Healing Point Acupuncture and Healing Arts
10710 Charter Drive Suite G050 • Columbia • 21044 *(410) 964-9100*
4 Riggs Avenue • Severna Park • 21146 *(410) 437-3187*

Acupuncture Health History Questionnaire

The following questionnaire will help us to better understand your health history, as well as the state of your current health. Please answer the following to the best of your ability. Often minor symptoms are major clues to what is going on. This is a confidential record of your medical history and will be protected according to HIPAA standards.

Name_____Today's date:_____
Address_____
Home Phone_____Work Phone_____Cell Phone_____
Email_____Would you like to receive a monthly newsletter?_____
Marital Status_____Date of Birth_____Age_____Number of Children_____
Occupation_____Referred by_____Had acupuncture before____

What is your major concern?_____
_____

What are other areas of pain or concern?_____
_____

When did you first notice your major concern?_____
What activities aggravate the condition?_____
Is this condition getting worse?____Yes____No_____Constant_____Comes and goes
Is this condition interfering with your_____Work?_____Sleep?_____Daily routine?
What have you done to get relief?_____

HEALTH HISTORY
Please list any surgeries or hospitalizations you have had and the year in which they occurred:_____
_____

Are there any familial disease tendencies of which you are aware?_____
_____

Please list all medications, over the counter preparations, herbs, and supplements you currently take:_____
_____

Please indicate whether you experience any of the following conditions and describe any important details. Please give the date or age of onset and the duration of the condition where significant.

Condition	***Yes***	***Occasionally***	***Please Describe. Give Date Or Age Of Onset And Duration If Relevant***
Anemia			
Cancer			
Contagious Disease			
Epilepsy			
Genetic Disease			
Arthritis/Bursitis			
Rheumatism			
Gout			
Measles			
Mumps			
Chicken Pox			
Whooping Cough			
Broken Bones			
Stitches For Wound Closure			
Car Accident With Injuries			
Been In Shock			
Trauma			
Hyperactivity			
Birth Trauma			
Pneumonia			
Chronic Cough			
Cough Blood			
Pleurisy			
Bronchitis			
Emphysema			
Asthma			
Shortness Of Breath			

Scarlet Fever			
Rheumatic Fever			
Polio			
Constipation			
Diarrhea			
Condition	***Yes***	***Occasionally***	***Please Describe. Give Date Or Age Of Onset And Duration If Relevant***
Flatulence			
Hemorrhoids/Bleeding			
Black Stools			
Colitis			
Diverticulosis			
Heartburn			
Nausea			
Skin Diseases			
Hair Dry Or Oily			
Dandruff			
Nails Soft or Split			
Bite Nails			
Poor Circulation			
Fainting Spells			
Convulsions or Fits			
Tremors			
Jumpiness			
Numbness/Tingling			
Paralysis			
Chronic Headaches			
Migraine Headaches			
Eye Injury or Disease			
Eyeglasses/Contacts			
Eyesight Worsening			
Eyes Painful Or Itchy			
Eyes Watery or Dry			
Glaucoma			

Difficulty Hearing			
Earaches			
Ears Ring Or Buzz			
Vertigo			
Motion, Air, Or Sea Sickness			
Dental Problems			
Gum Problems			
Mouth Sores			
Tongue Sores			
Jaw/Mouth Pain			
Loss Of Taste			
Condition	***Yes***	***Occasionally***	***Please Describe. Give Date Or Age Of Onset And Duration If Relevant***
Loss Of Smell			
Frequent Colds			
Frequent Sore Throats			
Sinus Pain Or Blocked			
Runny Nose/Sneezing			
Nosebleeds			
Cough Up Mucous			
Voice Hoarse			
Speech Difficulty			
Reading Difficulty			
Enlarged Glands			
Infections, Boils			
Belching			
Bad Breath			
Abdominal Pain			
Abdominal Bloating			
Appetite Excessive			
Loss Of Appetite			
Difficulty Swallowing			
Dry Mouth			

Indigestion			
Hepatitis			
Liver Disease			
Gall Bladder Disease			
Gall Stones			
Mononucleosis			
Ulcer			
Diabetes			
Hernia			
High Blood Pressure			
Low Blood Pressure			
Palpitations			
Irregular Heart Beat			
Dizziness			
Night Sweats			
Chest Pain			
Shortness Of Breath			
Muscle Cramps			
Varicose Veins			
Condition	***Yes***	***Occasionally***	***Please Describe. Give Date Or Age Of Onset And Duration If Relevant***
Back Pain Or Injury			
Pain In Knees			
Pain In Feet			
Pain In Hips			
Shoulder Pain			
Neck Pain			
Swollen Feet/Ankles			
Swollen Face/Hands			
Cold Or Hot Hands			
Cold Or Hot Feet			
Urinary Frequency			
Night Frequency			
Urinary Burning			

Difficulty Urinating			
Urine Seepage/ Leakage/Or Dribbling			
Kidney Stones			
Venereal Infections			
Herpes			
Cloudy Urine			
Dark Or Bloody Urine			
Tropical Diseases			
Parasitic Infections			
Insomnia			
Recent Weight Change Over 10 Lbs			
Tumors Or Growths			
Bruise Easily			
Skin Oily Or Dry			
Skin Itchy			
Skin Eruptions/Rash			
Shingles			
Non-Prescription Drug Use			
Drug Addiction			
Alcoholism			
Memory Trouble			
Trouble Concentrating			
Fatigue			
Condition	***Yes***	***Occasionally***	***Please Describe. Give Date Or Age Of Onset And Duration If Relevant***
Trouble Making Plans			
Often Depressed			
Often Anxious			
Often Worried			
Often Hopeless			
Difficult To Relax			
Cry Easily			

