

# Amy C. Darling, LAc, MAcOM ~ Health Questionnaire

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Phone: (h) \_\_\_\_\_ (alt.) \_\_\_\_\_

please \* the number where I can leave confidential information

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Place of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Partnership status: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ In emergency, notify? \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Name & contact \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

How did you learn about this clinic? \_\_\_\_\_

Have you been treated with Acupuncture before? Yes  No

Chinese Herbal Medicine? Yes  No

## PRIMARY CONCERN

What primary concern brings you here today? \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

To what extent does this interfere with you daily life? \_\_\_\_\_

What treatments have you tried? \_\_\_\_\_

\_\_\_\_\_

Have you been given a western diagnosis for this problem? If so, what is it? \_\_\_\_\_

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**On the images to the right,  
mark areas of concern  
(pain, weakness, numbness, rash etc).  
Describe these sensations.**

\_\_\_\_\_

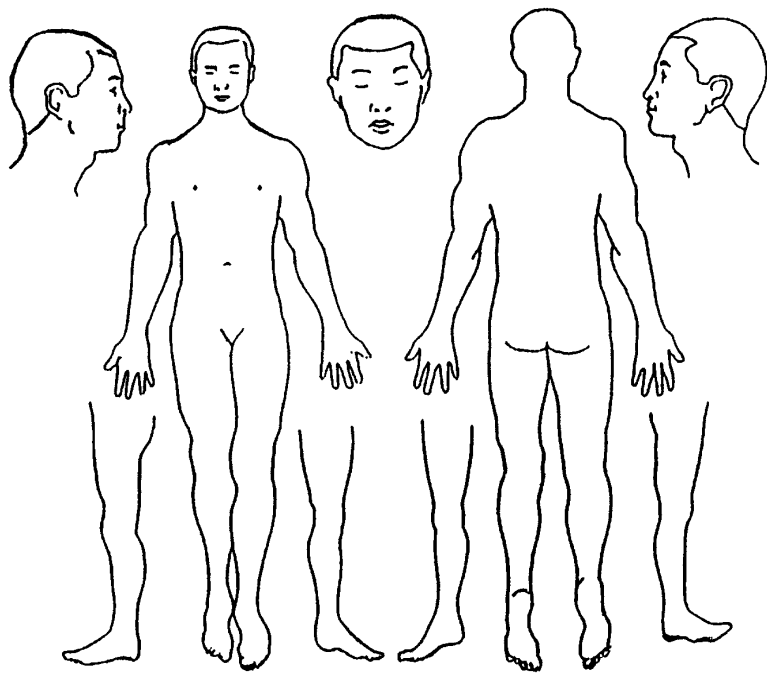
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In the space below write your food intake for an average day (include snacks & beverages)

<b>AM</b>					<b>PM</b>						
12	2	4	6	8	10	12	2	4	6	8	10

Have you ever been or are you currently on a restricted diet? Yes  No  If so, what kind & when?

**Check any that apply:**  Bleeding Disorder  Blood Thinning Medication  Pacemaker  Pregnancy

Allergies (drugs, chemicals, foods)? \_\_\_\_\_

Do you consider yourself an active person? Yes  No

If/ when you exercise, what form does that take? \_\_\_\_\_

What are major sources of stress in your life? \_\_\_\_\_

**Indicate use per week.** If you have quit any of the following, how long ago?

Alcohol _____	Caffeine _____	Other illicit drugs _____
Tobacco _____	Marijuana _____	_____

**CURRENT MEDICATIONS** (include all vitamins, supplements, herbs and pharmaceutical medications)

item	dosage	for what condition	prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**MEDICAL HISTORY** (please indicate date & information as appropriate)

	<b>SELF</b>	<b>FAMILY MEMBER</b>
Asthma	_____	_____
Allergies	_____	_____
Cancer	_____	_____
Blood Disorders/ Anemia	_____	_____
Diabetes	_____	_____
Eating Disorder	_____	_____
Hepatitis	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Thyroid Disease	_____	_____
Depression/Mental Illness	_____	_____
Seizures	_____	_____
Sexually Transmitted Disease	_____	_____
Stomach & Intestinal Disorders	_____	_____
Drug or Alcohol Abuse	_____	_____
Birth History (prolonged labor, forceps, caesarian)?	_____	_____
Surgery (type & date)?	_____	_____
Other	_____	_____

**GENERAL**

- Poor Appetite
- Fevers
- Chills
- Sweat Easily
- Localized Weakness
- Bleed or Bruise Easily

- Peculiar Tastes or Smells
- Strong Thirst (cold or hot drinks)
- Sudden Energy Drop? Time? \_\_\_\_\_
- Fatigue
- Poor Sleeping
- Night Sweats

- Cravings for? \_\_\_\_\_
- Change in Appetite
- Weight Gain
- Weight Loss
- Other? \_\_\_\_\_

**SKIN & HAIR**

- Rashes
- Itching
- Dandruff
- Loss of Hair

- Change in hair or skin texture
- Eczema
- Ulcerations
- Hives

- Pimples
- Recent moles
- Other? \_\_\_\_\_

**HEAD, EYES, EARS, NOSE & THROAT**

- Dizziness
- Glasses
- Color Blindness
- Poor Vision
- Spots in Front of Eyes
- Eye Pain
- Eye Strain
- Night Blindness
- Cataracts

- Blurry Vision
- Ringing in Ears
- Poor Hearing
- Sinus Problems
- Nose Bleeds
- Grinding Teeth
- Facial Pain
- Jaw clicks
- Teeth Problems

- Concussions
- Migraines
- Earaches
- Recurrent Sore Throats
- Sores on Lips or Tongue
- Headaches?
- Where? \_\_\_\_\_
- When? \_\_\_\_\_
- Other? \_\_\_\_\_

**CARDIOVASCULAR**

- High Blood Pressure
- Low Blood Pressure
- Irregular Heartbeat
- Dizziness
- Cold Hands or Feet

- Swelling of Hands
- Blood Clots
- Phlebitis
- Chest Pain

- Fainting
- Swelling of Feet
- Difficulty in Breathing
- Other? \_\_\_\_\_

**RESPIRATORY**

- Cough
- Coughing Blood
- Bronchitis

- Pneumonia
- Difficulty Breathing Lying Down
- Pain with Deep Breathing

- Production of Phlegm
- Phlegm Color? \_\_\_\_\_
- Other? \_\_\_\_\_

**MUSCULOSKELETAL**

- Neck Pain
- Shoulder Pain
- Hand/Wrist Pain
- Back Pain

- Hip Pain
- Knee Pain
- Foot/Ankle Pains
- Muscle Weakness

- Muscle Pains
- Other? \_\_\_\_\_

**GASTROINTESTINAL**

- Nausea
- Vomiting
- Constipation
- Gas
- Black Stools

- Blood in Stools
- Bad Breath
- Rectal Pain
- Chronic Laxative Use
- Hemorrhoids

- Diarrhea
- Belching
- Indigestion
- Abdominal Pain or Cramping
- Other? \_\_\_\_\_

**GYNECOLOGY & PREGNANCY**

- # of Pregnancies \_\_\_\_\_
- # of Births \_\_\_\_\_
- Miscarriages \_\_\_\_\_
- Abortions \_\_\_\_\_
- Premature Births \_\_\_\_\_
- Age at First Menses \_\_\_\_\_
- First Date of Last Menses \_\_\_\_\_
- Period Between Menses \_\_\_\_\_

- Duration \_\_\_\_\_
- Unusual Character (Heavy or Light, Frequency)
- Painful Periods
- Clots
- Vaginal Discharge
- Vaginal Sores
- Irregular periods

- Breast Lumps
- Changes in Body/Psyche Prior to Menstruation
- Last Pap smear date \_\_\_\_\_
- Do you use birth control? Yes  No
- What type and for how long? \_\_\_\_\_
- Other? \_\_\_\_\_

