Northwest Acupuncture Center
8811 S. Tacoma Way, Ste. 102, Lakewood, WA 98499
Tel: (253) 344-9374 Fax: (253) 954-3315
Patient Record

Health History Questionnaire

Please take a moment to answer each question as completely as you can. This will help me to better help you. Please sign and date the bottom of this form. Thank you.

Name:

Date of Birth:

Height/Weight:

Address & Tel. No.:

What is the main reason you are here today and when did it start?

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

What prescription and over the counter medications are you taking?

What kind of treatment have you tried or are presently trying for this problem?

How does this problem affect your Activities of Daily Living, i.e., walking, bending, sleeping, bathing, stretching, brushing your teeth, taking a shower, etc.?

Are you allergic to anything? If so, what?

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Health History Questionnaire Page 2 of 4 Pages Name:

Please take a moment to answer each question as completely as you can. This will help me to better help you. Thank you.

On a scale of 1-10, 1 being low and 10 being high, where would you rate your level of pain? ____

2-item Graded Chronic Pain Scale (2-item GCPS)

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be." [That is, your usual pain at times you were in pain.] Please circle your level of pain.

No Pain Pain As Bad As Could Be

0 1 2 3 4 5 6 7 8 9 10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities

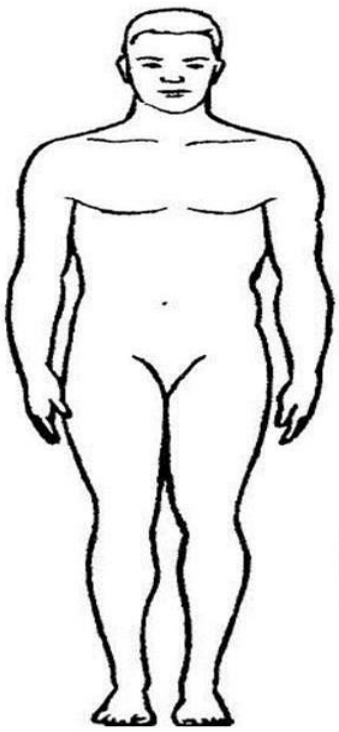
No Interference Unable To Carry On Any Activities

0 1 2 3 4 5 6 7 8 9 10

BURNING STABBING

XXXXXXX ///////

XXXXXXX ///////



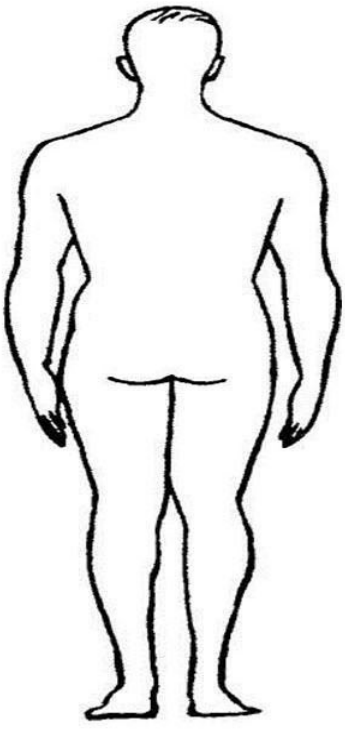
Please MARK THE AREAS ON THE FIGURES BELOW WITH THE APPROPRIATE SYMBOLS WHERE YOU FEEL THE DESCRIBED SENSATIONS :

NUMBNESS. PINS & NEEDLES

——————— 0000000

——————— 0000000

——————— 0000000



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Health History Questionnaire Page 3 of 4 Pages Name:

Please Check Any Conditions That May Apply to You

GENERAL

- ○ Chills
- ○ Fever
- ○ Sweating Easily
- ○ Night Sweating
- ○ Local Weakness
- ○ Bleeding or Bruising Easily
- ○ Strange Tastes or Smells
- ○ Strong Thirst for Hot/Cold Liquids
- ○ Fatigue
- ○ Energy Drop (Time of Day/Night)
- ○ Fluid Retention (Where)
- ○ Poor Sleep
- ○ Tremor (Shaking)
- ○ Poor Balance
- ○ Cravings (For What)
- ○ Poor Appetite
- ○ Unexplained Weight Gain/Loss

SKIN AND HAIR

- ○ Rashes
- ○ Itching
- ○ Changes in Hair/Skin
- ○ Ulcerations
- ○ Eczema
- ○ Hives
- ○ Pimples
- ○ Moles
- ○ Oozing Skin Lesions
- ○ Recent Moles
- ○ Hair Loss
- ○ Dandruff
- ○ Dry Skin

