



Ancient Arts
 Acupuncture & Herbal Medicine
 Katie McBready-Shields, M.S., L.Ac.



Health History Questionnaire

This is a confidential questionnaire to help me determine the best treatment plan for you. If you have any questions, please do not hesitate to ask. Thanks!

Name _____ Date _____

Home Number _____ Work Number _____

Cell Number _____

Address _____

City/ State/ Zip _____

Email Address _____

Sex: M F Date of Birth: _____ Age: _____

Marital Status: Single Married Separated Divorced Widowed

Employer Name _____ Occupation _____

S.S. No. _____ Driver's License No. _____

Family Physician _____ Phone Number _____

Emergency Contact _____ Phone Number _____

Referred By _____

What is/ are the main problem(s) you would like to help you with? _____

How long ago did this problem begin (be specific)? _____

To what extent does this problem interfere with your daily activities? _____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatment have you tried? _____

Past Medical History (Please include the date):

- | | | |
|--|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Thyroid Disease _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Venereal Disease _____ |
| <input type="checkbox"/> Other: _____ | | |

Surgeries (Type of and date): _____

Significant Trauma (auto accidents, falls, etc.): _____

Allergies (drugs, chemicals, foods/ result): _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

Occupational Stress (chemical, physical, psychological, etc.): _____

Do you have a regular exercise program? Yes No Please describe: _____

Have you ever been on a restricted diet? Yes No What kind?: _____

How many packs of cigarettes do you smoke per day? _____

How many caffeinated beverages do you drink per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Family Medical History:

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other _____ |

Please check any symptoms that have been persistent in the last three months:

General

- Chills
- Fevers
- Sweat easily
- Night sweats
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- Thirst, no desire to drink
- Sudden energy drop
- Poor sleeping
- Edema
- Where? _____
- Tremors
- Poor balance
- Cravings
- Change in appetite
- Poor appetite
- Weight gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Change in hair or skin
- Ulcerations
- Eczema
- Oozing on skin lesion
- Hives
- Pimples
- Recent moles
- Loss of hair
- Dandruff
- Other hair/skin problems _____

Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Migraines
- Headaches

- Facial pain
- Glasses
- Poor vision
- Night blindness
- Blurry vision
- Color blindness
- Blind field
- Spots in front of eyes
- Eye pain
- Eye strain
- Cataracts
- Eye dryness
- Excessive tear
- Discharge from eyes
- Poor hearing
- Ringing in ears
- Earaches
- Discharge from ear
- Nose bleeds
- Sinus congestion
- Nasal drainage
- Grinding teeth

- Teeth problems
 - Jaw clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips or tongue
- Other head/neck problems
-

Cardiovascular

- High blood pressure
 - Low blood pressure
 - Chest discomfort/pain
 - Heart palpitations
 - Cold hands or feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart problems
-

Respiratory

- Cough
 - Asthma/wheezing
 - Pain with a deep breath
 - Difficulty in breathing when lying down
 - Production of phlegm
What color? _____
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems
-

Gastrointestinal

- Bad breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion
- Diarrhea
- Constipation

- Chronic laxative use
 - Blood in stools
 - Black stools
 - Abdominal pain or cramps
 - Gas
 - Rectal pain
 - Hemorrhoids
- Other digestion problems
-

Genito-Urinary

- Pain on urination
 - Frequent urination
 - Blood in urine
 - Decrease in flow
 - Unable to hold urine
 - Kidney stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Other genito-urinary system problems
-

Pregnancy and Gynecology

- Number of pregnancies _____
 - Number of births _____
 - Miscarriages _____
 - Abortions _____
 - Age at first menses _____
 - Length between menses _____
 - Duration _____
 - First date of last menses: _____
/ /
 - Heavy
 - Light
 - Painful periods
 - Irregular periods
 - Clots
 - Menopause:
Age _____
Year _____
 - Vaginal sores
 - Breast lumps
- Do you practice birth control?
- Yes
 - No

Musculoskeletal

- Neck pain
- Shoulder pain
- Back pain
- Elbow pain
- Hand/wrist pain
- Hip pain
- Knee pain
- Foot/ankle pain
- Muscle pains
- Muscle weakness

Neuropsychological

- Seizures
 - Areas of numbness
 - Weakness
 - Sleep disorder
 - Concussion
 - Bad temper
 - Loss of control/potential for violence
 - Vertigo
 - Lack of coordination
 - Depression
 - Easily susceptible to stress
 - Loss of balance
 - Poor memory
 - Anxiety
 - Substance abuse
- Other neurological or psychological problems
-

Have you ever been treated for emotional problems?

- Yes
- No

Have you ever considered or attempted suicide?

- Yes
- No

REQUEST AND CONSENT

I HEREBY REQUEST THE Acupuncturist (Katie McBrearty-Shields) to treat me. I also authorize him/her to perform on me the treatment known as Acupuncture as his/her judgment may indicate and authorize him/her to use whatever therapeutic methods he/she may see fit, whether or not such methods are commonly and generally accepted and practiced in this community.

The Acupuncturist has fully explained to me the nature and purpose of the treatment, the risks involved, the collateral hazards and possibilities of complications during or as a result of the treatment. I understand what the term "complications" means, and in giving my consent to the treatment, I have in mind his/her full explanation. If any unforeseen condition arises in the course of treatment, and in the judgment of the Acupuncturist it is advisable to use procedures in addition to or different from those now contemplated, I also request and authorize him/her to do whatever he/she deems advisable.

If you are suffering from any of the following disease conditions, please notify the acupuncturist at this time:

1. Heart condition _____
2. Stroke _____
3. Water retention from diabetes _____
4. Fainting from needles _____
5. Bruise easily _____

PLEASE CONFIRM THAT THE ACUPUNCTURIST HAS SHOWN YOU THE DISPOSABLE NEEDLES YES _____ NO _____

In the event that my condition is such that treatment is beyond the normal capabilities of the acupuncturist, I understand that I may be referred to a medical physician

I have been given no guarantee as to the results that may be obtained.

Date: _____ Signature _____

FOR TO BE COMPLETED BY PATIENT, NOTIFYING THE ACUPUNCTURIST OF WHETHER HE/SHE HAS BEEN EVALUATED BY A PHYSICIAN, AND OTHER INFORMATION.

(Pursuant to the requirements of Section 6.11, Subsections (b) through (d), V.A.C.S., Article 4495b, governing the practice of acupuncture.)

I (patient's name) _____, am notifying the acupuncturist (practitioners' name) _____ of the following:

_____ **Yes** _____ **No** I have been evaluated by a physician or dentist for the condition being treated within six months before the acupuncture was performed.

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. _____ (patient's initials) Date: _____

_____ **Yes** _____ **No** I have received a referral from my chiropractor within the last 30 days for acupuncture.

After being referred by a chiropractor, if after 30 days or 20 treatments, whichever Comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice to follow this advice.

Signature _____ Date _____

FOR TO BE COMPLETED BY PATIENT, ATTESTING THAT THE ACUPUNCTURIST HAS REFERRED HIM/HER

The acupuncturist has referred me to see a physician. It is my responsibility and choice to follow his advice.

Patient's Signature _____ Date _____

Acupuncturist's Signature _____ Date _____

Katie McBrearty-Shields, L.Ac., Ancient Arts Acupuncture and Herbal Medicine, is not responsible for false statements made by patients.

Katie McBrearty-Shields, M.S., L.Ac.

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Yes - I acknowledge that I have received a copy of Ancient Arts Acupuncture & Herbal Medicine's Notice of Privacy Practices.

Your name Printed

Signature

Date

OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient

Other (Please provide specific details) _____

Employee signature

Date