



FIVE POINTS
acupuncture & wellness

HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: 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. The organ names listed refer to categories based on Traditional Chinese Medicine
All information is strictly confidential.

I GENERAL PATIENT INFORMATION

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ What is the best number for us to call? _____
Age: _____ Date of Birth: _____ Place of Birth: _____
Guardian (if under 18): _____
Gender: Male Female Height: ft in Weight: lbs
Occupation: _____ Employer: _____
Emergency Contact: _____ Phone Number: _____

Major Complaint(s), in order of significance to you:

1. _____
2. _____
3. _____
4. _____
5. _____ Additional _____

How do these conditions impair your daily activities?

II INSURANCE INFORMATION

Insurance Company:

Phone #:

Policy Holder Name:

Date of Birth:

Relationship to Insured (If other than self):

ID Number:

Group Number:

Financial Policy: As a courtesy to you, we will contact your insurance company to verify if you have coverage. If your insurance covers acupuncture, and we are able to bill your insurance company, we will do so. Verification of coverage is not a guarantee of payment.

You are responsible for paying any co-payments at the time of your visit. If we bill your insurance company and the claims are denied, or applied towards your deductible, you will be responsible for paying for all non covered costs, co-payments, and co-insurances for services provided. Please keep in mind that insurance claims can take 30-45 days for the insurance company to respond. In addition, I authorize insurance payment of medical benefits to Five Points Acupuncture & Wellness.

Signature:

Date:

III PATIENT MEDICAL HISTORY

How was your childhood health?

Hospital visits/stays?

Recent tests: (please indicate test results and date below)

Physical	Cholesterol	Prostate	Blood (which?)
HIV/STD	Pap Smear	Mammogram	Other:

Test Results and Dates:

Check if you have had in the past:

Diabetes	Allergies	Glaucoma	Rheumatic Fever
Heart Disease	CVA	Vein Conditions	Thyroid Disorder
Asthma	Pneumonia	Tuberculosis	Emphysema
Jaundice	Gonorrhea	Mumps	Bleeding Tendency
Syphilis	Measles	Chicken Pox	Nervous Disorder
Meningitis	HIV	Polio	Mononucleosis
Epilepsy	High Fever	Hepatitis	Multiple Sclerosis
Paralysis	Cancer	Migraine	High Blood Pressure
Other Lung Illness	Other Liver Illness	Other Heart Illness	Other Kidney Illness

III PATIENT MEDICAL HISTORY CONTINUED

Immunizations:

Surgeries:

Current Medications:

Medication

Dosage

Reason for Taking

Current Physician Name and Phones Number:

May we communicate with your physician?

Yes

No

IV PATIENT PROFILE

Please check the following that currently pertain to you in the last 2-3 months

Overall Temperature (Kidney function):

Cold hands

Cold feet

Sweaty hands

Hot body temperature (sensation)

Afternoon flashes

Heat in the hands, feet and chest

Thirsty

Lack of perspiration

Cold fingers

Cold toes

Sweaty feet

Cold body temperature (sensation)

Night sweats

Hot flashes any time of the day

Perspire easily

Overall Energy (Lung, Kidney Function):

Shotness of breath

Difficulty keeping eyes open in the daytime

General weakness

Easily catch colds

Low energy

Feel worse after exercise

Thirsty

Overall Blood (Liver, Spleen, Heart Function):

Dizziness

Floating black spots

Heart Function:

Palpitations

Sores on the tip of the tongue

Mental Confusion

Frequent dreams

Drink Coffee - # of cups per week:

Anxiety

Restlessness

Chest pain traveling to shoulder

Wake unrefreshed

IV PATIENT PROFILE CONTINUED

Lung Fuction:

Nasal Discharge - Color:
 Nose Bleeds
 Dry Mouth
 Dry nose
 Allergies - To What:
 Sneezing
 Overall achy feeling
 Stiff shoulders
 Difficulty breathing
 Sadness

Cough
 Sinus congestion
 Dry throat
 Dry skin
 Alternating fever and ch
 Headache - Location:
 Stiff neck
 Sore throat
 Smoke cigarettes - # per day
 Melancholy

Digestion:

Low appetite
 Abrupt weightloss
 Abdominal gas
 Fatigue after eating
 Hemorrhoids
 Over-thinking
 Polapsed organs - Previously diagnosed, which organ?

Abrupt weight gain
 Abdominal bloating
 Gurgling noise in stomach
 Easily bruised
 Pensive
 Worry

Bowel Movements:

Loose
 Constipated
 Incomplete
 Diarrhea

Blood in stool
 Mucous in stool
 Undigested food in stool

Do you have to bear down to start a bowel movement?

Yes No

Dampness Trapped in the Body

General sensation of heaviness in the body
 Mental sluggishness
 Swollen hands
 Swollen joints
 Nausea

Mental heaviness
 Mental foginess
 Swollen feet
 Chest congestion
 Snoring

Stomach Funtion:

Burning sensation after eating
 Bad breath
 Bleeding, swollen painful gums
 Acid regurgitation
 Belching
 Stomach pain

Large appetite
 Mouth (canker) sores
 Heart Burn
 Ulcer (diagnosed)
 Hiccoughs
 Vomiting

Gall Bladder Function:

Alternating diarrhea and constipation
 Tight sensation in the chest
 Anger easily
 Depression
 Skin rashes
 Tingling sensation
 Muscle spasms
 Muscle cramping
 Convulsions
 Neck tension
 Shoulder tension
 High-pitched ringing in the ears
 Drink Alcohol
 Recreational drugs - Which?
 How much per week?
 Frequently unable to adapt to stress -What causes the stress?

