

# RUSSELL FAMILY ACUPUNCTURE

HOLISTIC HEALTHCARE  
210 4<sup>TH</sup> STREET, SUITE C  
PETALUMA, CA (707) 773-3375

## PATIENT HEALTH HISTORY

Welcome to Russell Family Acupuncture. To help us provide you with the best possible care, please fill out this form as accurately as possible. All your information will be kept confidential in your patient file.

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F Marital status: S M D W

Name of Physician(s) \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

MAJOR COMPLAINT: Please describe your major health concerns.

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If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

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Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### Hospitalizations and Surgeries:

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____

**Emotional** (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings                      Nervousness                      Mental Tension                      Irritability

**Energy and Immunity** (please circle any that you experience now and underline any that you have experienced in the past): Fatigue

Slow Wound Healing                      Chronic Infections                      Frequent colds and flues

**Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any you have experienced in the past):

Impaired Vision                      Eye Pain/Strain                      Glaucoma                      Glasses/Contacts                      Tearing/Dryness

Impaired Hearing                      Ear Ringing                      Earaches                      Headaches                      Sinus Problems

Nose Bleeds                      Frequent Sore Throats                      Teeth Grinding                      TMJ/Jaw Problems                      Hay Fever

**Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia                      Frequent Common Colds                      Difficulty Breathing                      Emphysema

Persistent Cough                      Pleurisy                      Asthma                      Tuberculosis

Shortness of Breath                      Other Respiratory Problems: \_\_\_\_\_

**Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease                      Chest Pain                      Swelling of Ankles                      High Blood Pressure

Palpitations/Fluttering                      Stroke                      Heart Murmurs                      Rheumatic Fever                      Varicose Veins

**Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers                      Changes in Appetite                      Nausea/Vomiting                      Epigastric Pain                      Frequent Gas                      Heartburn

Belching                      Gall Bladder Disease                      Liver Disease                      Hepatitis B or C                      Hemorrhoids                      Abdominal Pain

**Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease                      Painful Urination                      Frequent UTI                      Frequent Urination                      Heavy Flow

Kidney Stones                      Impaired Urination                      Blood in Urine                      Frequent Urination at Night

**Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles                      Breast Lumps/Tenderness                      Nipple Discharge                      Heavy Menstrual Flow

Vaginal Discharge                      Premenstrual Problems                      Clotting                      Bleeding Between Cycles

Menopausal Symptoms                      Difficulty Conceiving                      Painful Periods

**Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_

4. Birth Control Type: \_\_\_\_\_

7. # of Abortions: \_\_\_\_\_

2. # of Days of Menses: \_\_\_\_\_

5. # of Pregnancies: \_\_\_\_\_

8. # of Live Births: \_\_\_\_\_

3. Length of Cycle: \_\_\_\_\_

6. # of Miscarriages: \_\_\_\_\_

**Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

**Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain      Muscle Spasms/Cramps      Arm Pain      Upper Back Pain      Mid Back Pain  
Low Back Pain      Leg Pain      Joint Pain (if so, where?): \_\_\_\_\_

**Neurological** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness      Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

**Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

**Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

\_\_\_\_\_

**Lifestyle:**

a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested?      Y      N

e. Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y/N      Why/Why not? \_\_\_\_\_

f. Nicotine/Alcohol/Caffeine/Drug Use: \_\_\_\_\_

g. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_

\_\_\_\_\_

h. How many glasses of water do you drink per day? \_\_\_\_\_

i. Interests and hobbies: \_\_\_\_\_

j. Have you had acupuncture before? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Would you like to receive our mail/email newsletter? \_\_\_\_\_

RUSSELL FAMILY ACUPUNCTURE

- ◆ My signature authorizes David Russell, L.Ac. to treat me (or the patient for whom I am legally responsible) with acupuncture, massage and medicinal herbs with the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Committee.
- ◆ I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels based upon the facts then known, is in my best interests.
- ◆ I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
- ◆ I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment and other healthcare operations.
- ◆ I acknowledge the cancellation policy as follows: Russell Family Acupuncture requests 48 hours notice of appointment cancellation. If we receive notice of less than 24 hours, you will be charged a \$35 missed appointment fee.
- ◆ I have received the Notice of Privacy Policies (see following page).

Signature: \_\_\_\_\_  
(patient, parent or guardian)

Date: \_\_\_\_\_

**RUSSELL FAMILY ACUPUNCTURE**

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION  
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

**NAME** \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

*I request the following restrictions to the use of disclosure of my health information:*

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**Patient:**

**X** \_\_\_\_\_  
**Patient Signature or Legal Representative** **Date**