HEALTH QUESTIONAIRE

NANARITA ACUPUNCTURE
Nan Schwarz, EAMP, MAcOM
Lic # AC60177866

Today's date

Name Cell (other phone)

Address City, State, Zip

Age Date of Birth Place of Birth

Height Weight Gender Marital Status

Email Address

Primary Care Physician Referred By

Emergency Contact & Phone

Insurance Provider ***Member ID***

Plan Name ***Group #***

Have You Been Treated By Acupuncture or Oriental Medicine Before?: Yes ☐ No ☐

Main Problem(s) you would like help with

How long ago did this problem begin (be specific)?

To what extent does this problem interfere with your daily activities (work, sleep, etc)?

Have you been given a diagnosis for this problem: If so, what?

What kinds of treatment have you tried?

Please note the severity of your problem: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Past Medical History

☐ Cancer	☐ Diabetes	☐ Hepatitis	☐ High Blood Pressure
☐ Heart Disease	☐ Infectious Disease	☐ Thyroid Disease	☐ Seizures
☐ Venereal Disease	☐ HIV/AIDS	☐ Other	

Surgeries (type and date)

Significant Trauma (auto accidents, falls, etc)

Significant Dental Work (type and date)

Infancy or Childhood Disease

Allergies (drugs, chemicals, foods/result)

Family Medical History (check): Diabetes □ Cancer □ High Blood Pressure □

Heart Disease □ Stroke □ Seizures □ Asthma □ Allergies □

Other □

Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Occupational Stress (physical, chemical, psychological, etc)

Do you have a **regular exercise program**? Yes □ No □ Please Describe

Have you ever been on a **restricted diet**? Yes □ No □ What Kind?

Please describe your **average daily diet**:

Morning

Afternoon

Evening

How many **packs of cigarettes** do you smoke per day?

How much **coffee, tea or cola** do you drink per day?

How much **alcohol** do you drink per week?

Please describe any use of recreational drugs

Please check any you have had in the last three months:

General
□ Poor appetite
□ Fevers
□ Sweat easily
□ Localized weakness
□ Bleed or bruise easily
□ Peculiar tastes or smells
□ Strong thirst (cold or hot)
□ Thirst, no desire to drink
□ Sudden energy drop – what time of day?
□ Poor sleep
□ Chills
□ Tremors
□ Poor balance
□ Fatigue
□ Night sweats
□ Cravings
□ Change in appetite
□ Weight gain
□ Weight loss

Skin and Hair
□ Rashes
□ Itching
□ Dandruff
□ Change in hair or skin
□ Ulcerations
□ Eczema
□ Loss of Hair
□ Hives
□ Pimples
□ Recent moles
□ Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat
□ Dizziness
□ Glasses
□ Poor vision
□ Cataracts
□ Ringing in ears
□ Sinus problems
□ Grinding teeth
□ Teeth problems
□ Concussions
□ Eye strain
□ Night blindness

- Blurry vision
- Poor hearing
- Nose bleeds
- Facial pain
- Jaw clicks
- Migraines
- Eye pain
- Color blindness
- Earaches
- Spots in front of eyes
- Recurrent sore throats
- Sores on lips or tongue
- Headaches - where and when

- Other head or neck problems

Cardiovascular
- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Phlebitis
- Chest pain
- Fainting
- Swelling of feet
- Difficulty in breathing
- Other heart or blood vessel problems

Respiratory
- Cough
- Bronchitis
- Difficulty in breathing when lying down
- Production of phlegm what color
- Coughing blood
- Pneumonia
- Asthma
- Pain with a deep breath
- Other lung problems

Gastrointestinal
- Nausea
- Constipation
- Black stools
- Bad breath
- Abdominal pain or cramps
- Chronic laxative use
- Vomiting
- Gas
- Blood in stools
- Rectal pain
- Diarrhea
- Belching
- Indigestion
- Hemorrhoids
- Other stomach or intestinal problems

Genito-urinary
- Pain on urination
- Urgency to urinate
- Frequent urination
- Unable to hold urine
- Impotency
- Blood in urine
- Kidney stones
- Sores on genitals
- Other genital or urinary SX

Do you wake up to urinate?
Yes No.
How often?

Any particular color to your urine?

Pregnancy and Gynecology
Number of pregnancies
Number of births
Premature births
Miscarriages
Abortions
Age at first menses
Days between menses
Duration
First day of last menses

- Unusual character (heavy or light)
- Painful periods
- Vaginal discharge
- Changes in body/psyche prior to menstruation
- Clots
- Vaginal sores
- Irregular periods
- Last Pap
- Breast lumps

Do you practice birth control?
Yes No

What type and for how long?

Musculoskeletal
- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain

Neuropsychological
- Seizures
- Areas of numbness
- Concussion
- Bad temper
- Dizziness
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Other neurological or psychological problems

Treatment Authorization Nanarita Acupuncture CONFIDENTIAL

An East Asian medicine practitioner's scope of practice includes the following techniques and services:

(a) Acupuncture, including the use of acupuncture needles or lancets
(b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points;
(c) Moxibustion;
(d) Acupressure;
(e) Cupping;
(f) Dermal friction technique;
(g) Infra-red;
(h) Sonopuncture;
(i) Laserpuncture;
(j) Point injection therapy (aquapuncture);
(k) Dietary advice and health education based on East Asian medical theory, including the recommendation/ sale of herbs, vitamins, minerals, and dietary/ nutritional supplements;
(l) Breathing, relaxation, and East Asian exercise techniques;
(m) Qi gong, Tai Qi;
(n) East Asian massage and Tuina, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation;
(o) Superficial heat and cold therapies.

I understand the services and techniques the East Asian medicine practitioner is authorized to provide may not resolve an underlying potentially serious disorder(s).

Date Signature of Patient

ONLY SIGN BELOW IF REQUIRED RELEASE FOR POTENTIALLY SERIOUS HEALTH DISORDER(S):

I, , acknowledge I may have a potentially serious health disorder. Nan Schwarz, EAMP may request a consultation or recent diagnosis from a physician or physician's assistant, osteopathic physician or osteopathic physician's assistant, naturopath or ARNP on that potentially serious disorder. I acknowledge that failure to pursue treatment from my primary care provider may involve high risks associated with:

[list disorder(s) here]

I, nonetheless, refuse to authorize a consultation or to provide a recent diagnosis from such a primary care provider and wish to continue with treatment.

Signature of Patient

APPOINTMENT & FINANCIAL POLICY

Initial Office Visit $95.
Return Office Visit $80.
Payments can be made by credit card, cash or check.
Billed payments will be sent to your designated insurance provider.

PERSONAL INJURY- You will need to provide our office with the following information:
accident report, your car insurance information, the other party's insurance information, your attorney information, and other party's attorney information (if applicable).

Chinese herbal medicine varies in price and is not included in the above fees for office visits.
Acupuncture in the state of WA is not covered under Labor & Industries or Workers Compensation.

CANCELLATIONS & NO SHOW
A broken appointment is a loss to everyone. Clinic hours are limited and there may be a waiting list. Please inform me one day in advance if you are unable to keep your appointment so that another patient may take your place.

Appointments cancelled with less than 24 hours notice and appointments missed with no notification will incur a $70 charge. Please pay for the missed visit at or before the next appointment. Please show respect and plan ahead if you must cancel or change your appointment. A Monday appointment must be cancelled the previous Friday, as there is no front desk during the weekends.

By signing this form, I am indicating that I understand and accept this policy.

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend to terminate my care/terminate my care/treatment, any fee for professional services rendered to me will be immediately due and payable.

PRIVACY POLICY - Your personal information is confidential in accordance with the HIPPA patient privacy law. Your information will be shared only with your insurance company and your referring practitioner, unless you give written permission to do otherwise. Correspondence via e-mail is not guaranteed to be secure. If you choose to contact me through e-mail, I will assume you are aware of privacy risks.

I have read the above:

Signature of patient or legal guardian Date