

PHOENIX INSTITUTE OF HERBAL MEDICINE & ACUPUNCTURE
301 East Bethany Home Road, Suite A-100, Phoenix, Arizona 85012
College: 602-274-1885 Clinic: 602-274-1878 Fax: 602-274-1895
Website: www.pihma.edu



NEW PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Mobile _____

E-Mail (for upcoming discounts and events) _____

How did you hear about us? Please circle one:

Referral: Intern Staff/Faculty Patient

Yellow Pages: Acupuncture Acupuncture Schools Colleges & Universities

Internet: Natural Healer Google Search Other _____

Newspaper Other Ad _____

Speaking Engagement _____

Health Fair _____

Thank you for telling others about PIHMA!

24 HOUR CANCELLATION POLICY

Due to costs associated with each appointment, you will receive a bill for scheduled appointments that are missed. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice. In some cases we can fill a vacancy from a waiting list. We will make every attempt to fill your appointment time, and if this is possible, you will not be billed for the missed appointment.

Signature

Date

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PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

Home telephone: () _____

OK to leave a message with detailed information

Leave message with call-back number only

Written communication

OK to mail to my home address

OK to fax to this number:

() _____

Work telephone: () _____

OK to leave a message with detailed information
address

Leave message with call-back number only

Extension: _____

OK to mail to my work/office

Other _____

Patient Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom: Address or Fax Number	Description of Disclosure; Purpose of Disclosure	By Whom Disclosed

Health History Questionnaire

Please help us provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If anything you wish to bring to our attention is not asked on this form, please note it in the comments section. Thank you.

Name: _____ E-Mail: _____

Phone(s)-- Home: _____ Work: _____

Cell: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of Birth: _____ Place of Birth: _____ Marital Status: _____

Employer Name: _____ Occupation: _____

Family Physician: _____

In Emergency, Notify: _____ Phone: _____

Have you been treated by acupuncture or Oriental medicine before? Yes _____ No _____

What was that experience like? _____

Main condition(s) you would like us to help you with: _____

How long ago did this condition begin? (Please be specific.) _____

To what extent does this condition interfere with your daily activities (work, sleep, sex)? _____

Have you been given a diagnosis for this condition? If so, what? _____

What kinds of treatment have you tried? _____

Do you wear a pacemaker? Yes No Do you have any metal implants in your body? Yes No
Past Medical History (please indicate in the space provided and include dates):

Abnormal Pap Smear	Alcoholism	Bleeding/Clotting Disorder
Blood Transfusion	Cancer (malignancy) specify type	Depression
Diabetes (specify type)	Hepatitis (specify type)	Heart Disease (specify type)
High Blood Pressure	Rheumatic Fever	Seizures
Stroke	Thyroid Problem (specify type)	Venereal Disease
Other		

Childhood illnesses: Chicken pox ___ Measles ___ Mumps ___ Other _____

As well as you can recall, what vaccines have you had?

Surgical History:

Operation	Date	Operation	Date

Significant Trauma (auto accidents, falls, broken bones, etc.—please specify date(s)): _____

Significant Dental Work (type and dates): _____

Your Birth History, If Known (any abnormalcies?): _____

Allergies or Reactions to Medicines/Foods/Other Agents:

Medicine/Food/Etc.	Reaction or Side Effect

Occupational Stress (chemical, physical, psychological, etc.): _____

Have you ever been on a restricted diet? Yes ___ No ___ If yes, what kind? _____

Medicines taken within the last three months (drugs, herbs, vitamins, supplements, etc.) _____

Please describe your average daily diet:

Morning _____

Afternoon _____

Evening

Family Medical History:

Medical Condition	√	Medical Condition	√
AIDS/HIV		Hearing Problems	
Alcoholism		Heart Attack	
Allergies		High Blood Pressure	
Arthritis (Osteo)		High Cholesterol	
Asthma		Kidney Disease	
Birth Defects		Libido Problems	
Cancer (type _____)		Lupus	
Depression		Mental Retardation	
Diabetes Type I		Migraine Headaches	
Diabetes Type II		Multiple Sclerosis	
Eczema		Osteoporosis	
Epilepsy		Rheumatoid Arthritis	
Eye Disease		Stroke	
Fatigue		Thyroid Problems	
Glaucoma		Other	

Tobacco Use: Cigarettes-- Quit: Date _____ Never Smoked _____

Current Smoker: Packs/day _____ # of years _____

Other Tobacco: Pipe _____ Cigar _____ Chew _____ Are you interested in quitting? Yes _____ No _____

How much alcohol do you drink per week? _____

Please check (√) any of the following symptoms/conditions you have had in the past three months. Please put a "P" beside those prior to that.