HEAD, EYES, EARS, NOSE AND THROAT

- ○ Dizziness
- ○ Migraines
- ○ Face Pain
- ○ Glasses
- ○ Poor Vision
- ○ Night Blindness
- ○ Color Blindness
- ○ Blind Fields
- ○ Floaters
- ○ Eye Pain
- ○ Eye Strain
- ○ Cataracts
- ○ Dry Eyes
- ○ Too Many Tears
- ○ Poor Hearing
- ○ Ringing in the Ears
- ○ Ear Discharge
- ○ Earaches
- ○ Nose Bleeds
- ○ Sinus Congestion
- ○ Nasal Discharge
- ○ Teeth Grinding
- ○ Teeth Problems
- ○ Jaw clicking
- ○ Concussion
- ○ Repeated Sore Throats
- ○ Hoarse Voice
- ○ Lip, Tongue or Mouth Sores

HEART RELATED

- ○ High Blood Pressure
- ○ Low Blood Pressure
- ○ Chest Pain
- ○ Heart Palpitation

HEART RELATED

- ○ Cold Hands/Feet
- ○ Swollen Hands/Feet
- ○ Blood Clots
- ○ Fainting
- ○ Breathing Difficulties

STOMACH AND BOWELS

- ○ Bad Breathe
- ○ Nausea
- ○ Vomiting
- ○ Heartburn
- ○ Burping
- ○ Indigestion
- ○ Diarrhea
- ○ Constipation
- ○ Laxatives
- ○ Bloody Stools
- ○ Black Stools
- ○ Stomach Pain
- ○ Gas

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Health History Questionnaire Page 4 of 4 Pages Name:

Please Check Any Conditions That May Apply to You

- Rectal Pain
- Hemorrhoids

LUNGS AND BREATHING

- Coughing
- Wheezing
- Asthma
- Pain When Taking a Deep Breathe
- Hard to Breathe When Laying Down
- Coughing Blood
- Phlegm
- Pneumonia
- Bronchitis
- Emphysema

PPREGNANCIES AND WOMEN'S PROBLEMS

- Number of Pregnancies
- Number of Births
- Number of Premature Births
- Number of Miscarries
- Age at First Period
- Time Between Periods
- Length of Menses
- Date of Last Period
- Are You Now Pregnant
- Heavy Periods
- Light Periods
- Painful Periods
- Irregular Periods
- Clots
- Mood Changes
- Menopause
- Vaginal Discharge
- Breast Lumps
- Nipple Discharge
- Birth Control

NERVOUS SYSTEM AND EMOTIONAL

- Seizures
- Numbness
- Weakness
- Sleep Problems
- Temper
- Vertigo
- Anxiety
- Depression
- Fumble Fingers
- Poor Memory
- Loss of Balance

ANY OTHER COMMENTS THAT YOU WOULD LIKE TO MAKE (USE BACK OF SHEET IF NECCESSARY)

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Informed Consent/Release Form Page 1 of 2 Pages Name:

Information For Patients

The Practitioner in This Clinic: Douglas L. Daniels, Doctor of Acupuncture, Diplomat of Acupuncture (National Certification Commission for Acupuncture and Oriental Medicine), Licensed Acupuncture and Eastern Medicine Practitioner (Washington State), License Number: 029501 AC00001875. I graduated from the Pacific College of Oriental Medicine and the Northwest Institute of Acupuncture & Oriental Medicine. I taught the martial art of Moo Duk Kwan, Tae Kown Do, for 25 years in the Republic of South Korea, Federal Republic of Germany and the United States of America.

The Nature and Purpose of Treatment: Treatment may include Acupuncture (the placement of needles in or over specific acupuncture points or sensitive locations); Moxibustion (the burning of herbs over or on specific points or locations either directly or indirectly on the skin surface); Cupping (the use of cups to obtain suction around specific points or locations); Electroacupuncture (the use of micro electricity on or along points or locations for stimulation); Magnetic Stimulation (the use of magnets to stimulate points or locations); Acupressure (pressing on specific points or locations); Dermal Friction (rubbing specific points or locations—Gua Sha); Chinese Massage/Manipulation (Tui Na); Infra red stimulation; Sonopuncture (sound stimulation of points or locations); Laserpuncture (laser stimu-lation of points or locations); point injection therapy (injection of herbs into points or locations); Asian and/or Domestic Herbs for internal/external use to relieve problems; Therapeutic Exercises, and; Dietary Advise based on the theories and principles of Asian medicine.