**GENITO-URINARY**

- Pain When Urinating
- Frequent Urination
- Urgency to Urinate
- Unable to Hold Urine
- Decrease in Flow

- Halting Urination
- Blood in Urine
- Kidney Stones
- Sores on Genitals
- Impotency

Do you wake at night to urinate?  
 Yes  No   
 How often? \_\_\_\_\_x  
 Particular color to your urine?  
 Other? \_\_\_\_\_

**NEUROLOGICAL**

- Seizures
- Parasthesia (abnormal sensation)
- Areas of Numbness
- Lack of Coordination

- Poor Memory
- Concussion
- Stroke
- Tremors

Loss of Balance  
 Dizziness  
 Other? \_\_\_\_\_

**PSYCHOLOGICAL**

- Depression
- Anxiety
- Bipolar

- Anger/Bad Temper
- Addiction Issues
- Easily Susceptible to Stress

Panic Attacks  
 Other? \_\_\_\_\_

Have you ever considered or attempted suicide? Yes  No   
 Have you ever been treated for emotional/psychological concerns? Yes  No

**PLEASE NOTE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS ~**

**CONSENT FOR TREATMENT**

I, the undersigned, hereby authorize Amy C. Darling, LAc to provide the following care:

**Acupuncture** ~insertion of sterilized, single use needles through the skin into underlying tissues at specific points.

**Electrical stimulation** ~stimulation of acupuncture points with a mild electrical current.

**Herbal prescriptions** ~ may be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally or externally. I recognize that herbal medicine may be a necessary component of my treatment and will comply with instructions. Herbal formulas may include shell, mineral, and animal products.

**I will make it known if I do not want animal-based products prescribed.**

**Tui-Na** ~ a form of Chinese bodywork which may include massage or stretching.

**Moxibustion (moxa)** ~ indirect or direct burning of mugwort leaf (artemesia) on specific areas of the body.

**Cupping** ~ cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Some bruising may result.

**Gua Sha** ~ rubbing or scraping of an area of the body with a blunt, round instrument. Some bruising may result.

**Plum Blossom** ~ light tapping of an area of the body with a small sterile hammer which has seven points.

I recognize the **potential side effects** to include discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of skin; nausea; loose bowel movements; abdominal cramping; and aggravation of symptoms existing prior to the acupuncture treatment. Treatment may also result in other unforeseen consequences.

I hereby release Amy C. Darling from any and all liability which may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand I am free to withdraw my consent and discontinue treatment at any time. I recognize it is my responsibility to communicate if I am experiencing discomfort in any way during treatment. Additionally, I recognize that I am both free and in fact encouraged to ask questions about my treatment at any time.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

## Notice of Privacy 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.

### THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

### MY PLEDGE REGARDING YOUR MEDICAL INFORMATION

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situations, the law requires me to disclose your health information without either a written or verbal consent.

### USE AND DISCLOSURE WITH CONSENT

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities such as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

### USE AND DISCLOSURE WITHOUT CONSENT

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosures relating to worker's compensation programs.
- We may share your protected health information with a third party "business associate" that performs various activities (e.g., billing, transcription services). Whenever an arrangement between a business associate and us involves the use or disclosure of your protected health information, we will have a

written contract that contains terms that will protect the privacy of your protected health information.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc.). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.**

I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices form this office.

You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.

**For more information about my privacy practices:**

Privacy Officer  
Amy C. Darling  
509 Olive Way Suite 1358  
Seattle, WA 98101  
(206) 920-9929

**For more information on HIPAA or to file a complaint:**

The US Dept. of Health &  
Human Services  
Office of Civil Rights  
200 Independence Ave SW  
Washington, DC 20201  
877-696-6775

This notice has been issued and considered effective as of the date signed. This copy shall be retained by the department for a minimum of six (6) years.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date