GENERAL

- | | |
|---|--|
| <input type="checkbox"/> Pain problems | <input type="checkbox"/> Elimination problems |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Neuropsychological problems |
| <input type="checkbox"/> Ear problems | <input type="checkbox"/> Gynecological problems |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Teeth/jaw problems | <input type="checkbox"/> Sweating problems |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Swelling problems |
| <input type="checkbox"/> Heart problems | Other _____ |
| <input type="checkbox"/> Digestive problems | _____ |

ENERGY/PAIN/LUNG/HEART CONDITIONS

- | | |
|--|--|
| <input type="checkbox"/> Overall energy level 1-10: _____ | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath _____ Tight chest _____ |
| <input type="checkbox"/> Sudden energy drop. Time of day? _____ | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Asthma/wheezing |
| <input type="checkbox"/> Pain anywhere in body | <input type="checkbox"/> Difficult inhalation _____ exhalation _____ |
| Where do you have pain? _____ | <input type="checkbox"/> Cough. Wet _____ Dry _____ |
| _____ | Thick _____ Thin _____ Phlegm color _____ |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Weight: Recent gain _____ Recent loss _____ | <input type="checkbox"/> Bronchitis |

- Heartbeat: Rapid ___ Slow ___ Irregular ___
- Heart murmur
- Heart palpitations
- Fainting
- Clotting problems
- Varicose/spider veins

- Cold hands ___ Cold feet ___
- Swelling of hands ___ Feet ___
- Sweaty palms ___ Soles ___
- Libido: Decreased ___ Increased ___
- Other _____

APPETITE/DIGESTION

- Poor appetite
- Strong appetite
- Change in appetite
- Peculiar taste in mouth. Describe: _____
- Strongly like cold drinks
- Strongly like hot drinks
- Thirst, no desire to drink
- Cravings. Describe: _____

- Favorite flavor(s) _____
- Nausea ___ Vomiting ___
- Acid regurgitation
- Belching
- Gas
- Hiccup
- Bloating
- Bad breath
- Other _____

ELIMINATION/REPRODUCTION

- Diarrhea
- Constipation
- Stools: Bloody ___ Mucus ___
- Hemorrhoid
- Anus: Itchy ___ Burning ___
- Intestinal pain or cramping
- Rectal pain
- Anal fissures
- Laxative use:
 - What kind? _____
 - How often? _____
- Bowel movements:
 - Frequency _____ Color _____
 - Texture/form _____ Odor _____
- Other stomach or intestinal problems _____
- Pain on urination
- Urination: Frequent ___ Urgent ___

- Blood in urine
- Colorless urine
- Foul-smelling urine
- Unable to hold urine
- Urination: Incomplete ___ Dribbling ___
- Decrease in flow
- Bedwetting
- Wake to urinate. How many times? _____
- Kidney stone
- Impotence
- Premature ejaculation
- Nocturnal emission
- Herpes sores on genitals
- Venereal disease
- Genital: Warts ___ Itching ___
- Other _____

NEUROLOGICAL/PSYCHOLOGICAL

- Seizures
- Numbness. Where? _____
- Tingling. Where? _____
- Tremors/tics. Where? _____
- Poor memory
- Poor concentration
- Depression
- Anxiety
- Irritability/bad temper
- Easily stressed
- Abuse survivor

- Dizziness or vertigo
- Lack of coordination
- Poor balance
- Loss of control/violence potential
- Have you ever been treated for emotional problems?
Yes ___ No ___
- Have you ever considered or attempted suicide?
Yes ___ No ___
- Other _____

SLEEP

- Sleep soundly and wake refreshed
 - Sleep deeply and wake tired
 - Difficulty getting to sleep
 - Difficulty staying asleep
- If so, how long do you sleep before waking?

If you awaken at the same time during each

- night, what time? _____
- Awake startled
 - Dream-disturbed sleep
 - Night sweats
 - Sleepy during day and not at night
- Other _____

GYNECOLOGICAL

- Menopause: Age began _____ Year began _____
 - Hysterectomy: Year performed _____
 - Age menses began _____
 - Length of cycle (1st day of menses to 1st day of next menses) _____
 - Duration of flow _____
 - Painful periods
 - Mood swings
 - Edema/swelling prior to menses
- Describe period flow (blood color, amount, clot size, and how may change during the period) _____

- Date of 1st day of last menses _____
- Breast: Lumps _____ Tenderness _____

- Vaginal discharge. Color _____
 - Vaginal sores _____ Odor _____
 - Nipple discharge
 - Postcoital bleeding
 - Pain during intercourse
 - Last Pap test _____ Results _____
 - # of pregnancies _____
 - # of births _____
 - Premature _____ Miscarriages _____
 - Do you practice birth control? Yes _____ No _____
- If so, what type and for how long? _____

Other gynecological conditions _____

Comments

Remarks

We would appreciate it if you would take a little time to share what you do or have done for yourself and your life that supports you. You may choose to answer any or all of these questions or not.

Do you have a regular exercise program? Yes _____ No _____ If yes, what type(s) of exercise do you do and how often? _____

Do you engage in some form of meditation? Yes _____ No _____ If yes, please give a brief description _____

Do you specifically do anything to make yourself healthier? Yes _____ No _____ If yes, what? _____

What do you do that makes you happier? _____

Thank you for your time. We hope to serve you well, and we look forward to making Asian medicine a positive experience in your life.