TALENTO ACUPUNCTURE CLINIC
HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with complete evaluation by taking the time to fill out this questionnaire carefully. If you have questions, please ask. If there is anything you wish to bring to our attention please note it in the COMMENTS section at the end. Please print clearly. Thank You.

Name_____**Today's Date**_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone_____ **Cell Phone**_____ **Emergency**_____ **Sex**_____ **Marital Status**_____

Date of Birth_____**Age**_____**Place of Birth**_____**Height**_____**Weight**_____ **Occupation**_____

Social Security #_____ _____ _____**Physician**_____ **Phone**_____ **Employer**_____

Insurance Carrier_____ **Policy #**_____ **Insured's Name**_____

Have you had acupuncture before? _____ Whom may we thank for referring you to our office? _____

Are you allergic to anything? _____

_____

MEDICATIONS:

MEDICATION:	**DOSAGE**	**START DATE**
Reason	Side affects	**STOP DATE (**if any)
MEDICATION:	**DOSAGE**	**START DATE**
Reason	Side affects	**STOP DATE (**if any)
MEDICATION:	**DOSAGE**	**START DATE**
Reason	Side affects	**STOP DATE (**if any)
MEDICATION:	**DOSAGE**	**START DATE**
Reason	Side affects	**STOP DATE (**if any)

*** Please write on back or attach your list of medications if you need more space. ***

Main problem you would like help with _____

_____

_____

If you have been given a diagnosis what is it? _____

To what extent does this problem interfere with your daily activities_____

_____

_____

When did this problem start_____ what types of treatment have you tried_____

Are you under the care of a physician for this problem_____ physician's name_____

Are you under the care of a physician for any other problems? List problem & physician_____

_____

Were you often sick as a child? _____ Recurrent or major childhood illnesses_____

_____

NAME:_____

Significant illnesses:	Liver disease	Heart disease	Seizures or epilepsy	Asthma	Chronic fatigue
Kidney stones	Mononucleosis	Stroke	Arthritis	Eczema	Herpes
Kidney infection	Gallstones	High blood pressure	Cancer	Hemophilia	Sexually transmitted
Kidney disease	Heart attack	Rheumatic fever	Diabetes	Thyroid problems	HIV positive
Hepatitis	Coronary artery	Scarlet fever	Tuberculosis	Parasites	AIDS or ARC

Other_____

_____

Surgeries (please include dates)_____

_____

Significant trauma (auto accidents, falls, fractures, deep cuts, scars, serious sprain, head injuries, etc. Please include dates)_____

_____

Family medical history:	Arthritis	Lung disease	Alcoholism	Coronary artery disease
Cancer	Allergies	Kidney disease	Stroke	High blood pressure
Diabetes	Asthma	Liver disease	Heart disease	Psychological problems

Other health problems of note in your family_____

Occupational stress (chemical, physical, psychological, etc.) _____

What type of exercise do you get? _____

Please list any dietary restrictions_____

Please describe your average daily diet:

Morning_____

Afternoon_____

Snacks _____

Evening _____

List all the vitamins or supplements you take _____

_____

_____

How much coffee, tea or cola do you drink per week? _____

How much liquor, wine or beer do you drink per week? _____

How much tobacco do you use a day (cigarettes, cigars, pipe-fuls, smokeless tobacco)? _____

List any preferences for a particular season, climate, temperature, and weather, time of day, taste or food _____

_____

_____

List any dislike for a particular season, climate, temperature, weather, time of day, taste or food_____

_____

NAME:_____

Please check the appropriate box if you have recently had problems with any of the following. If any symptoms were a major concern in the past, write the year(s) they were active.

GENERAL

☐ Head or chest cold	☐ Night sweats	☐ Anemia	☐ Recent weight loss	☐ Difficulty relaxing
☐ Flu	☐ Perspire easily - no exertion	☐ Always fatigued	☐ Recent weight gain	☐ Hyperactive
☐ Recurrent fevers	☐ Perspire with difficulty	☐ Fatigue easily	☐ Often thirsty	
☐ Chills	☐ Jaundice (yellowish coloring)	☐ Sudden drop in energy	☐ Seldom thirsty	

GASTROINTESTINAL

☐ Constipation	☐ Blood in stool	☐ Gas (flatulence)	☐ Abdominal bloating	☐ Gallstones
☐ Hard stool	☐ Black stool	☐ Belching	☐ Abdominal pain or cramping	☐ Poor appetite
☐ Bowel movements feel incomplete	☐ Mucus in stool	☐ Bad Breath	☐ Stomach pain or cramping	☐ Excessive appetite
☐ Loose stool	☐ Colitis	☐ Nausea	☐ Stomach acidity	
☐ Erratic bowel movements	☐ Diverticulitis	☐ Vomiting	☐ Indigestion	
☐ Foul smelling stools	☐ Parasites	☐ Ulcer	☐ Gurgling noise in stomach	
☐ Undigested food in stool	☐ Hemorrhoids	☐ Hiatal hernia	☐ Bitter taste in mouth	

What particular type of food do you often crave? _____ How often do you have bowel movements? _____

Any other problems with your digestive system or bowel movements? _____

SLEEP

☐ Difficulty falling asleep	☐ Wake at night - thinking	☐ Wake at night - mind empty, eyes open	☐ Need to nap	☐ Sleep on a water bed
☐ Shallow sleep	☐ Nightmares	☐ Difficulty waking in morning	☐ Sleep too much	☐ Sleep with an electric blanket
☐ Dream disturbed sleep	☐ Snoring	☐ Sleepy in the afternoon	☐ Sleep too little	

How many hours do you sleep in a 24-hour period? _____ During what hours do you sleep? _____

Any other sleep related problems:_____

_____

EYES

☐ Nearsighted (myopia)	☐ Cataracts	☐ Floating spots	☐ Watery eyes	☐ Use eyeglasses or contacts
☐ Farsighted (hyperopia)	☐ Night blindness	☐ Pressure behind eyes	☐ Itchy eyes	☐ Blindness
☐ Astigmatism	☐ Sensitivity to light	☐ Eye pain	☐ Red eyes	
☐ Glaucoma	☐ Blurred vision	☐ Dry eyes	☐ Conjunctivitis	

Any other problems with your eyes? _____

HEAD, EARS, NOSE, MOUTH AND THROAT

☐ Frequent colds	☐ Dentures	☐ Ringing in ears	☐ Decreased sense of smell	☐ Sore throat
☐ Sinus congestion or pain	☐ Dizziness / imbalance	☐ Difficulty hearing	☐ Dry mouth	☐ Strept throat
☐ Facial pain	☐ Concussion	☐ Deafness	☐ Excessive salvia or drooling	☐ Tonsillitis
☐ Jaw tension or clicking (TMJ)	☐ Seizures	☐ Nasal congestion	☐ Sores on tongue	☐ Swollen lymph nodes
☐ Grinding teeth	☐ Headache	☐ Runny nose	☐ Sores in mouth (canker sores)	
☐ Frequent dental cavities	☐ Migraine headache	☐ Nose bleeds	☐ Sores around lips (fever blisters)	
☐ Gum problems	☐ Congestion in ears	☐ Sneezing	☐ Difficulty swallowing	
☐ Bleeding gums	☐ Earache	☐ Allergies	☐ Lump or pit in throat	

Any other problems with your head, ears, nose, mouth or throat? _____

NAME:_____

CARDIOVASCULAR

☐ High blood pressure	☐ Heart valve problems (murmur)	☐ High Cholesterol	☐ Bruise easily	☐ Hot hands or palms
☐ Low blood pressure	☐ Rapid heartbeat or palpitations	☐ Stroke	☐ Swelling of hands	☐ Hot feet or soles
☐ Blackouts or fainting	☐ Angina or chest pain	☐ Blood clots	☐ Swelling of feet	☐ Generally too cold
☐ Irregular heartbeat	☐ Coronary artery disease	☐ Phlebitis	☐ Cold hands	☐ Generally too hot
☐ Anemia	☐ Edema	☐ Varicose veins	☐ Cold feet	

Any other problems with your heart or circulation? _____

RESPIRATORY

☐ Chronic cough	☐ Cough up thick sticky phlegm	☐ Cough up blood	☐ Shortness of breath	☐ Asthma – more difficulty exhaling
☐ Dry cough	☐ Cough up thin watery phlegm	☐ Bronchitis	☐ Emphysema	☐ Asthma – more difficulty inhaling
☐ Tight rattling cough	☐ Cough up clear or white phlegm	☐ Pneumonia	☐ Wheezing	☐ Asthma – worse with exertion
☐ Loose cough	☐ Cough up yellowish phlegm	☐ Pain with deep breath		

Any other problems with your lungs or breathing? _____

SKIN AND HAIR

☐ Rashes	☐ Herpes zoster (shingles)	☐ Infections or inflammations	☐ Dry skin	☐ Fungus under nails
☐ Hives	☐ Boils	☐ Recent moles	☐ Moist feet	☐ Weak or brittle nails
☐ Itching	☐ Pimples or acne	☐ Recent change in mole	☐ Moist palms	☐ Loss of hair
☐ Eczema	☐ Ulceration or sores	☐ Warts	☐ Fungus on skin	☐ Dandruff

Any numb areas? _____ Where? _____

Other problems with your skin or hair? _____

URINARY – GENITAL

☐ Scanty / small amount of urine	☐ Dark urine	☐ Unable to hold urine	☐ Pain in bladder area	☐ Inability to achieve orgasm
☐ Strong smelling urine	☐ Cloudy urine	☐ Urgency to urinate	☐ Bladder infection	☐ Prostate problems
☐ Profuse / large amount of urine	☐ Clear urine	☐ Frequent urination	☐ Sores on genitals	☐ Low sperm count
☐ Decreased flow of urine	☐ Dribbling	☐ Difficulty urinating	☐ Pain during intercourse	☐ Ejaculation during sleep
☐ Flow does not stop quickly	☐ Bed wetting	☐ Blood in urine	☐ Low sexual energy	☐ Premature ejaculation
☐ Pain /burning when urinating	☐ Kidney stones	☐ Kidney infection	☐ Excessive sexual energy	☐ Inability to maintain an erection

How often do your urinate in 24 hours:_____ How often do you wake to urinate? _____ Any other problems with your urinary system or genitals? _____

PREGNANCY AND GYNECOLOGICAL

# Of pregnancies _____	☐ Hysterectomy	☐ Premenstrual- irritability	☐ Vaginal discharge – burning
# Of births _____	☐ Have not begun to menstruate	☐ Premenstrual- emotional sensitivity	☐ Uterine fibroids or cysts
Premature births _____	☐ Irregular cycle	☐ Premenstrual- breast sensitivity	☐ Ovarian cysts
Miscarriages _____	☐ Heavy flow	☐ Premenstrual- bloating	☐ Breast cysts or lumps
Abortions _____	☐ Light flow	☐ Premenstrual- fluid retention	☐ Pelvic inflammatory disease
Difficult deliveries_____	☐ Clots, dark or brownish blood	☐ Premenstrual- headache	☐ Currently have an IUD
Cesarean sections _____	☐ Light colored or pale blood	☐ Premenstrual-constipation	☐ Previously had an IUD
Age of children_____	☐ Painful periods	☐ Premenstrual diarrhea	☐ Currently use birth control pills
Age at first menses _____	☐ Cramps before start of period	☐ Vaginal discharge – no odor	☐ Previously used birth control pills
Start of last menses _____	☐ Cramping after start of period	☐ Vaginal discharge – foul smelling	☐ Infertility
Duration of flow _____	☐ Low back ache with period	☐ Vaginal discharge – brownish	☐ Cannot maintain pregnancy
Length of cycle _____	☐ Spotting between periods	☐ Vaginal discharge – white, curd-like	☐ Trying to become pregnant
Age menopause began_____	☐ Missed periods	☐ Vaginal discharge –frothy and profuse	☐ Nursing
☐ Hot flashes	☐ Abnormal PAP	☐ Vaginal discharge – itchy	☐ Pregnant ☐ Nausea or morning sickness

Any other pregnancy or gynecological problems? _____

NAME:_____

PSYCHOLOGICAL

☐ Depression	☐ Frequently angry or irritated	☐ Manic episodes	☐ Anxiety or fear	☐ Poor memory
☐ Suicidal feelings	☐ Tend to repress emotions	☐ Sadness or grief	☐ Indecisiveness	☐ Difficulty concentrating
☐ Mood swings	☐ Obessiveness or compulsiveness	☐ Frequent crying	☐ Difficulty handling stress	☐ Confusion

Have you ever been emotionally, physically or sexually abused? _____ Have you been treated for emotional problems? _____

Have you recently had any unusually stressful experiences (i.e. divorce, death, bankruptcy, loss of job, illness, injury, etc.)?_____

Is there a constant stress in your life, at work, with your family, etc.? _____

Any other psychological problems? _____

MUSCULOSKELETAL

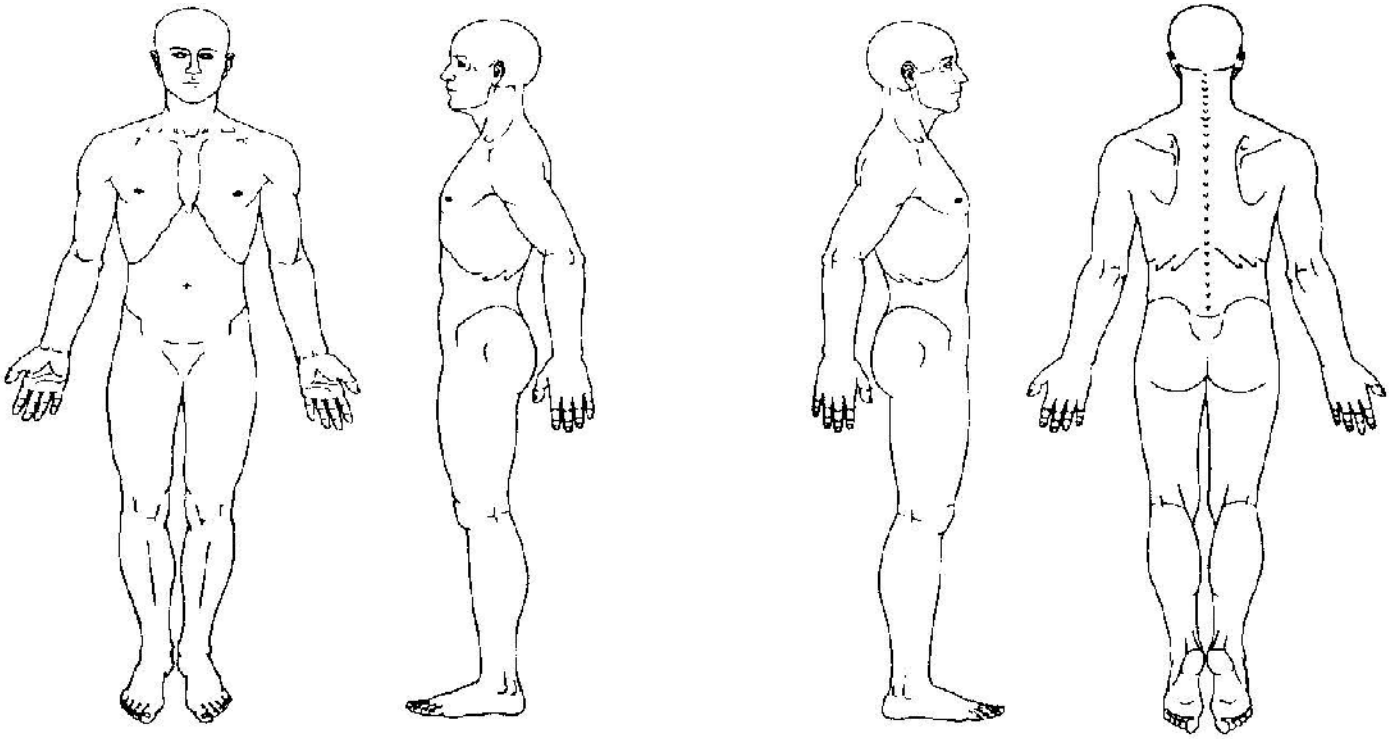
☐ Neck pain or stiffness	☐ Numbness / tingling in hands	☐ Hip joint pain / stiffness	☐ Leg or calf cramping	☐ Paralysis
☐ Shoulder blade pain	☐ Hand / finger pain / stiffness	☐ Pain into thigh or upper leg	☐ Ankle pain / stiffness	☐ Stiff all over
☐ Shoulder joint pain / stiffness	☐ Upper back pain / stiffness	☐ Pain into calf or lower leg	☐ Weak ankles	
☐ Upper arm pain / stiffness	☐ Mid back pain / stiffness	☐ Weak legs	☐ Foot or toe pain / stiffness	
☐ Elbow pain / stiffness	☐ Low back pain / stiffness	☐ Knee pain or stiffness	☐ Numbness / tingling in feet	
☐ Wrist pain / stiffness	☐ Sacroiliac pain / stiffness	☐ Weak knees	☐ Muscle spasms	

Is the problem helped by ☐ pressure ☐ heat ☐ cold ☐ other_____

Is the problem aggravated by ☐ pressure ☐ heat ☐ cold ☐ damp weather ☐ windy weather ☐ other_____

Any other problems with your muscles tendon or bones? _____

Please mark areas of pain: X for pain O for numbness



For additional comments please write on back of form._____

Talento Acupuncture Clinic

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 & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law 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. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your Protected Health Information for the purposes of treatment, payment and health care operations, and in certain other circumstances as required by law:

Treatment **means providing, coordinating, or managing health care and related services by one or more health care providers.**

Payment **means such activities as obtaining reimbursement of services, confirming coverage, billing or collection activities, and utilization review.**

Health Care Operations **include the business aspects of running our practice, such as using your confidential information to remind you of an appointment, or assessing our documentation protocols, etc.**

In addition **we would disclose your Protected Health Information when required to do so by federal, state or local law.**

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain right in regards to your Protected Health Information (PHI):

The right **to access, inspect and receive a copy of your PHI.**

The right **to request restriction on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.**

The rig**ht to request to receive confidential communications of PHI such as not leaving a message on a phone machine, or only contacting you at work, for example**

The right **to request an amendment to your PHI.**

The righ**t to receive an accounting of disclosures of PHI outside of the treatment, payment and health care operations.**

The right **to obtain a paper copy of this notice from us upon request.**

We are required by law to abide by the terms of the Notice of Privacy Practices currently in effect. At some time in the future we may need to change the terms of our Notice of Privacy practices and to make the new notice provision effective for all PHI that we maintain. Revisions to our Notice of Privacy Practices will be posed on the effective date and you may request a written copy of the revised Notice.

You can contact the Department of Health and Human Services, Office of Civil Rights which administers HIPAA, with questions or to file a complaint.