Frightening Dreams			
Shy Or Sensitive			
Dislike Criticism			
Lose Temper Easily			
Easily Frustrated			
Difficulties At Work			
Difficulties At Home			
Sexual Difficulties			
Difficult To Express Joy			
Considered Suicide			
Seen Psychologist			
Seen Psychiatrist			
Nervous Breakdown			
Men Only			
Pain In Scrotum Or Testicles			
Discharge From Penis			
Premature Ejaculation			
Difficult Erection			
Prostatitis			
Women Only			
Irregular Menstruation			
Painful Menstruation			
Light Flow			
Heavy Flow			
Clots Pass With Flow			
Menstrual Bloating			
Irritable Before Period			
Bleed Between Period			
Menopause			
Hysterectomy			
Condition Women Only	***Yes***	***Occasionally***	***Please Describe. Give Date Or Age Of Onset And Duration If Relevant***
Hot Flashes			

Take Birth Control Pills			
Lumps In Breasts			
Tender Breasts			
Vaginal Discharge			
Vaginal Itching/Pain			
Infertility			
Abnormal Pap Smear			

Women Only	
Date Of Last Pap Smear	
Age At First Period	
Number Of Days Between Periods	
Number Of Days Of Flow	
Date Of Last Period	
Number Of Pregnancies	
Number Of Children Born	
Number Of Miscarriages	
Number Of Stillbirths	
Number Of Abortions	
Number Of Caesarean Sections	
Birth Control Method	

For Men and Women

Is there anything you are allergic to?_____

How many times a day do you have the following:
Alcohol:_____Coffee:_____Tea:_____Tobacco:_____

What do you do for exercise?_____Frequency:_____

Please list the number of times a day you urinate:_____

Please estimate the number of bowel movements you have had in the past week:_____
Your height:_____ Current weight:_____

FAMILY HEALTH HISTORY

Family Member	*Age*	*Illnesses, Surgeries*	*Cause Of Death*
Mother's Father			
Mother's Mother			
Father's Father			
Father's Mother			
Mother			
Father			
Sister(s)			
Brother(s)			
Children			

Are there any other concerns that you have?_____

Please list any well-being goals you need to achieve:_____
_____
_____
_____
_____

Please indicate whether any discretion must be used in contacting you at your home or work phone number:_____

_____ _____
Signature Date

HEALING POINT LLC
Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Your Health Information, describe how health information about you may be used and disclosed and how you can get access to this information. A hard copy is given to all individuals receiving care. Please review it carefully.

Understanding your treatment record: A record is made each time you visit Healing Point LLC. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights: Your health record is the physical property of Healing Point LLC, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health information, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should Healing Point LLC need to contact you, you have the right to request communication by alternate means or to alternate locations.

Responsibilities: Healing Point LLC is required to maintain the privacy of your health information and to provide you with this notice of privacy practices. Healing Point LLC is required to follow the terms of this notice and to notify you if unable to grant your request to disclose or restrict disclosure of your health information to others. Healing Point LLC reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Healing Point LLC agrees not to use or disclose your health information without your consent.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact Healing Point LLC. If you believe your privacy rights have been violated, you have the right to file a complaint with Healing Point LLC and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

Practices Regarding Disclosure of Your Health Information

Your health information will be routinely used for treatment/consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

- **Treatment/Consultation** – Information obtained by Healing Point LLC will be entered in your record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Healing Point LLC's own expectations and those of others involved in your care may also be recorded.
- **Payment** – Your record may be used to receive payment for services rendered by the Healing Point LLC. While payment is due at time of service, in some cases a bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your practitioner's impressions, and procedures performed.
- **Quality Monitoring –** The practitioners in this office may use your health information to assess the care you received and compare your treatment outcome to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and Drug Administration (FDA) –** This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation –** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health –** This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.
- **Law Enforcement –** As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) In response to a valid subpoena; (2) In the event that a staff member or business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect, or domestic violence.

It is Healing Point LLC's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, Healing Point LLC will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Business Associates –** Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

- **Communications with Family –** Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information relevant to your care to assist them in enhancing your well-being or to confirm your whereabouts.

Patient Consent and Agreement

Voluntary

I hereby voluntarily consent to be treated by acupuncture. I understand I am free to discontinue treatment at any time and that there is not a guarantee of any specific result. I intend this consent to cover the entire course of treatment for my present condition(s).

Possible Side Effects/Healing Reactions

I understand that acupuncture may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment.

Medical Referral

I understand that acupuncture is a specific therapy with its own rewards and limitations, and that if there is a worsening of my ailment or condition, or if it does not improve in a time suitable to me, or if a new ailment or condition arises, I am free to seek adjunct treatment or therapy, or consult a licensed physician. I also understand that if I am currently under a physician's care I should continue as long as my physician and I deem it necessary, and that I should consult my personal physician or provider before altering medications or other therapies.

I further understand that I am encouraged to have yearly physical examinations and pap smears as an important component of routine preventative health care.

Infectious Disease/Clean Needle Procedures

I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that during my acupuncture treatments all precautions are taken to guard against the spread of infection, including hand-washing and using sterilized, prepackaged, disposable needles that are used only on me, and are inserted according to clean procedures based on nationally prescribed standards.

Non-emergency Cancellation Fees

_____Please initial: I understand that payment is due at time of service and that I am liable for the fee for any missed appointments which I did not call to cancel with 24 hours notice unless due to an emergency.

I have read and understand this form. I have also received the Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Client Health Information. I understand my health information will be used and disclosed consistent with this Notice, and that I have the right to request restrictions on certain uses and disclosures of my health information. Further, I have felt free to ask my practitioner questions regarding the proposed services and other pertinent information and have received satisfactory explanations.

_____	_____	_____
Patient Name (Printed)	Patient/Guardian Signature	Date