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HEALTH HISTORY QUESTIONNAIRE

Name: **DOB:** **Age:** **Height:** **Weight:**

Address: **City:** **State:** **Zip:**

Email:

Have you tried acupuncture? **Yes** **No**

Phone #: **Cell:** **May we leave a voicemail?** **Yes** **No**

Occupation: **Marital status:**

Emergency Contact Name: **Phone:**

Who may we thank for referring you?

Recent Health Care Providers: Name, Date, Service Provided:

What is your Main Concern?

How does this problem affect your daily activities?

When did you first notice symptoms?

If you have been diagnosed, what is diagnosis?

What kinds of treatment or therapies have you tried?

Hospitalizations/Surgeries/Accidents:

Allergies:

FAMILY HEALTH HISTORY

Family Member	*Age*	*Important Diseases/Illnesses*	*Deceased Y/N*

PERSONAL HISTORY			
General	☐ Poor Appetite	☐ Weight Gain	☐ Night Sweats
	☐ Insomnia	☐ Weight loss	☐ Fever
	☐ Disturbed Sleep	☐ Sweating easily	☐ Chills
	☐ Localized Weakness	☐ Bleeding/bruising	☐ Sudden energy drop
	☐ Cravings	☐ Tremors	☐ Poor Balance
	☐ Strong Thirst		
Skin and Hair	☐ Rashes	☐ Eczema	☐ Recent moles
	☐ Ulcerations	☐ Pimples	☐ Changes in hair texture
	☐ Hives	☐ Dandruff	☐ Hair loss
	☐ Itching		
Head, Eyes, Ears, Nose, Throat	☐ Dizziness	☐ Color blindness	☐ Recurrent sore throats
	☐ Concussions	☐ Cataracts	☐ Nose bleeds
	☐ Migraines	☐ Blurry vision	☐ Grinding teeth
	☐ Glasses	☐ Earaches	☐ Sores on lips or tongue
	☐ Spots in front of eyes	☐ Ringing in the ears	☐ Facial pain
	☐ Eye pain	☐ Poor hearing	☐ Teeth problems
	☐ Poor vision	☐ Eye strain	☐ Headaches
	☐ Night blindness	☐ Sinus problems	☐ Jaw clicks
	☐ Photophobia	☐ TMJ	☐ Gum/teeth problems
Cardiovascular	☐ Dizziness	☐ High B.P.	☐ Swelling of feet
	☐ Low blood pressure	☐ Fainting	☐ Blood clots
	☐ Chest pain	☐ Cold hands or feet	☐ Difficulty in breathing
	☐ Irregular heartbeat	☐ Swelling of hands	☐ Phlebitis
	☐ Tightening in chest	☐ Palpitations	☐ Stroke
Respiratory	☐ Cough	☐ Bronchitis	☐ Frequent colds or flu
	☐ Asthma	☐ Shortness of breath	☐ Excessive phlegm
Gastrointestinal	☐ Nausea	☐ Belching	☐ Rectal pain
	☐ Vomiting	☐ Black stools	☐ Hemorrhoids
	☐ Diarrhea	☐ Blood in stools	☐ Abdominal pain/cramps
	☐ Constipation	☐ Indigestion	☐ Chronic laxative use
	☐ Gas/ Bloating	☐ Bad breath	☐ Crohn's
	☐ Parasites	☐ Diverticulitis	☐ Colitis
Genitourinary	☐ Pain on urination	☐ Incontinence	☐ Sores on genitals
	☐ Urinary infections	☐ Decrease in flow	☐ Impotence/frigidity
	☐ Blood in urine	☐ Kidney stones	☐ Low to no sex drive
Musculoskeletal	☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
	☐ Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐ Knee pain	☐ Numbness/Tingling	☐ Hip pain
	☐ Sciatica	☐ Tinnitus	☐ Arthritis
	☐ Migraines	☐ Varicose veins	☐ Foot/ankle pains

Neuropsychological	☐ Seizures	☐ Poor memory	☐ Anxiety
	☐ Dizziness	☐ Depression	☐ Bad temper
	☐ Loss of balance	☐ Concussion	☐ Frequent mood swings
Other Illness	☐ HIV positive	☐ Rheumatic fever	☐ Eating disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr	☐ Diabetes	☐ Hepatitis
	☐ Mononucleosis	☐ Underweight	☐ Overweight

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation: Date of last menstruation:		
Period occurs every ______ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Hot flashes or sweating at night?	☐ Yes	☐ No
Menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Breast tenderness, lumps, nipple discharge?	☐ Yes	☐ No

