
HEALTH HISTORY QUESTIONNAIRE

Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
All information is strictly confidential.

PERSONAL INFORMATION

Name _____

Sex M ___ F ___ DOB: _____ Age _____

Address _____ City _____ State _____

Zip code _____

Primary Phone Number _____ Home _____ Cell _____ Work _____

Email _____

Would you like to be on our email list? Yes ___ No ___

Marital Status _____ # of children _____ their age(s) _____

Occupation _____

Emergency Contact :

Name _____ Phone _____ Relationship _____

Physician's Name _____ Phone _____

Under 18 – Guardian Information:

Name _____ Relationship to Patient _____

Previous experience with acupuncture? Yes ___ No ___

HEALTH HISTORY

Please list your major health concerns in order of importance to you:

Check any conditions that you have had in the past or are currently experiencing:

- Alcoholism
- Allergies
- Anemia
- Arthritis
- Asthma
- Auto Immune
- Birth Trauma
- Bleeding Disorders
- Bronchitis
- Cancer or tumor
- Candida (Yeast)
- Chronic Fatigue
- Chronic pain condition
- Colitis
- Defibrillator
- Diabetes
- Diverticulitis/Irritable bowels
- Eating Disorder
- Emphysema
- Fainting Disorders
- Fibromyalgia
- Food Allergies/Intolerance
- Gallstones
- Gastritis
- Glaucoma
- Gout
- Headaches
- Hemorrhage
- Heart Disease
- Hepatitis
- Hernia
- Herniated disc
- Herpes
- High Cholesterol
- High/Low Blood Pressure
- HIV/AIDS
- Immune Disorder
- Impotence
- Jaundice
- Joint Replacement
- Kidney Disease
- Liver /Gallbladder disease
- Lyme's Disease
- Macular Degeneration
- Mental Illness
- Migraine
- Mono
- Multiple Sclerosis
- Organ Transplant
- Osteoporosis
- Pacemaker
- Parkinson's disease
- Pneumonia
- Rheumatic Arthritis
- Rheumatic Fever
- Seizures/Epilepsy
- Skin disease
- Stroke
- Substance Abuse
- Suicide Attempt
- Thyroid imbalance
- Tuberculosis
- Ulcer
- Vein Condition
- STD
- Whooping Cough
- Other

List any serious diseases, injuries, surgeries, or hospitalizations you have had and the year they occurred:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

FAMILY HISTORY

List any family physical or mental illnesses and age of death:

Mother _____
Father _____
Siblings _____

Prescription Medications, Herbs, and Supplements (List those that you are currently taking)

Allergies (medication, food, chemical/environmental) Yes _____ No _____

If yes, list and describe the allergies reaction _____

Do you smoke ? Yes _____ No _____ If yes, how much per day? _____

Do you drink coffe/black tea? Yes _____ No _____ If yes, how much? _____

Do you use alcohol ? Yes _____ No _____ If yes, how much? _____ How Often? _____

Do you exercise? Yes _____ No _____ If yes, Days per week _____

Length of workout _____ Type of activity _____



PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

LIV/GB(WOOD)

- | | | |
|---|--|---|
| <input type="radio"/> Irritability/anger | <input type="radio"/> Muscle cramping/twitching
Tension | <input type="radio"/> Herpes simples |
| <input type="radio"/> Depression/stress | <input type="radio"/> Joints/neck/shoulder pain | <input type="radio"/> Indecisive |
| <input type="radio"/> Headaches/migraines | <input type="radio"/> Poor circulation | <input type="radio"/> Shoulder/neck tension |
| <input type="radio"/> Visual problems/ Blurred vision | <input type="radio"/> Soft/brittle nails | <input type="radio"/> Insomnia 11pm-3am |
| <input type="radio"/> Red/dry/itchy eyes | <input type="radio"/> Ringing in ears | |
| <input type="radio"/> Gallstones | <input type="radio"/> Abdominal distension/Pain | |
| <input type="radio"/> Dizziness | <input type="radio"/> Difficulty digesting oily foods | |
| <input type="radio"/> Feeling of lump in the throat | <input type="radio"/> Tremors | |
| <input type="radio"/> Clenching of teeth at night | | |
-

