Lisa Jensen, L.Ac., MAOM
175 Washington St., Ste. A6
Winchester, MA 01890
857-998-0385

Health History Questionnaire Date: _____

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This document is part of your confidential medical record. If anything is unclear, please ask. Thoughtful consideration of your answers will help me better address your unique health makeup.

Name (First & Last)			Home Phone		Cell or Work Phone
Street Address			City		State/Zip
Date of Birth	Age	Height	Weight	Marital Status	
Occupation			Emergency Contact with phone number		
Family Physician				Physician Phone number	
How did you hear about us?			E-mail (for clinic use only—will not be shared)		

Have you been treated by acupuncture or Chinese herbal medicine before? Yes No
Main problem(s) you would like help with:
How long ago did this problem begin? Please be specific:
Have you been given a diagnosis for this problem? If so, what?
How much does this problem interfere with daily activities like work, sleep, recreation, etc.?
What kinds of treatment have you tried?

Past medical history *Circle all that are applicable and please include dates:*

Cancer Diabetes Hepatitis High Blood Pressure Heart Disease Rheumatic Fever

Thyroid Disease Seizures Venereal Disease H.I.V.

Other (Please list)

Surgeries, hospitalizations, significant trauma (auto accidents, falls, etc.)? Please include dates.

Allergies (drugs, chemicals, foods)

Family Medical History

Diabetes Cancer High Blood Pressure Heart Disease Stroke Seizures

Asthma Allergies Other:

NAME:_____ DATE:_____

Medicines, herbs and vitamins taken in past 2 months (please include dose if applicable):
Do you have a regular exercise program? If yes, please describe:
Have you ever been on a restricted diet? If yes, what kind? Why?
Do you smoke? If yes, how much and how long?
How many caffeinated beverages do you drink per week?
How much water do you drink per day? How much alcohol do you drink?

Please circle if you have had any of the following in the past 3 months:

General:

Fevers	Poor sleeping	Fatigue
Sweat easily	Chills	Night Sweats
Bleed or bruise easily	Strong thirst (hot or cold drinks?)	Cravings
Peculiar tastes or smells	Weight loss	Change in appetite
Sudden energy drop	Weight gain	

Skin and Hair:

Rashes	Ulcerations	Hives
Itching	Eczema	Pimples
Dandruff	Loss of hair	Recent moles
Change in hair or skin texture	Any other hair or skin problems?	

Head, Neck, Eyes, Ears, Nose, and Throat:

Dizziness	Concussions	Migraine
Glasses/Contact lenses	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes/floaters
Sinus problems	Nose bleeds	Recurrent sore throats
Grinding teeth	Facial pain	Sores on lips or tongue
Teeth problems	Jaw clicks	Headaches (where? when?)
Any other head or neck problems?		

NAME:_____ DATE:_____

Cardiovascular:

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Difficulty in breathing	Fainting
Cold hands or feet	Swelling of hands	Swelling of feet
Blood clots	Pacemaker (date implanted)	

Respiratory:

Coughing	Coughing blood	Asthma
Bronchitis	Pneumonia	Pain with breathing
Difficulty inhaling/exhaling	Production of phlegm What color?	
Any other lung problems?		

Gastrointestinal:

Nausea	Vomiting	Diarrhea
Constipation	Gas	Belching
Black stools	Blood in stools	Indigestion
Bad breath	Rectal pain	Hemorrhoids
Abdominal pain or cramps	Chronic laxative use	
Any other problems with your stomach or intestines?		

Genito-Urinary:

Pain when urinating	Frequent urination	Blood in urine
Urgency to urinate	Unable to hold urine	Kidney stones
Decrease in urine flow	Impotence	Sores on genitals
Strong odor to urine	Cloudy urine	
Do you wake up to urinate? How often?	Any particular color to your urine?	
Any other problems with your genital or urinary system?		

NAME:_____ DATE:_____

OB/GYN

# of Pregnancies_____	# of Live births_____	# of Miscarriages_____
# of Abortions_____	# of Premature births_____	Age of first menses_____
Date of Last PAP smear_____	Duration of menses_____	Length of cycle_____
Irregular periods	Painful periods	Heavy or Light flow?
Period between menses	Vaginal discharge	Clots in menses
Breast lumps	Age of menopause onset_____	Vaginal sores

Changes in body/psyche prior to menstruation

Are you currently pregnant? Yes No Are you trying to get pregnant? Yes No
Do you practice birth control? What type and for how long?

Musculoskeletal:

Neck pain	Muscle pain	Knee pain
Back pain: Upper? Lower?	Muscle weakness	Foot/ankle pains
Hand/wrist pain	Shoulder pain	Hip pain

Any other joint or bone problems?

Neuropsychological:

Seizures	Dizziness	Loss of balance
Areas of numbness	Lack of coordination	Poor memory
Concussion	Depression	Anxiety
Bad temper	Easily susceptible to stress	

Have you ever been treated for emotional problems? Please list:

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?