MEN ONLY

Recent kidney, bladder, or prostate infections?	☐ Yes	☐ No
Problems emptying your bladder completely?	☐ Yes	☐ No
Difficulty with erection or ejaculation?	☐ Yes	☐ No
Testicle pain or swelling?	☐ Yes	☐ No
BPH or chronic prostatitis?	☐ Yes	☐ No
Burning or discharge from penis?	☐ Yes	☐ No

Please List all medicines, herbs and supplements you currently take:

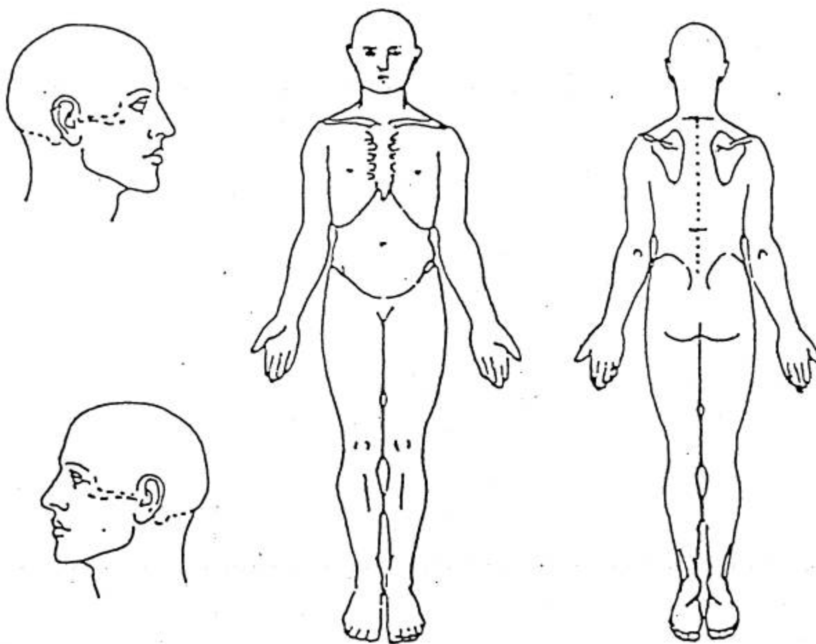
____

____

____

____

Please mark painful or distressed areas on the charts below.



Symbol	Reaction
Pain	
X XX XXX	little moderate strong
Swelling	
^ ^^ ^^^	slight moderate severe
Pulsing	
O OO OOO	slight moderate strong
Weakness/Temperature	
~ +	weak hot
Skin Problems	
*	skin issue

LIFESTYLE

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (workout/recreation, less than 4x/week for 30 min.)
	☐ Regular vigorous exercise (i.e., workout or recreation 4x/week for 30 minutes)
Diet	Are you dieting? ☐ Yes ☐ No
	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
	Number of meals you eat in an average day?
	Describe daily diet:
Caffeine/ Alcohol/ Drugs Tobacco	*Indicate # of cups/cans per day* ☐ Coffee ☐ Tea ☐ Cola
	☐ Tobacco ______ packs per day Type? # of years?
	Do you drink alcohol? ☐ Yes ☐ No
	If so, how many drinks per week?
	Do you use recreational drugs? If yes, what type?

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PAYMENTS & CANCELLATIONS

Payments Accepted: In order to keep our fees as affordable as possible, we only accept cash or checks.
We do not accept credit cards or debit cards.

CANCELLATION & BROKEN APPOINTMENT POLICY

Our number one concern is our patient's health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of treatments as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and facilities are not being utilized.

We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep their reserved appointment. This allows us time to fill our schedule with other patients who are in pain and are waiting to be seen.

POLICY & FEES

Cancellation or rescheduling of an appointment with 48 hours or more notification: No charge applied

Failure to give 24-hour advance notice:
- We allow for one (1) broken appointment within a 12 month period
- All additional broken appointments within that same period will be a fee of $75 per appointment

Definition of "Broken Appointment": A broken appointment is when you:
- **Cancel or reschedule** an appointment with **less than 24 hour notice**
- **Do not show up** for the scheduled appointment

We appreciate your understanding and consideration regarding our appointment policy

Thank you for your understanding.

James DeYoe, LAc, Diplomate DeYoe Wellness

I have read and understand the above mentioned Payment & Cancellations policies.

______________________________________ ______________________
Patient signature (Parent or Guardian if minor) Date

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HIPAA CONSENT AGREEMENT

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

I understand that as part of my healthcare, DeYoe Wellness originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A a means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that DeYoe Wellness is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that DeYoe Wellness has already take action in reliance thereon.

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

____

____

Date Notice Effective Date or Version _____Accepted _____ Denied

____
PRINT NAME DATE

____
SIGNATURE DATE

____
DEYOE WELLNESS, LLC DATE