Name: _____ Date _____

Congratulations on taking a very important step in your health and in your life!

Thank you for giving me the opportunity of working together to maximize your health so you can fully enjoy life.

This questionnaire contains many question about your health that I will need to understand before your first session. This will also empower you with the knowledge of seeing all your health issues in one place. Sometimes people don't realize the extent of their ill-health nor more importantly that much of it is connected. Getting quality care will help with not just your main problem but the other ones you didn't realize were connected.
NOTE: Everything is confidential and will not be disclosed to anyone.

Upon completion, please email this to atlanticacupuncturenj@gmail.com at least 24 hours before your first consultation.

Before filling out this questionnaire, **OPEN THIS IN ADOBE READER DC** **(see below)** in order for your answers to be saved and not lost. I recommend you update your Adobe Reader to this version to avoid any complications.

UPDATE OR DOWNLOAD ADOBE READER DC INSTRUCTIONS:

Click on: https://get.adobe.com/reader/**.**

I suggest you **UNCLICK** the small boxes in the middle column (**Optional Offers)** if you do not want to download McAfee.

Once this is done, open this PDF up in Adobe Reader DC, click on the "File" tab, then click "Save As." Save it onto your computer whether in the folder "My Documents" or another folder.

To make the most of this session, I invite you to find 45 min to 1 hour where you can have an appointment with yourself, uninterrupted. Find an environment that is relaxing, pleasing and allows you to be at your best, 100% focused on yourself. **Give yourself the gift of time**. Allow your answers to come from your whole engaged being.

Use this tool anyway you would like. Take some time to ponder the questions. Please answer all the questions. This is not to be stressful so answer them to the best of your ability.

Yours in health,

Rob Balko, L. Ac.

THE ATLANTIC CENTER
FOR ACUPUNCTURE & ORIENTAL MEDICINE

Health History Questionnaire

Important: Complete this document as thoroughly as possible.
All information is strictly confidential

I . **General Patient Information** Date: ___/____/____

Name: _____

Address:_____

City, State, ZIP:_____

Best Phone #: _____ Second Best Phone: _____

Email Address:_____ Age: _____

Date of Birth: _____/_____/_____ Place of Birth:_____

Guardian (if under 18): _____

Gender: M F Height: ____' ____" Weight: ____lbs.

Health Insurance (if applicable): _____

Occupation: _____ Employer:_____

How did you hear about our office? _____

Other physicians/therapists seen for this condition? _____

Medications (if any): _____

_____

Supplements (if any vitamins, herbs, minerals, etc.): _____

_____

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

	Condition	**Severe**	**Moderate**	**Slight**
1				
2				
3				
4				
5				
6				

Health History Questionnaire

How do these conditions impair your daily activities?_____
_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

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

☐ Physical ☐ Cholesterol ☐ Prostate ☐ Blood _____

☐ HIV/STD ☐ Pap Smear ☐ Mammography ☐ Other

Test Results and Date: _____

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic Fever
☐ Heart Disease	☐ CVA (stroke)	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Bleeding Tendency	☐ Gonorrhea	☐ Mumps	☐ Jaundice
☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous Disorder
☐ Meningitis	☐ Mononucleosis	☐ Polio	☐ HIV
☐ Epilepsy	☐ High Fever	☐ Lupus	☐ Lyme
☐ Paralysis	☐ Cancer	☐ Hepatitis	☐ Multiple Sclerosis
☐ Migraines	☐ High blood pressure		
☐ Other lung illness	☐ Other liver illness	☐ Other heart disease	☐ Other kidney illness

Other please describe:
_____
_____

Immunizations: _____

Surgeries: _____

III. Familly History

Family Member	Alive	Deceased	Present health or cause of death
Father			
Mother			
Sister			
Sister			
Brother			
Brother			
Spouse			
Child			
Child			
Child			

Where are you in the birth order: ☐ first ☐ last ☐ middle ☐ only

Check the following that have occurred in your blood relatives:

☐ Diabetes ☐ Cancer ☐Heart Disease ☐ High blood pressure

☐ Allergies ☐ Obesity ☐ Tuberculosis ☐ Bleeding Tendency

☐ Alcoholism ☐ Nervous Illness ☐ Mental Illness ☐ Kidney Disease

☐ Stroke ☐ Other _____

IV. Patient Profile

Is the pain: ☐ Sharp ☐ Burning ☐ Aching

☐ Cramping ☐ Dull ☐ Moving

☐ Fixed ☐ Other: _____

Do the following lessen the pain?

☐ Pressure ☐ Cold ☐ Heat

☐ Exercise ☐ Other: _____

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have problem with that organs function)

Overall temperature (Kidney functions)	**Overall energy (Lung & Kidney)**
☐ Cold hands ☐ Cold fingers ☐ Cold feet ☐ Cold toes ☐ Sweaty hands ☐ Sweaty feet ☐ Hot body temperature (sensation) ☐ Afternoon flushes ☐ Cold body temperature (sensation) ☐ Night sweats ☐ Heat in the hands, feed and chest ☐ Hot flashes any time of the day ☐ Thirsty / ☐ Take water to bed ☐ Perspire easily ☐ Lack of perspiration	☐ Shortness of Breath ☐ Difficulty keeping eyes open in the daytime ☐ General weakness ☐ Easily catch cold ☐ Low energy ☐ Feel worse after exercise **Overall blood (Liver, Spleen Heart function)** ☐ Dizziness ☐ Seeing floating black spots
Spleen, Stomach, Large Intestine, Small Intestine function ☐ Loose stools ☐ Constipated ☐ Incomplete bowel movement ☐ Diarrhea ☐ Blood in the stools ☐ Mucous in the stools ☐ Undigested food in the stools	**Heart function** ☐ Palpitations ☐ Anxiety ☐ Sores on the tip of the tongue ☐ Restlessness ☐ Mental confusion ☐ Chest pain traveling to the shoulder ☐ Frequent dreams ☐ Wake un-refreshed ☐ Drink coffee (# cups/day: _____)

Spleen function	**Lung function**
☐ Low appetite ☐ Abrupt weight gain ☐ Abrupt weight loss ☐ Abdominal bloating ☐ Abdominal gas ☐ Gurgling noise in the stomach ☐ Fatigue after eating ☐ Prolapsed organs (previously diagnosed, which organs: _____) ☐ Easily bruised ☐ Hemorrhoids ☐ Pensive ☐ Over-thinking ☐ Worry	☐ Nasal discharge (Color:_____) ☐ Cough ☐ Nose bleeds ☐ Sinus congestion ☐ Dry: ☐ mouth ☐ throat ☐ nose☐ skin ☐ Allergies (List: _____) ☐ Alternating fever and chills ☐ Sneezing ☐ Headache Location:_____) ☐ Overall achy feeling in the body ☐ Stiff neck, __ Stiff shoulders__ ☐ Sore throat__ ☐ Difficulty breathing__ ☐ Smoke cigarettes (# of cigarettes per day:_____) ☐ Sadness/Grief ☐ Melancholy
Eyes (Liver Function)	**Dampness Trapped in the Body**
☐ Itchy ☐ Bloodshot ☐ Hot ☐ Dry ☐ Watery ☐ Gritty ☐ Blurry vision ☐ Decreased night vision ☐ Near-sighted ☐ Far-sighted ☐ Low-pitched ringing in the ears ☐ Kidney stones ☐ Bladder infections ☐ Wake during the night twice or more to urinate ☐ Lack of bladder control ☐ Fear ☐ Easily startled	☐ General sensation of heaviness in the body ☐ Mental heaviness ☐ Mental sluggishness ☐ Mental fogginess ☐ Swollen hands ☐ Swollen feet ☐ Swollen joints ☐ Chest congestion ☐ Nausea ☐ Snoring

Stomach Function ☐ Burning sensation after eating ☐ Large appetite ☐ Bad breath ☐ Mouth (canker) sores ☐ Bleeding, swollen or painful gums ☐ Heartburn, __Acid regurgitation ☐ Ulcer (diagnosed) ☐ Belching, Vomiting ☐ Hiccoughs ☐ Stomach pain **Urination** ☐ Normal color ☐ Dark yellow ☐ Clear ☐ Reddish, ☐ Cloudy ☐ Scanty, ☐ Profuse ☐ Strong odor ☐ Burning ☐ Painful ☐ Discharge ☐ Difficult ☐ Painful __Urgent	**Liver, Gall Bladder Function** ☐ Alternating diarrhea and constipation ☐ Chest pain ☐ Tight sensation in the chest ☐ Bitter taste in the mouth ☐ Anger easily ☐ Frustration ☐ Depression ☐ Irritability ☐ Frequently unable to adapt to stress - What causes the stress? _____ ☐ Skin rashes ☐ Headache at the top of the head ☐ Tingling sensation ☐ Numbness ☐ Muscle spasms ☐ Muscle twitching ☐ Muscle cramping ☐ Seizures
Libido ☐ Normal ☐ High ☐ Low	**Men Only** ☐ swollen testes ☐ impotence ☐ testicular pain ☐ premature ejaculation ☐ feeling of coldness or numbness in the external genitalia other_____

Women Only

Regular menstrual cycle? ☐ Y ☐ N
Number of children: ____
Age of first menstruation: _____
Average number of days of flow: ___

Pregnant? ☐ Y ☐ N
Number of pregnancies: ___
Age of menopause (if applicable) _____
Average number of days of entire cycle: ____

☐ Vaginal discharge

☐ Bleeding between periods

Do you experience any of the following pre-menstrual syndromes?

☐ nausea ☐ vomiting ☐ water retention ☐ breast swelling

☐ food cravings ☐ headaches ☐ migraines ☐ breast tenderness

☐ depression ☐ irritability ☐ anxiety

☐ other emotions _____

☐ dull pain, where?_____

☐ sharp pain, where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow(normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Vomiting (check if yes)	☐	☐	☐	☐	☐	☐	☐
Nausea (check if yes)	☐	☐	☐	☐	☐	☐	☐
Other							

ALL PLEASE FILL OUT:

Other comments: _____

_____

Patient Signature: _____

Acupuncturist Signature: _____

The Atlantic Center for Acupuncture and Oriental Medicine, LLC

CANCELLATION & RE-SCHEDULING POLICY

We understand that there are times when you will need to cancel and/or reschedule your appointment. We are pleased to accommodate your needs. It is our policy, however, that all cancellations and/or rescheduling be done at least 24 hours prior to the date of your appointment. Cancellations must be made either in person or on the telephone. Email confirmations are not accepted.

A fee of $50.00 will be charged if your cancellation is not done 24 hours prior to the date of your appointment.

If you are late for an appointment, we will make the best effort to treat you in the time remaining. If your appointment starts late as a result of delays at The Atlantic Center, we will ensure you receive a full treatment.

Thank you for your understanding.

Please sign here indicating that you understand and accept this policy:

_____

Date: _____

Credit Card #: _____ Exp. Date: ____/____

The Atlantic Center for Acupuncture and Oriental Medicine, LLC

Consent to the Use or Disclosure of my Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by The Atlantic Center for Acupuncture and Oriental Medicine, LLC (known hereafter as TAC) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bill or to conduct health care operations of TACAOM.

I understand that diagnosis or treatment of me by TAC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. TACAOM is not required to agree to the restrictions that I may request. However, if TAC agrees to a restriction that I request, the restriction is binding on TAC.

I have the right to revoke this consent in writing, at any time, except to the extent that TAC has taken action in reliance of this consent.

My 'protected health information' means health information, including my demographic information, collected from me and created or received from my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review TAC's Notice of Privacy Practices prior to signing this document. TAC's Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices also describes my rights and the duties of TACAOM with respect to my protected health information.

TAC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or for asking for on at the time of my next appointment.

_____	_____
Signature of Patient or Patient's Representative	Print Name of Patient's Representative
_____	_____
Date	Relationship or Authority of Representative

The Atlantic Center for Acupuncture and Oriental Medicine, LLC

INFORMED CONSENT TO ACUPUNCTURE AND ORIENTAL MEDICINE TREATMENT AND CARE

Print Patient's Name _____

I hereby request and consent to the performance of procedures which are within the scope of practice of acupuncture and oriental medicine including, but not limited to, acupuncture, moxibustion, cupping, electro acupuncture, herbology, various modes of physiotherapy, on me (or on the patient named above, for whom I am legally responsible) by the acupuncturist named above 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 above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electro-acupuncture, herbology, physiotherapy, and other procedures. I understand that results are not guaranteed.

I understand and am informed that there are some risks to acupuncture and oriental medicine treatment, including, but not limited to, slight burning, tingling near the needling sites, nausea, infection, and blisters. There have been instances of fainting, infections and scarring. There have been instances reported of spontaneous miscarriage and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about it content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for the present condition and for any future condition(s) for which I seek treatment.

_____ _____

Signature of Patient or Patient's Representative Print Name of Patient's Representative

_____ _____

Witness to Patient's Signature Date Relationship or Authority of Representative

_____

Translated by Date