The Benefit of Treatment: Asian medicine has been used effectively to treat many types of medical problems for thousands of years. The World Health Organization and National Institutes of Health list more than 40 conditions that Asian medicine effectively treats.
While I'm confident that my treatments will benefit you, I can't guarantee results.

The Risks of Treatment: Treatment is safe, however, there are some uncommon, potential risks that may include, but are not limited to:

>discomfort during or after needle insertion
>"needle sickness" (dizziness, fainting, nausea)
>localized, minor bruising or inflammation
>minor burns
>upset stomach or bowels
>temporary aggravation of symptoms
>infection
>broken needles

Please immediately tell me if you have any problems

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Special Situations: Some herbal formulas and acupuncture points ***are not*** to be used in cases of elevated blood pressure, during pregnancy , if you have a severe bleeding disorder, wear a pacemaker or any other electronic medical device. ***Please tell me of these situations before you receive any treatment.***

Use of Disposable Needles: I only use disposable sterile needles in my clinic. The same needle is never used twice. I am certified in Clean Needle Technique and Universal Precautions which prevent the possibility of any contamination.

Unforeseen Risks: If unexplained complications arise during treatment, I will exercise my professional judgment based on your best interests in order to help you.

Confidentiality of Medical Records: I will review your medical records and reports within my clinic to determine treatment methods and to update records. ***Upon your written consent***, your record may be provided to an insurance carrier, legal authority or another health care provider, and ***will not*** be given to any third party by written or electronic means without this consent.

Requirements of Washington State Law: State Law ***does not permit*** Licensed East Asian Medicine Practitioners to treat certain disorders without prior consultation with a licensed physician (MD/DO). These conditions are:

>cardiac conditions including uncontrolled hypertension
>acute abdominal symptoms
>acute undiagnosed neurological changes
>unexplained weight loss/gain in excess of 15% of body weight within a 3 month period
>suspected bone fracture or dislocation
>suspected systemic infection
>any serious undiagnosed hemorrhagic disorder
>acute undiagnosed respiratory distress

Consent: I,_____, request and consent to treatment using Asian Medicine procedures. I understand that I am free to withdrawal my consent and stop treatment at any time. I understand that my signature on this form signifies that I have read and understand the information and that I release the Northwest Acupuncture Center and their Licensed East Asian Medicine Practitioner from any and all liability that may be incurred in connection with my treatment, except for failure to perform the treatment with appropriate medical care.

Patient Name/Signature:_____

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Notice of Privacy Practices Page 1 of 2 Pages Name:

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your Medical Information

The privacy of your medical information is important to me and I will protect it. I create a record of the treatments that you receive so that I may provide you with quality care and to comply with the law. This notice explains to you how I use this information and your rights and my duties in regard to your medical information disclosure.

Legal Duties

The law requires me to keep your information private; give you this notice describing my legal duties; your medical information rights, and; how to follow the terms of this notice. I have the right to change the terms of this notice at any time as permitted by law and to make these changes effective for all medical information kept including that previously created or received before any changes are made. Before changes are made, I will change this notice and make it available to you.

Medical Information Use and Disclosure

The following describes how I may use and disclose your medical information. Disclosure or use of your medical information ***will not*** take place unless I have your written permission to do so and you may revoke your permission ***any time*** you wish to.

Treatment

>to provide treatment or services
>to doctors, nurses, technicians, medical students or others taking care of you
>to other health care providers to assist in you treatment

Payment

>to receive payment for services

Health Care Operations

>to measure and improve quality, conduct training or to renew certification and licenses

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Notification

>to notify or help notify a family member, personal representative or other person responsible for your care
>to give information to medical personnel necessary for your emergency care

Research

>to conduct research that has been approved by a review board

Coroner or Medical Examiner

>to help them perform their legal duties

Government Agencies

>to public health officials in the prevention or control of disease, injury, neglect or abuse
>to conduct activities required by the Food and Drug Administration
>to notify a person who may have been exposed to or is at risk of contracting a disease
>to courts by order, subpoena, discovery request or warrant
>to law enforcement concerning a suspect, fugitive, witness, victim, missing person or inmate
>to governmental programs providing public benefits
>to Department of State, correctional institutions or other law enforcement agencies
>to National Security, Intelligence or Presidential Protective Services
>to Military Medical Facilities or the Department of Veterans Affairs

Your Rights

>to look at and receive copies of your medical information in any format that you request
>to request restrictions on the disclosure of information and to cancel consent at any time
>to request a change to your medical information
>to complain about your treatment to State/Federal Department of Health and Human Services

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Privacy Practices Acknowledgement

I have reviewed and received a copy of the Notice of Privacy Practices

Name:_____

Signature:_____

Date:_____