for more information:

1) Avoid caffeine, alcohol and excessive amounts of sugar and exercise the day of your appointment. Please refrain from wearing perfumes, colognes, or strong odors. Some patients may have chemical sensitivities.

2) Drink plenty of water the day before your appointment and try to come well-rested.

3) Please refrain from brushing your tongue the day before your treatment. The tongue coating serves as a diagnostic tool in Chinese medicine.

4) **Eat a meal at least 1-2 hours before your acupuncture session.** Side-effects such as needle sickness can be avoided by coming to your treatment with food in your stomach. Patients who have not eaten within hours of their session will be offered a snack (if available) or an alternate appointment time.

5) **Please refrain from using your cellphone** during your treatment sessions unless you have an emergency. This is a time for you to relax and tap into your body's healing abilities. Extraneous distractions and loud conversations should be avoided.

6) Arrive wearing loose comfortable clothing - skinny jeans, tight shirts, etc. are not ideal.

7) Please have your paperwork completely filled out before your session time begins, otherwise arrive 20 minutes early to fill it out in the office. If you arrive to your appointment at the scheduled time and have not filled out the paperwork, the treatment session will be cut short to accommodate for this.

8) If you are taking prescription or over-the-counter medications, please bring a list including the dosages you take.

9) Relax :) It's natural for many people to feel nervous about needles. My goal is to make the experience as comfortable as possible. If you have any questions or concerns please do not hesitate to ask questions!