Cornerstone Healing
ACUPUNCTURE. HERBS. BODYWORK

HEALTH HISTORY

Date: ____ / ____ / _____

Name, first and last (as you would like to be called):		Gender (identity):	Age:
Address:	City:	Zip Code:	
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Date of Birth:	Emergency contact:	Contact #:	Relationship:
Best form of contact:	Want to join our mailing list?	If your legal name is different from your prefered name and you want us to have it, put here:	
What pronouns would you like to be addressed by? (her, him, hir, they, etc.)	Occupation:		
Physician:	Physician's Phone #:		
How did you hear of our clinic? Who can we thank for the referral?	Have you been treated by acupuncture before? ☐ No ☐ Yes ____/____/____		

MAIN CONCERNS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Circle the 🧍 if you have / had the condition and note the year it started.
Circle the 👪 if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?* _____	🧍	_____	👪
Diabetes	🧍	_____	👪
Hepatitis ____	🧍	_____	👪
High Blood Pressure	🧍	_____	👪
Heart Disease	🧍	_____	👪
Stroke	🧍	_____	👪
Seizure Disorder	🧍	_____	👪
Thyroid Disease	🧍	_____	👪
Asthma	🧍	_____	👪
Pacemaker	🧍	_____	👪
Osteoporosis	🧍	_____	👪
Kidney Disease	🧍	_____	👪
Autoimmune Disease	🧍	_____	👪
Anemia	🧍	_____	👪
Rheumatic Fever	🧍	_____	👪
Alcoholism	🧍	_____	👪
Allergies *type(s)?* _____	🧍	_____	👪
Other _____			

Would you like support cutting back on any addictive habits?_____
Are you in recovery?_____
Any recent major life change?_____

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:
_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly (prescribed or otherwise)

_____
_____
_____

SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

On the following page, please check the appropriate boxes and indicate where you fall on the continuums.

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TEMPERATURE

How warm/cold do you feel (not in degrees) relative to other people? (do you wear more or less layers, etc.)

COLD			HOT
☐ Cold hands or feet	☐ Thirst with no desire to drink	☐ Night sweats	☐ Hot hands , feet, chest
☐ Chills	☐ Absence of thirst	☐ Unusual sweats	☐ Hot flashes
☐ Cold "in the bones"	☐ Excessive thirst	When _____am/pm	☐ Hot in the afternoon
☐ Areas of numbness	☐ Thirst for cold / hot drinks	Where on body_____	☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY			OILY
☐ Dry skin/hair/nails	☐ Dry lips	☐ Edema/Swelling _____where on body?	☐ Oily skin/hair
☐ Dry eyes	☐ Dry throat	☐ Rashes _____	☐ Pimples
☐ Dry nose / nosebleeds	☐ Dry mouth	☐ Itching _____	☐ Weight gain / loss

DIGESTION

DIARRHEA			CONSTIPATION
BM: How often? ___ x / every____ days	☐ Gas/ Bloating	☐ Nausea / Vomiting	☐ Dry stools
Stools keep shape? ☐ Y ☐ N	☐ Belching	☐ Bad breath	☐ Difficult to pass
☐ Alternating diarrhea/constipation	☐ Poor appetite	☐ Heartburn	☐ Tired after BM
☐ Indigestion	☐ IBS	☐ Excessive hunger	☐ Foul smelling stools

ENERGY

LOW			HIGH
☐ Sudden energy drop	☐ Dependence on caffeine	☐ Shortness of Breath	☐ Hard to concentrate
Time of day: _____	☐ Wired / ungrounded feeling	☐ Heart palpitations	☐ Poor memory
☐ Energy drop after eating	☐ Body / Limbs feel heavy	☐ Blood pressure high/low	☐ Dizziness / lightheaded
☐ Fatigue	☐ Body / Limbs feel weak	☐ Bleed / Bruise easily	☐ Headaches _____/wk

SLEEP

Hours per night _____
☐ Difficulty falling asleep
☐ Wake ____x night @ ____am/pm
☐ Wake to urinate *How often?*___
☐ Disturbing dreams
☐ Restless sleep
☐ Not rested on waking

EMOTIONS

☐ Anger	☐ Grief
☐ Irritability	☐ Depression
☐ Anxiety	☐ Joy
☐ Worry	☐ Fear
☐ Obsessive thinking	☐ Timid/Shy
☐ Sadness	☐ Indecision

EYES, EARS, NOSE THROAT

☐ Poor vision	☐ Poor hearing
☐ Night blindness	☐ Ringing in ears
☐ Red eyes	☐ Excess earwax
☐ Itchy eyes	☐ Sore throat
☐ Spots in front of eyes	☐ Dental problems
☐ Sinus congestion	☐ Mouth sores
☐ Phlegm (color_____)	☐ Cough

HORMONAL BALANCE

HORMONAL CHANGES

Age at last menses:_____
Year changes began:_____

☐ Hot flashes _____x/day
☐ Night sweats _____x/wk
☐ Vaginal dryness
☐ Loss of sex drive
☐ Other

Age at first menses: _____
Length of full cycle _____ days
Length of menses: _____ days
Last menses start date ____/____
# of pregnancies _____
# of births ____ premature ____
# of abortions/miscarriages ____

☐ Heavy periods
☐ Light periods
☐ Painful periods
☐ Irregular periods
☐ Changes in body/psyche prior to menstruation (pms)
☐ Cramps
  ☐ Before bleeding
  ☐ First day
  ☐ During period
☐ Clots
☐ Breast tenderness
☐ Mood changes
☐ Fatigue with menses
☐ Digestive changes w/menses
☐ Midcycle spotting
☐ Yeast infections

URINARY

Fluid in = fluid out ☐ Y ☐ N
☐ Decrease in flow/dribbling
☐ Difficulty starting/stopping
☐ Incontinence
☐ Kidney stones
☐ Urgent urination
☐ Frequent urination
☐ Pain/burning sensation
☐ Cloudy urine
☐ Blood in urine

OTHER

☐ Change in sex drive: ⇑ ⇓
☐ Erectile dysfunction
☐ Premature ejaculation
☐ Infertility
☐ Discharge
☐ Prostate disease
☐ Genital pain
☐ Fibroids/cysts
☐ Hernia
☐ Hemorrhoids

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW? PLEASE DESCRIBE ON THE BACK OF THIS FORM OR A SEPARATE SHEET OF PAPER. THANKS!

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within 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, and nutritional counseling. 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 smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a 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 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 and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not 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, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

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Insurance Information

The insurance/billing information questions are necessary. Please provide your insurance ID card for photocopying.

Insurance Company: _____ Phone: (_____) _____
Insured's ID #_____ Group # _____ Birth Date: ____ / ____ / ____

I understand that if I am not paying for treatment at the time of service, I need to supply Cornerstone Healing with my Social Security Number.

As a service to our patients, Cornerstone Healing will submit the charges for medical treatment to the patient's insurance company. However, the patient is primarily responsible for paying any and all medical expenses incurred at this office. We may attempt to verify, in advance, that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever the insurance does not pay.

Although we will verify insurance coverage for our records, we strongly encourage our patients to call their insurance company to verify their coverage prior to their first appointment.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Cornerstone Healing. I also authorize my insurance company to release any information required to process claims. I agree to be responsible for payment of service in the event my insurance company does not agree to pay for these services. (Not signing this document does not release you from responsibility of payment.)

_____ _____
Patient's or Authorized Person's Signature Date