Ht/SI (Fire)

- | | | |
|---|---|---|
| <input type="radio"/> Heart palpitations | <input type="radio"/> Skin rash | <input type="radio"/> Facial redness |
| <input type="radio"/> Chest pain | <input type="radio"/> Cyst/tumor | <input type="radio"/> Itchy/ burning skin |
| <input type="radio"/> Insomnia/sleep problems | <input type="radio"/> Ear infection | <input type="radio"/> Thirst |
| <input type="radio"/> Easily startled | <input type="radio"/> Sore throat | <input type="radio"/> Night sweats |
| <input type="radio"/> Restlessness/agitation | <input type="radio"/> Lymph swelling | <input type="radio"/> Excess joy |
| <input type="radio"/> Vivid dreams | <input type="radio"/> Bitter taste in the mouth | <input type="radio"/> Borborygmus |
| <input type="radio"/> Lack of joy in life | <input type="radio"/> Gum problems | <input type="radio"/> Flatulences |
| <input type="radio"/> Dry scalp | <input type="radio"/> Nose bleed | |
-

Sp/ST (Earth)

- | | | |
|---|---|---|
| <input type="radio"/> Heavy sensation in body | <input type="radio"/> Easily bruised and bleeding | <input type="radio"/> Abdominal bloating |
| <input type="radio"/> Fatigue after eating | <input type="radio"/> Bad breath | <input type="radio"/> Hemorrhoids |
| <input type="radio"/> Hard to get up in morning | <input type="radio"/> Decrease/increase appetite | <input type="radio"/> Constipation |
| <input type="radio"/> Edema (swelling) | <input type="radio"/> Crave sweets | <input type="radio"/> Diarrhea |
| <input type="radio"/> Muscles feel tired often | <input type="radio"/> Hypoglycemia | <input type="radio"/> Abdominal pain |
| <input type="radio"/> Cold limbs | <input type="radio"/> Nausea/vomiting | <input type="radio"/> Indigestion/heartburn |
| <input type="radio"/> Prolapse Organs | <input type="radio"/> Gas/belching | <input type="radio"/> Over-thinking |

- Tendency to gain weight
- Brain foggy
- Food allergy
- Excess worry

Lu/LI (Metal)

- | | | |
|---|---|--|
| <input type="radio"/> Dry cough | <input type="radio"/> Dry mouth/throat/nose | <input type="radio"/> Shortness of breath |
| <input type="radio"/> Cough with sputum | <input type="radio"/> Thirsty | <input type="radio"/> Asthma/allergies |
| <input type="radio"/> Nasal congestion | <input type="radio"/> Sore throat | <input type="radio"/> Low resistance to colds or flu |
| <input type="radio"/> Post-nasal drip | <input type="radio"/> Skin rashes/hives/dry | <input type="radio"/> Sneezing |
| <input type="radio"/> Sinus trouble | <input type="radio"/> Snoring | <input type="radio"/> Mild fever comes and goes |
| <input type="radio"/> Itchy/red/painful | <input type="radio"/> Grief/sadness | |

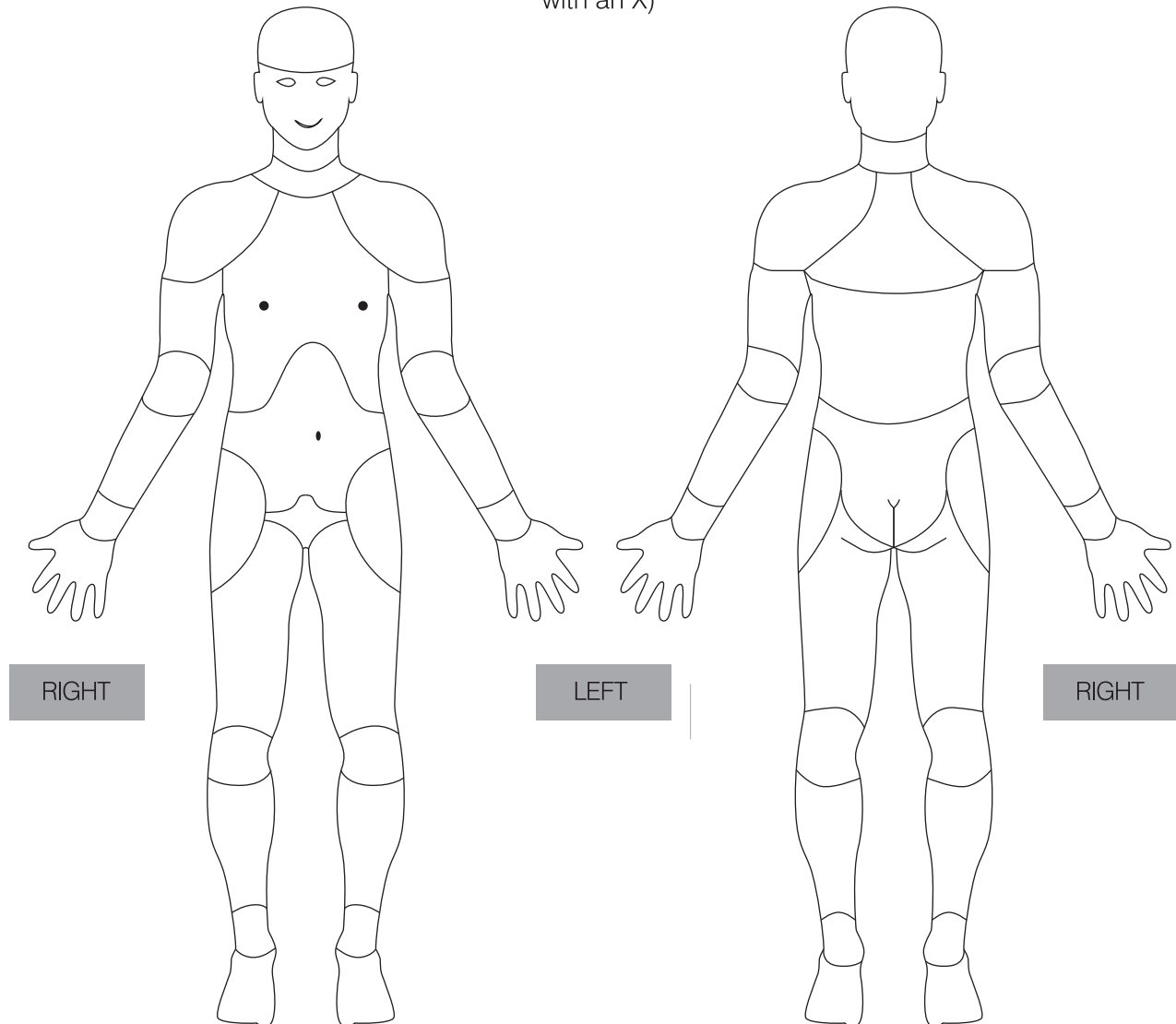
Kid/UB (water)

- | | | |
|---|---|---|
| <input type="radio"/> Urinary problems | <input type="radio"/> Poor memory | <input type="radio"/> Rapid weight change |
| <input type="radio"/> Bladder problems | <input type="radio"/> Loss of hair | <input type="radio"/> Emotional instability |
| <input type="radio"/> Lack of bladder control | <input type="radio"/> Hearing problems | <input type="radio"/> Inestabilidad emocional |
| <input type="radio"/> Weakness/pain in lower back | <input type="radio"/> Cavities/tooth loss | |
| <input type="radio"/> Decrease bone density | <input type="radio"/> Fear | |
| <input type="radio"/> Feel cold easily | <input type="radio"/> Hot flashes/high sweating | |
| <input type="radio"/> Low/ Excess sexual drive | <input type="radio"/> Weak leg/knees | |

OTROS

- Sciatica
- Nerve pain
- Carpal tunnel
- Numbness
- Bursitis/tendonitis

Please clearly mark areas of pain and any scars (please indicate areas of pain with a circle and scars with an X)



This graphic was designed using images from: Freepik.com .

Is the pain:

- Sharp
- Burning
- Stabbing
- Cramping
- Dull
- Moving
- Fixed
- Other

What makes the pain BETTER:

- Pressure
- Cold
- Heat
- Exercise
- Other

What makes the pain WORSE:

- Pressure
- Cold
- Heat
- Exercise
- Other

Libido:

- Normal
- High
- Low

Women only

1. Are you pregnant? Yes _____ No _____
2. Number of pregnancies _____
3. Age of first period _____
4. Age of menopause if applicable _____
5. Is your menses cycle regular? Yes _____ No _____
 - a. Average number of days of flow _____
 - b. The Flow is _____normal _____Heavy _____light

Do you experience any premenstrual syndromes? Yes _____ No _____

Do you have clots during your period? Yes _____ No _____

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Patient Signature: _____ Date _____

Reviewed with Patient _____ Dr. Isabel C Silva, AP, DOM Date: _____

CONSENT FORM

I hereby request and consent to the performance of acupuncture treatments and other procedures with the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, Acupoint Injection Therapy, and nutritional counseling. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the sites that may last a few days, and dizziness or fainting. Burns and/or scarring are the potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean safe environment.

I understand that vitamins and/or homeopathic remedies in the form of sterile supplements are injected into acupuncture points by means of hypodermic needles, may be recommended to me to treat bodily dysfunctions or disease. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: pain, mild bleeding, bruising, redness, swelling or numbness around injection site, muscle stiffness, soreness at site of injection, fatigue, diarrhea, mild to severe allergic reactions, and possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the Acupoint Injection Therapy (AIT)

I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. The herbs and nutritional supplements (which are from plant, animal and mineral substances) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am pregnant or become pregnant.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. While I do expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, and is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: X _____ Date: _____

(Or Patient Representative)

Acupuncturist Signature: _____ Dr. Isabel C Silva AP, DOM

NOTICE OF PRIVACY POLICIES

The following is the privacy policy of Oriental Medical Center as described in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA requires Oriental Medical Center by law to maintain the privacy of your personal information and to provide you with notice of Oriental Medical Center's legal duties and privacy policies with respect to your Personal Health Information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information. This office may send birthday cards, newsletters and appointment reminders (telephone, text, email, letters, etc.)

Use or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. The following are the circumstances under which we are permitted by law to use or disclose your Personal Health Information:

As Required By Law. We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Your rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your Personal Health Information. It is your right to request the following regarding your Personal Health Information:

- Right to request restrictions of use or disclosure of your Protected Health Information.
- Right to receive confidential communications.
- Right to inspect and copy your Personal Health Information.
- Right to request amendment of your Personal Health Information.
- Right to receive and Accounting of Disclosures of your Personal Health Information.

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. Complaints files with the Secretary of DHHS must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred.

*U.S. Department of Health and Human Services
DHHS (Office of Civil Rights)
200 Independence Ave. SW Room 509 Building F
Washington, DC 20201*

If you have questions or want more information regarding HIPAA, please contact:
Isabel Cristina Silva AP, DOM at telephone: (407) 223-7419.

Patient Signature: X _____ Date: _____
(Or Patient Representative)

**AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION
BY ALTERNATE MEANS**

Patient Name: _____ DOB: _____

From time to time it may be necessary for a representative of Satori Vitae Health and Wellness to contact patients for various notification purposes that could include Personal Health Information such as:

- Appointment reminders/confirmation/rescheduling

I authorize Satori Vitae Health and Wellness and/or staff to leave detailed, personal health information by the following means.

Check and complete all that apply:

METHOD	NUMBER WITH AREA CODE
<input type="radio"/> Cell Phone/Voice Message	_____
<input type="radio"/> Text Message	_____
<input type="radio"/> Email	_____

With my signature below, I acknowledge and understand that this Authorization will be kept as part of my medical record and that the communication instructions listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Satori Vitae Health and Wellness in writing should I wish to change any of information noted above and to notify Satori Vitae Health and Wellness if my contact information changes.

Patient or Legally Authorized Representative's Signature

Date