

Seattle Healing Acupuncture, LLC

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General Information

Date _____ Name _____
Phone (H) _____ (W) _____ (C) _____
Address _____ City _____ State _____ Zip _____
Age _____ Date of Birth _____ SS# _____
E-mail Address _____ Family Physician _____
Referred By _____ Relationship to you _____
Emergency Contact _____ Phone _____

Health Insurance Information

In Order To Bill Your Private Health Co. Please Complete The Following and Give a Copy of Your Insurance Card:

Insurance Co. Name _____	Phone # (____) _____
Address _____	City _____ State _____
Zip _____	
Policy # _____	Claim # _____ Group/Plan # _____

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office. I hereby authorize the insurance company or attorney to remit payment directly to this office. I understand quotes of benefits are NOT a guarantee of payment.

Signature _____ **Date** _____

History Questionnaire

Have You Been Treated By Acupuncture or Oriental Medicine Before?: Yes No

May we contact you via email?: Yes No

Main Problem(s) you would like help with _____

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

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

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

What kinds of treatment have you tried? _____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____
High Blood Pressure _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____
Seizures _____ Venereal Disease _____ HIV/AIDS _____ Other _____

Surgeries (type of and date) _____

Significant Trauma (auto accidents, falls, etc) _____

Significant Dental Work (type and date) _____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History (check):
Diabetes Cancer High Blood Pressure
Heart Disease Stroke Seizures Asthma Allergies

Other _____

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

Occupational Stress (physical, chemical, 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? _____

Please describe your **average daily diet**:

Morning _____

Afternoon _____

Evening _____

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

How much **coffee, tea or cola** do you drink per day? _____

How much **alcohol** do you drink per week? _____

Please describe any use of recreational drugs _____

Please check any you have had in the last three months:

General

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

Skin and Hair

- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Recent moles
- Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat

- Dizziness
- Glasses
- Poor vision
- Cataracts
- Ringing in ears
- Sinus problems
- Grinding teeth
- Teeth problems
- Concussions
- Eye strain
- Night blindness
- Blurry vision

- Poor hearing
- Nose bleeds
- Facial pain
- Jaw clicks
- Migraines
- Eye pain
- Color blindness
- Earaches
- Spots in front of eyes
- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when _____
- Other head or neck problems _____

Cardiovascular

- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Phlebitis
- Chest pain
- Fainting
- Swelling of feet
- Difficulty in breathing
- Other heart or blood vessel problems _____

Respiratory

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

Gastrointestinal

- Nausea
- Constipation
- Black stools
- Bad breath
- Abdominal pain or cramps
- Chronic laxative use
- Vomiting
- Gas
- Blood in stools
- Rectal pain
- Diarrhea
- Belching
- Indigestion
- Hemorrhoids
- Other stomach or intestinal problems _____

Genito-urinary

- Pain on urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Impotency
- Blood in urine
- Kidney stones
- Sores on genitals
- Other genital or urinary system problems _____
- Do you wake up to urinate?
 Yes No. How often? _____
- Any particular color to your urine? _____

Pregnancy and Gynecology

- Number of pregnancies _____
- Number of births _____
- Premature births _____
- Miscarriages _____
- Abortions _____
- Age at first menses _____
- Days between menses _____
- Duration _____
- First day of last menses _____
- Unusual character (heavy or light)

- Painful periods
 - Vaginal discharge
 - Changes in body/psyche prior to menstruation
 - Clots
 - Vaginal sores
 - Irregular periods
 - Last Pap _____
 - Breast lumps
- Do you practice birth control?
 Yes No
- What type and for how long?

Musculoskeletal

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

Neuropsychological

- Seizures
- Areas of numbness

- Concussion
- Bad temper
- Dizziness
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Other neurological or psychological problems

Please note the severity of your problem now:

_____ | _____ | _____

No Problem Worst Imaginable

Please note the severity of your problem within the last week:

_____ | _____ | _____

No Problem Worst Imaginable

Comments (please mention any other problems you would like to discuss) _____

Indicate painful or distressed areas: