points east™
Acupuncture and Herbal Medicine

Mark Mamuszka, L.Ac.
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(802) 291-3236

Patient Health History

Name: _____ Date: _____/_____/_____
(first) (middle) (last)

Address: _____ Phone (h): _____

_____ Phone (c): _____

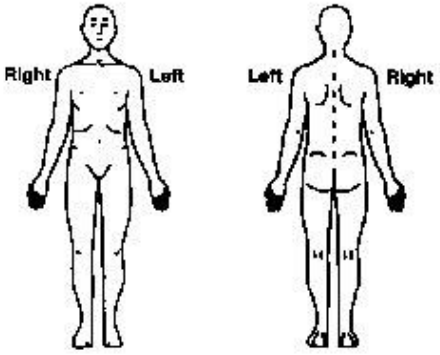
Date of Birth: _____/_____/_____ Age: _____ Gender: M/F Marital status: S M D W

Please complete this questionnaire as thoroughly as possible.

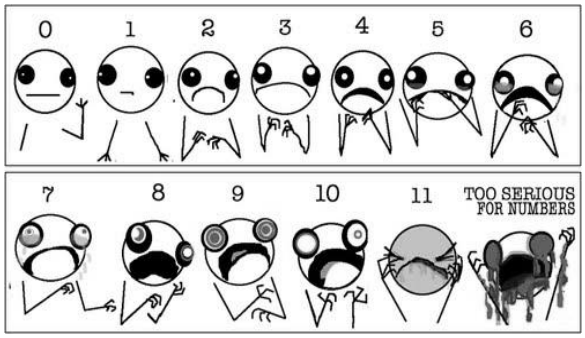
1. Please identify the health concerns that have brought you to here today, in order of importance:

Condition	**What Treatment(s) have you tried so far?**
a. _____	_____
What makes it better/worse? _____	
b. _____	_____
What makes it better/worse? _____	
c. _____	_____
What makes it better/worse? _____	

Please indicate areas of Pain or Discomfort:



Please indicate the severity of the Pain: _____



2. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

3. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

_____

4. Do you have any reason to believe you may be pregnant? Y N If so, how far along are you? _____

5. Do you have any infectious diseases? Y N If yes, please identify: _____

6. **Family History:**	Self	Parent(s)	Siblings
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Disease	_____	_____	_____
High Blood Pressure	_____	_____	_____
Stroke	_____	_____	_____
Mental Illness	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____
Kidney Disease	_____	_____	_____

7. **Height:** _____ **Weight:** Currently: _____ Past Maximum: _____ When? _____

8. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

9. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	

10. **Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Anxiety Stress Depression Insomnia

11. **Energy and Immunity**

Low Energy Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

12. **Eye, Ear, Nose, Throat, and Respiration**

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts	Tearing/Dryness
Impaired Hearing	Ear Ringing	Earaches	Headaches	Sinus Problems
Nose Bleeds	Frequent Sore Throats	Teeth Grinding	TMJ/Jaw Problems	Hay Fever
Persistent Cough	Asthma	COPD	Frequent Colds	Shortness of Breath

13. **Cardiovascular**

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure	
Palpitations/Fluttering	Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins

14. **Gastrointestinal**

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Gas/Bloating Heartburn

Belching Gall Stones Constipation Diarrhea Irritable Bowel Abdominal Pain

15. **Genito-Urinary Tract**

Kidney Disease Painful Urination Frequent UTI Frequent Urination

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

16. **Female Reproductive/Breasts**

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow

Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods

17. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 2. Birth Control Type: _____ 3. Length of Cycle: _____

4. # of Days of Menses: _____ 5. # of Pregnancies: _____ 6. # of Live Births: _____

18. **Male Reproductive**

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Discharge

19. **Neurologic**

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Tremors Seizures/Epilepsy

20. **Endocrine**

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

21. **Other** Is there anything else we should know? _____

_____

22. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _____

b. Exercise routine: _____

c. How many hours per night do you sleep? _____ Do you wake rested? _____

d. Occupation: _____

e. Employer: _____ Hours/Week: _____

f. Nicotine Use: _____ Alcohol Use: _____

Caffeine Use: _____ Glasses of water per day: _____

Name of Family Physician: _____

Emergency Contact: _____ Phone: _____

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Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Points East Acupuncture. I understand that acupuncturists practicing in the state of Vermont are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

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 effect 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 Points East Acupuncture as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the 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.

Cancellation Policy: A $35 fee may be charged for missed appointments if 24-hours' notice is not given.

Health Insurance: If I have requested that Points East Acupuncture bill my insurance carrier directly: I acknowledge that in the event my treatment is not covered, I am responsible for the full cost of services rendered.

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: _____ **Date of Birth:** _____

Address: _____ **Email**:_____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____

I understand that as part of my healthcare, this organization 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.
- 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.
- For the purpose of sending claims, benefit checks, and questions regarding claims via email.
- 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 the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

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

Patient:
X_____ _____
Patient Signature or Legal Representative **Date**