The U.S. Department of Health & Human Services, Office of Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201 (toll-free) 877-696-6775 www.hhs.gov/ocr

For more information about our Privacy Practices, please ask:

Val Talento, DOM, our designated Privacy Official

711-A Encino Pl, NE Albuquerque, NM 87102 505-243-8058

Effective Date: April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT

TALENTO ACUPUNCTURE CLINIC PRIVACY PRACTICES

I have had an opportunity to read, and have received a copy, if requested, of Talento Acupuncture Clinic's Notice of Privacy Practices with an effective date of April 14, 2003

Patient Name (print)_____

Signature of Patient_____
(Legal Guardian)

Date_____

TALENTO ACUPUNCTURE CLINIC

INFORMED CONSENT TO HEALTH CARE BY A DOCTOR OF ORIENTAL MEDICINE

I hereby request and consent to the performance of the following on me (or on the patient named below, for whom I am legally responsible) by licensed doctors of oriental medicine who now or in the future provide me with healthcare while employed by, working or associated with, or serving as back-up for Talento Acupuncture Clinic, including those working at this clinic or any other associated clinic: acupuncture, and other oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, manual palpation on variety of areas of my body, range of motion evaluation, muscle, orthopedic and neurological testing; various physical medicine modalities and therapeutic procedures such as massage, manipulation of joints and viscera, heat and cold therapy and electrical or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplements and other natural health care products and devices; dietary recommendations, advise regarding exercise regimens, and lifestyle counseling.

I understand and am informed that, as in the practice of any system of medicine, there are risks associated with oriental medical treatment. I understand that while unlikely, possible risks that have occurred as a result of treatment at this clinic include an occasional small bruise, hematoma or spot of blood, general aches and, with some conditions, a temporary aggravation of the symptoms. In addition, even though the following have not occurred as a result of treatment at the Talento Acupuncture Clinic, other possible risks include but are not limited to: large bruises, bleeding, inflammations, infections, burns, sprains, strains, dislocation, fractures, disc injuries, strokes, puncture of organs, nerve pain and appearance of new symptoms. I do not expect the doctor to be able to anticipate and explain all risks and complications during the course of treatment. I wish to rely on the doctor's judgment based on the facts known at the time. With regard to acupuncture treatment, I understand that generally I should experience no pain or discomfort. However, some vigorous needle manipulation techniques may cause a variety of sensations, which may be somewhat painful at times for some people. These sensations may occur at the location where a needle is inserted or may radiate from that location.

I understand that there is no way to determine in advance exactly how many treatments may be necessary for my condition. I understand that in general the recommended treatment frequency is once or twice a week and as my condition improves treatment frequency decreases. I also understand that for some individuals and for some conditions less, or more, frequent treatment will provide satisfactory results. Since the number of treatments needed for a given condition will vary greatly depending on such factors as the patient's vitality, the patient's health history, the type of condition, the length of time the condition has existed, the patient's lifestyle and many other factors, I understand that it is not possible to initially determine how many I may need. However, after the initial examination and treatment the doctor will discuss with me what my options are with regard to treatment frequency and how many treatments I may need.

I understand that although acupuncture and other oriental medical therapies have helped millions of people no guarantee of cure or improvement in my condition is given or implied.

I have had an opportunity to discuss any questions I might have regarding the nature and purpose of acupuncture and other oriental medical procedures and the potential risks of treatment. I have read, or have had read to me, the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. I understand that I have the right, at any time, to decline a diagnostic or treatment procedure in full or in part.

The following is to be signed by the patient or by the patient's representative if necessary (e.g., if the patient is a minor or physically or legally incapacitated).

_____	_____
Printed Name of Patient	Printed Name of Patient's Representative (if applicable)
_____	_____
Patient Signature	Signature of Patient's Representative (if applicable)
_____	_____
Date Signed	Relationship or Authority of Patient's Representative

Regulations promulgated by the NM Board of Acupuncture & Oriental Medicine effective May 1, 1997 require that an "Informed consent" form be on file for each patient