Chest pain
 Bitter taste in the mouth
 Frustration
 Irritability
 Headaches at the top of the head
 Numbness
 Muscle twitching
 Seizures
 Lump in the throat
 Limited range-of-motion, neck
 Limited range-of-motion, shouler
 Gall stones (history or current)
 STD - Which?

How much per week?

IV PATIENT PROFILE CONTINUED

Eyes (Liver Function):

Itchy	Bloodshot
Hot	Dry
Watery	Gritty
Blurry Vision	Decreased night vision
Near-sighted	Far-sighted

Kidney, Urinary Bladder Function:

Frequent cavities	Easily broken bones
Sore knees	Weak knees
Cold sensation in the knees	Low back pain
Memory problems	Excessive hair loss
Low-pitches ringing in the ears	Kidney stones
Bladder infections	Easily startled
Lack of bladder control	Fear
Wake during the night twice or more to urinate	

Urination:

Normal color	Dark yellow
Clear	Reddish
Cloudy	Scanty
Profuse	Strong odor
Burning	Difficult
Discharge	Urgent
Painful	Frequent

Libido:

Normal High Low

Women Only:

Regular menstrual cycle?	Yes	No	Pregnant?	Yes	No
Number of children:			Number of pregnancies:		
Age of first menstruation:			Age of menopause (if applicable):		
Average number of days of flow:			Average number of days of entire cycle:		
Vaginal discharge			Bleeding between periods		

Do you experience any of the following premenstrual syndromes?

Nausea	Vomiting	Water retention	Breast swelling
Food cravings	Headaches	Migraines	Breast tenderness
Depression	Irritability	Anxiety	Other emotions:
Dull pain - Where?		<input type="checkbox"/> Sharp pain - Where?	

Men Only:

Swollen testes	Testicular pain	Impotence	Premature ejaculation
Feeling of coldness of numbness in external genitals			Other:

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or herbs from the Materia Medica by a licensed acupuncturist at Five Points Acupuncture & Wellness LLC. I understand that acupuncturists practicing in the state of Massachusetts 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. We will make sure you understand any procedure we would like to use. If you are uncomfortable with any of these, please remember you have the right to refuse any treatment.

Acupuncture: Acupuncture is performed by the insertion of thin, solid 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.

Chinese Herbs: I understand that substances from the 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 Five Points Acupuncture & Wellness as soon as possible.*

Cupping/Gua Sha : Cupping and Gua Sha are techniques used to release areas of tight musculature. In cupping therapy, suction cups are placed on the skin to create a vacuum effect. The cups may be left stationary or moved around an area with the aid of massage lotion. Gua Sha involves the use of a chinese spoon to massage an area of tight musculature. I am aware that certain adverse side effects may result from these treatments. These could include, but are not limited to: bruising, sore muscles, or aches that may last for 3-5 days. 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: mild electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I have read (or have had read to me) the above explanation of the treatments. I state that I have been informed and weighed the risks involved in treatment at this health care office. I have decided that it is in my best interest to receive treatment. I hereby give my consent to that treatment. I intend for this consent to cover the entire course of treatment for my present condition(s) and for any future conditions(s) for which I seek treatment

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:

Privacy Policy - Five Point Acupuncture & Wellness

We here at Five Points Acupuncture & Wellness LLC value our relationships with our patients and respect your right to privacy. Please read our Privacy Policy below.

This policy describes how we may use and disclose your medical information, how you can get access to this information, and the safeguards we have put in place to protect your privacy. In the normal course of doing business, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize. You have the right to request a restriction of the amount and type of information we can share. Please keep in mind that any information we share is done in the normal course of business and in an attempt to provide you with the best possible service.

Safeguards in place at our office include:

- Policies and procedures for handling information.
- Confidentiality agreements with third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file. All files are secured and out of public view.
- Only designated employees will have access to confidential information. All employees will be trained regarding this privacy policy.
- Limited access to facilities where information is stored.

In administering your health care, we gather and maintain information that may include non-public personal information such as:

- Financial transactions (billing history)
- Correspondence via letters, faxes, emails or telephone conversations to or from other health care practitioners.

Information from health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information). We use a third party administrator to verify insurance coverage, to bill and monitor insurance claims.

If you would like to gain access to your medical records, or to amend any information, you must submit your request in writing. If you have questions about our privacy guidelines, please call us during regular business hours at 1-781-944-3000. Thank you for your attention to this matter. We look forward to continue to serve your health care needs.

Please sign below to acknowledge understanding of these policies:

Signature:

ATTENDANCE POLICY

Regular attendance to your acupuncture treatments is crucial for a successful outcome. If you cancel, your progress is hindered and another patient misses an opportunity to be treated. Adherence to these policies is required to be a patient at Five Points Acupuncture & Wellness.

1. By agreeing to your Treatment Plan developed for you, you are committing to the frequency and duration of visits recommended. Please let me know of any concerns.
2. If you have provided us with an email address, you will receive one email when you schedule your appointment and a reminder email prior to your appointment.
3. Any cancellation for an appointment that is not rescheduled within the same week (Monday-Friday) is considered a missed appointment and will incur a \$50 cancellation fee.
4. No-shows to any appointment will incur a \$50 cancellation fee.
5. Arriving more than 10 minutes late to your appointment is considered a missed appointment, unless we can reschedule for another time in the same week.
6. Payment for no-shows or cancellations must be paid prior to your next treatment. If you are on a pre-paid plan, the amount of \$50 will be removed.
7. We understand that illnesses and emergencies may happen so please inform us of any need to miss/change an appointment right away so we may accommodate you.

I have read, understands and agree to the Five Points Acupuncture & Wellness Attendance Policy.

Signature: