Medical History Form

Thank you for taking the time to fill this out carefully. Some questions might seem irrelevant to your condition but every piece of information helps to form a complete diagnosis. Acupuncture treats the whole person, not just disease. All information is confidential. If you have any questions, please ask.

Patient Information

First Name:	Last Name:	Gender:
Date of birth:	Age:	Marital status:
Address:		
City:	State:	Zip:
Cell Phone:	Email:	
Emergency contact:	Relationship:	Phone:
Referred by or heard about us at:		Today's Date:

Occupation: _____

Have you ever received acupuncture therapy before? Yes ❒ No ❒

What are the main issues for which you are seeking treatment today?

_____

_____

What diagnosis, if any, have you received? _____

_____

When did it begin? _____

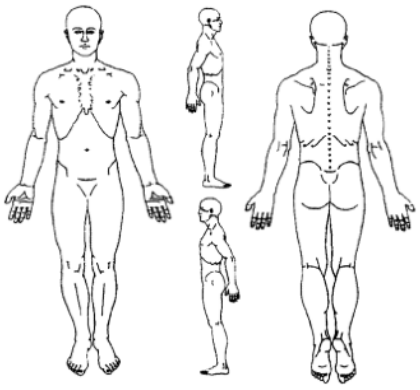
To what extent does this interfere with your daily activities (work, sleep, etc.)?

_____

What kind of treatment(s) have you tried? _____

What makes it worse? _____ Better? _____

Circle your current pain/discomfort on a scale (1–10): Very slight 1 2 3 4 5 6 7 8 9 10 **Unbearable**



Indicate painful or distressed areas:
(i.e., throbbing, burning, dull, sharp, constant, occasional, etc.)

Personal Medical History
(Please add the mo/yr when the event occurred or date of diagnosis)

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Diabetes			High blood pressure		
HIV/AIDS			Seizures			Heart Disease		
Liver issues			Thyroid disease			High cholesterol		
Anemia			Tuberculosis			Breathing problems		
Arthritis			Digestive disorders			Alcohol/drug addiction		
Emotional disorders			Depression/ anxiety			Other		

Surgical history, hospitalizations, accidents (head injuries, fractures, etc.) Indicate age/date:

Any emergency situations for us to be aware of (severe allergies, etc.) Or Implants or devices:

Please list any doctor prescribed **medications** taken over past three months:

Please list all **supplements** you are currently taking:

Daily Routines

Do you smoke? Yes ❒ No ❒ Do you exercise regularly? Yes ❒ No ❒ What kind of exercise?

How many hours do you sleep in general? _____ What time do you go to bed?_____

Do you wake to urinate? Yes ❒ No ❒ Do you wake the same time most nights? Yes ❒ No ❒

Do you have trouble **falling** asleep? Yes□ No□ Or trouble **staying** asleep? Yes ❒ No ❒

Diet - Describe your diet (veg, paleo, gluten-free etc): _____

How much **coffee** do you drink? ___ cups/day; **water** __ /day

What kind of alcoholic beverages do you usually drink, if any? _____ Avg #of drinks/wk?__

List what you ate for breakfast, lunch dinner & snacks for past 2 days:

Medical Symptoms

*Please check all symptoms that **currently** pertain to you.*

- ☐ Cold hands/feet
- ☐ Fatigue
- ☐ Feverish in the afternoon or flushes
- ☐ Heat sensation in hands, feet, chest
- ☐ Night sweats
- ☐ Catch colds easily
- ☐ Sweats easily during daytime
- ☐ Dizziness
- ☐ See floating black spots

- ☐ Palpitations
- ☐ Sore on tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain
- ☐ Insomnia

- ☐ Cough
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose, or skin
- ☐ Allergies - seasonal or food
- ☐ Chills and fever
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficult breathing

- ☐ Low appetite
- ☐ Loose stools
- ☐ Constipation
- ☐ Bloating or gas after eating
- ☐ Feeling tired after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruises easily
- ☐ General feeling of heaviness in body
- ☐ Mental heaviness or fogginess
- ☐ Swollen hands/feet
- ☐ Burning sensation after eating
- ☐ Bad breath
- ☐ Large appetite
- ☐ Mouth, canker or cold sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn/belching
- ☐ Stomach pain
- ☐ Vomiting/nausea

- ☐ Diarrhea alternating with constipation
- ☐ Tight/suffocating feeling in chest
- ☐ Bitter taste in mouth
- ☐ Blood shoot eyes/dry eyes
- ☐ Anger easily
- ☐ Skin rashes
- ☐ Headache
- ☐ Numbness of hands and feet
- ☐ Muscle spasms, twitching, cramping
- ☐ Seizures/convulsions

- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Get up more than 1x a night to urinate
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Hair loss
- ☐ Ringing in ears

Female

❒ Frequent vaginal infections ❒ Endometriosis
❒ Irregular periods ❒ Fibroids ❒ Cysts
❒ Breast tenderness ❒ Breast lumps
❒ Pain/cramping ❒ Fertility problems
❒ Hot flashes ❒ Moodiness related to periods

Pregnancies _____ # Births _____
Miscarriages _____ # Abortions _____
Premature births _____ # Cesareans _____
Difficult delivery _____

Age of first period: _____
Length of period (days): _____
# of days between periods: _____
Date of last period? _____

Describe menstrual flow:
❒ Heavy ❒ Moderate ❒ Light ❒ None
Color of menstrual flow: ❒ Dark ❒ Bright red
❒ Slightly reddish ❒ Brown (at beg./end of period)
Clotting: ❒ Bright in color ❒ Dark in color
Size of clots: ❒ Dime ❒ Nickel ❒ Larger

Do you practice birth control? Yes ❒ No ❒
If yes, what type and for how long?
_____

PMS symptoms:
_____

Are you currently pregnant? Yes ❒ No ❒
Menopause Age: _____
Hysterectomy/age and reason:
_____

Any Hormone Replacement Therapy (HRT)?
Type:
_____

Male

❒ Prostate issues ❒ Discharge
❒ Impotence ❒ Ejaculation issues
❒ Frequent seminal emission ❒ Fertility
❒ Painful/swollen testicles ❒ Other

_____
_____
_____
_____
_____

Other health concerns:

_____
_____
_____
_____
_____
_____

I have completed this form correctly to the best of my knowledge.

Signature:

_____
❒ Patient or ❒ Parent/Guardian

Print Name: _____

Date: _____

Informed Consent Policy

I hereby request and consent to the performance of acupuncture, Telehealth or other modalities within the scope of practice of Chinese Medicine and nutrition on me by Taissa Kira, L.Ac., who is licensed by the State of North Carolina Acupuncture Licensing Board.

Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Client health records
- Live two-way audio and video
- Output data from health devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by enabling a client to remain in his/her provider's office (or at a remote site) while the providers obtains test results and consults from practitioners at distant/other sites.
- More efficient client evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
- In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

Patient Consent

Acupuncture- I understand that there are some risks to treatment, including but not limited to some bruising and/or slight bleeding, some numbness or tingling at the insertion sight of the needle that may last a few days, dizziness or fainting, or possible aggravation of pre-existing symptoms. The risk of infection is very low and all needles used at are sterilized, single-use only, and disposable.

Telehealth- I have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

You should inform your practitioner if you are pregnant, have a history of seizures, have a pace maker or have any bleeding disorders.

I understand that results are not guaranteed. I do not expect Taissa Kira, L.Ac., to be able to anticipate and explain all outcomes and risks. I understand that I may stop treatments at any time. I understand that the health evaluation provided to me is an energetic assessment based on the theories of Chinese Medicine. I understand that Taissa Kira, L.Ac., is not providing Western medical care, and that I should consult my primary care physician for those services and other routine check-ups.

Payment in full is expected at the time of each appointment.

I agree to give **24 hours notice** in the event that I must cancel or re-schedule an appointment.

If I need to reschedule or cancel my appointment, I will notify Zen Place Wellness 24 hours in advance or be **charged a $50 late cancellation/no show fee,** not covered by insurance. (Exceptions may be made in a case of an emergency.)

I understand that in case of unavoidable lateness by me or by the clinic, the schedule may be adjusted to provide for my treatment in its entirety.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and telehealth and 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.

Signature (patient or guardian) **:** _____ **Date:** _____

Printed Name: _____

Acknowledgement of Privacy Practices

Please read the HIPPA - Notice of Privacy Practices found on the website under Forms at www.ZenPlaceWellness.com or ask the practitioner to review the document in the office.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of Zen Place Wellness, LLC.

Signature (patient or guardian) **:** _____ **Date:** _____

Printed Name: _____