Russell Family Acupuncture

HOLISTIC HEALTHCARE
210 4TH STREET, SUITE C
PETALUMA, CA (707) 773-3375

Patient Health History

Welcome to Russell Family Acupuncture. To help us provide you with the best possible care, please fill out this form as accurately as possible. All your information will be kept confidential in your patient file.

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

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ E-Mail: _____

Date of Birth: _____/_____/_____ SS# _____ Gender: M / F Marital status: S M D W
(required for VA patients)

Name of
Physician(s)_____

In case of emergency, contact:_____ Relationship: _____ Phone: (____) ____-_____

How did you hear about us? _____

MAJOR COMPLAINT: Please describe your major health concerns. _____

_____

_____

_____

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

_____

_____

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

_____

_____

Do you have any reason to believe you may be pregnant? Y N If yes, how far along?_____

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

Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	

Height: _____ **Weight:** _____

FOR THE FOLLOWING, PLEASE CHECK THE APPROPRIATE BOXES:

Yes Now	Yes Past	NO	**EMOTIONAL**
			Mood Swing
			Nervousness
			Mental Tension
			Irritability
Yes Now	Yes Past	NO	**ENERGY & IMMUNITY**
			Fatigue
			Slow Wound Healing
			Chronic Infections
			Frequent Colds or Flues
Yes Now	Yes Past	NO	**HEAD, EYE, EAR, NOSE, THROAT**
			Impaired Vision
			Eye Pain/Strain
			Glaucoma
			Glasses/Contacts
			Tearing/Dryness
			Impaired Hearing
			Ear Ringing
			Ear Aches
			Headaches
			Sinus Problems
			Nose Bleeds
			Frequent Sore Throats
			Teeth Grinding
			TMJ/Jaw Problems
			Hay Fever
Yes Now	Yes Past	NO	**RESPIRATORY**
			Pneumonia
			Frequent Common Colds
			Difficulty Breathing
			Emphysema
			Persistent Cough
			Pleurisy
			Asthma
			Tuberculosis
			Shortness of Breath
			Other Respiratory Problems
			Explain:
Yes Now	Yes Past	NO	**CARDIOVASCULAR**
			Heart Disease
			Chest Pain
			Swelling of Ankles
			High Blood Pressure
			Palpitations/Fluttering
			Stroke

Yes Now	Yes Past	NO	**CARDIOVASCULAR (Continued)**
			Heart Murmurs
			Rheumatic Fever
			Varicose Veins
Yes Now	Yes Past	NO	**GASTROINTESTINAL**
			Ulcers
			Changes in Appetite
			Nausea/Vomiting
			Epigastric Pain
			Frequent Gas
			Heartburn
			Belching
			Gall Bladder Disease
			Liver Disease
			Hepatitis B or C
			Hemorrhoids
			Abdominal Pain
Yes Now	Yes Past	NO	**GENITO-URINARY TRACT**
			Kidney Disease
			Painful Urination
			Frequent UTI
			Frequent Urination
			Heavy Flow (Women)
			Kidney Stones
			Impaired Urination
			Blood in Urine
			Frequent Urination at Night
Yes Now	Yes Past	NO	**NEUROLOGICAL**
			Vertigo/Dizziness
			Paralysis
			Numbness/Tingling
			Loss of Balance
			Seizures/Epilepsy
Yes Now	Yes Past	NO	**FEMALE REPRODUCTIVE/BREASTS**
			Irregular Cycles
			Breast Lumps/Tenderness
			Nipple Discharge
			Heavy Menstrual Flow
			Vaginal Discharge
			Premenstrual Problems
			Clotting
			Bleeding between Cycles
			Menopausal Symptoms
			Difficulty Conceiving
			Painful Periods

Yes Now	Yes Past	NO	**MALE REPRODUCTIVE**
			Sexual Difficulties
			Prostate Problems
			Testicular Pain/Swelling
			Penile Discharge
Yes Now	Yes Past	NO	**MUSCULOSKELETAL**
			Neck/Shoulder Pain
			Muscle Spasms/Cramps
			Arm Pain
			Upper Back Pain
			Mid Back Pain
			Low Back Pain
			Leg Pain
			Joint Pain
			Where?:
Yes Now	Yes Past	NO	**ENDOCRINE**
			Hypothyroid
			Hypoglycemia
			Hyperthyroid
			Diabetes Mellitus
			Night Sweats
			Feeling Hot or Cold
Yes Now	Yes Past	NO	**OTHER**
			Anemia
			Cancer
			Rashes
			Eczema/Hives
			Cold Hands/Feet

MENSTRUAL/BIRTHING HISTORY:

1. Age of First Menses: _____
2. # of Days of Mensus:_____
3. Length of Cycle: _____
4. Birth Control Type: _____
5. # of Pregnancies: _____
6. # of Miscarriages: _____
7. # of Abortions: _____
8. # of Live Births: _____

Is there anything else we should know? _____

_____

_____

LIFESTYLE:

a. Do you typically eat at least three meals per day?

Y N If no, how many? _____

b. Exercise routine:

_____

_____

c. Spiritual practice:

_____

_____

d. How many hours per night do you sleep? _____

Do you wake rested? Y N

e. Occupation: _____

Employer: _____

Hours/Week: _____

Do you enjoy work? Y N Why/Why not?

_____

f. Nicotine/Alcohol/Caffeine/Drug Use:

_____

g. Have you experienced any major traumas? Y N

Explain: _____

_____

_____

h. How many glasses of water do you drink per day? _____

i. Interests and hobbies:

_____

_____

j. Have you had acupuncture before? Y N

Your experience was:

_____

RUSSELL FAMILY ACUPUNCTURE

Patient Acknowledgement Form

CONSENT FOR TREATMENT

- My signature authorizes David Russell, L.Ac. to treat me (or the patient for whom I am legally responsible) with acupuncture, massage and medicinal herbs with the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.

- 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 based upon the facts then known, is in my best interests.

- 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.

RELEASE OF INFORMATION

- I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment and other healthcare operations.

- I authorize Russell Family Acupuncture to share my medical records with my referring doctor.

- I authorize Russell Family Acupuncture to leave medical, billing, or appointment information pertaining to my care by the following methods. I will assume responsibility to notify the practice whenever my preference changes.

Voice Mail/Answering Machine

Home phone: ___Yes ___No #_____

Cell phone: ____ Yes ___ No #_____

Work phone: ____Yes ____No #_____

Email

_____Yes ____No If yes, email address:_____

Please list people with whom we can discuss your health care:

Name/Relationship: _____

Name/Relationship:_____

HIPAA NOTICE OF PRIVACY PRACTICES

I have the right to request a copy of the Russell Family Acupuncture Notice of Privacy Practices and to request restrictions as to how my health information is used or disclosed to carry out treatment, payment or health care operations of the practice.

APPOINTMENT CANCELLATION POLICY

I acknowledge that Russell Family Acupuncture's cancellation policy requires 48 hours' notice of appointment cancellation. If I give less than 24 hours, I will be charged a $35 missed appointment fee.

PRINT NAME: _____

Signature: _____ Date:_____

(Patient, Parent or Guardian)