Please describe any other issues you would like to discuss:

_____

_____

_____

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Notice of Information Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your acupuncture health record information
Each time you visit this clinic, a record is made of your visit. Typically this record contains your health history, current symptoms, examination results, Oriental medicine diagnosis, and treatment plans. This information serves as:

- a basis for planning your care and treatment
- a means of communicating among different care providers (for example acupuncturists, chiropractors, massage therapists, family physicians, etc.)
- a legal document describing the care you received, written in a format appropriate to acupuncture and Chinese herbal medicine

Your rights under the Federal Privacy Standard
Although your health record is the physical property of Lisa Farwell Jensen, L.Ac., you have certain rights with regard to the information contained therein. You have the following rights:

- To request restrictions on the use and disclosure of your health information for treatment, payment, and health care operations. *Health care operations* consist of activities necessary to carry out the operations of this clinic such as quality assurance and peer review. This right does not include those required by law (for example, mandatory reporting of communicable diseases like tuberculosis).
- To ask us to communicate with you by alternative means and, if the method is reasonable, we must grant the request.
- To receive and keep a copy of this notice of information practices. If you do request a copy, the law requires us to ask you to acknowledge receipt of your copy.
- To inspect and copy your health information upon request. We reserve the right to charge a reasonable, cost-based fee for making copies.
- To request a correction of your health information, unless we did not create the record or if the record is accurate and complete.
- To obtain an accounting of non-routine uses or disclosures.
- To revoke authorization to use or disclose your health information at any time.

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With the regulatory consent granted by the Health and Human Services Department we may use or disclose your health information, payment, and operations. For example:

- This clinic can use your personal health information to diagnose, plan, and implement the best course of treatment for you.
- This clinic may also use your health information to receive payment from a third-party payer, if applicable and appropriate (for example, Workers' Compensation).

Examples of uses and disclosures of your personal health information other than for treatment, payment, and operation:

- The acupuncturist may discuss or present your health information in a peer-discussion group for review and treatment suggestions. All personal information will be withheld or obscured; only particulars related to your health and case will be discussed.
- This clinic may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- If this clinic uses your personal health information for other purposes, you will be informed and asked your permission in writing. You may revoke your consent for authorization at any time.

This clinic's responsibility under the Federal Privacy Standard
In addition to providing you your rights, the Federal Privacy Standard requires this clinic to perform the following:

- Maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information.
- Provide you with the notice as to our legal duties and privacy practices with respect to individually identifiable health information that we collect and maintain about you.
- Abide by the terms of this notice.
- Train any personnel and students concerning privacy and confidentiality.
- Implement a sanction policy to discipline those who break privacy and confidentiality policies.
- Lessen the harm of any breach of privacy or confidentiality.

How to get more information or to report a problem:
If you have any questions or problems, or would like any additional information, you may contact Lisa (who also serves as the designated security and privacy officer) directly at 857-998-0385. This clinic guarantees that your care will not be affected and no retaliatory action will be taken against you.

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My goal with each patient is to form a partnership in health, working together to create the best possible health. Please feel free to share any questions or concerns you have about your health or the treatments.

Please wear loose, comfortable clothing to your appointments. I might ask you to bring shorts or tank tops, depending on what area I will treat.

It is important that you eat regular meals on the day of your treatment. However, you should not overeat right before a treatment, nor should you consume alcohol or other intoxicants as these will affect the efficacy of the treatment.

When possible, please do not plan any strenuous or stressful activities for at least 2 hours after a treatment.

Below is a list of my policies and procedures regarding scheduling and keeping appointments, and my fee schedule. Please review and sign at the bottom, indicating that you understand my policies.

I, _____ understand that:
Name

- Appointments must be canceled 24 hours in advance.
- Failure to show up for a scheduled appointment will result in a bill for 1/2 of the cost of the scheduled treatment.
- Arriving late will result in a shorter appointment, so it is in my best interest to arrive on time for every appointment.

I also agree to the following fees for services provided (insurance discount included; other discounts may apply):

$80 for a 1 hour acupuncture treatment (includes intake and treatment; when requested, herbal consult included*)
$50 for an herbal consult*
* The cost for the herbs prescribed is separate from the consult, and varies depending on the prescribed remedy.
All fees are due at the time of service.

I have read and understood the scheduling policies, and agree to pay the fees, as listed, at the time of service.

_____ _____
Signature Date

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I, _____ understand that:

Acupuncture occasionally produces small bruises, which are generally not painful and will clear up in the time it normally takes for your bruises to go away.

In addition to needles, Lisa occasionally will use an herb called moxa, or mugwort (*Artemesia Vulgaris*). Moxa is used in several forms: a ball placed on the handle of the needle, a cone or thread placed directly on the skin or on a heat transfer medium like ginger or salt, or as a moxa pole waived over particular areas. Usually, the patient will experience a pleasant warming experience, but this procedure carries a small risk of a burn.

Gua Sha, is a special massage technique involving a Chinese soup spoon or flat Gua Sha tool, often used to relieve tight, painful muscles. Gua Sha leaves the skin with a red, bruised appearance. This discoloration is usually not painful and disappears in 1 to 5 days.

Suction cups are often used to relieve painful muscle tightness as well. They leave discoloration similar to Gua Sha.

Electrical stimulation is occasionally used to enhance the effects of the treatment. A small nine-volt battery powered machine produces a gentle current at certain inserted needles, producing a slight vibration or tapping sensation. The level of intensity is always adjusted to the patient's comfort level.

You have the right to decline any type of treatment, particularly if you have had an adverse reaction to it in the past.

You might feel lightheaded after a treatment. Please take the time to rest in our waiting area before venturing out to your car.

I also acknowledge that I have received Lisa Farwell Jensen's Notice of Information Practices. I have read and understood this document, and consent to receive treatment:

Print Name_____

Signature_____ Date:_____