

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT HEALTH HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Address: \_\_\_\_\_  
(STREET) (CITY/STATE) (ZIP CODE)

Phone Number: (CELL) \_\_\_\_\_ (WORK/HOME) \_\_\_\_\_

Email: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
(NAME) (PHONE NUMBER)

Emergency Contact: \_\_\_\_\_  
(NAME) (PHONE NUMBER)

*\*\*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically and mentally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.\*\**

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Please identify the health concerns that have brought you here in order of importance below:

CONDITION	PAST TREATMENT
a. _____	_____

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

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

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

7. **Family History:**

FATHER MOTHER BROTHERS SISTERS SPOUSE CHILDREN

Check those applicable:

Age (if living) \_\_\_\_\_

Health (G=Good, O=Ok, P=Poor) \_\_\_\_\_

Cancer \_\_\_\_\_

Diabetes \_\_\_\_\_

Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Stroke \_\_\_\_\_

Mental Illness \_\_\_\_\_

Asthma/Hay fever/Hives \_\_\_\_\_

Kidney Disease \_\_\_\_\_

Age (at death) \_\_\_\_\_

Cause of Death \_\_\_\_\_

8. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

9. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other severe illnesses with approximate date: \_\_\_\_\_

11. **Hospitalizations and Surgeries:**

WHAT REASON WHEN

12. **X-Rays/CAT Scans/MRI's/Special Studies:**

WHAT REASON WHEN

*\*\* For the following questions please **circle** any that you are currently experiencing problems with and underline any that you have had problems with in the past\*\**

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

Mood Swings Nervousness Stress Depression Anxiety Panic Attacks

Any diagnosed mental illness? \_\_\_\_\_

14. **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 Chronic Fatigue Syndrome

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15. **Head, Eye, Ear, Nose & Throat:** (please **circle** any that you experience now & underline any that you've experienced in the past)

Impaired/Blurry Vision    Red/Dry Eyes    Poor Night Vision    Floaters in Vision    Eye Pain/Strain  
Glaucoma    Tearing/Dryness    Glasses/Contacts    Impaired Hearing    Ear Ringing  
Earaches    Headaches/Migraines    Sinus Problems    Nose Bleeds    Frequent Sore Throats  
Teeth Grinding    TMJ/Jaw Problems    Hay Fever

16. **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    Pleurisy  
Phlegm    Persistent Cough    Asthma    Tuberculosis    Shortness of Breath  
Allergies    Chronic Bronchitis    Other Respiratory Problems: \_\_\_\_\_

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

Heart Disease    Chest Pain/Pressure    Swelling of Ankles    High Blood Pressure    Stroke  
Heart Murmurs    Rheumatic Fever    Varicose Veins    Palpitations/Fluttering    Abnormal Bleeding  
Easy Bruising    Low Blood Pressure    Stroke    Heart Attack

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

Ulcers    Nausea/Vomiting    Very Thirsty    No Thirst    Epigastric Pain    Passing Gas  
Heartburn    Changes in Appetite    Gall Bladder Disease    Liver Disease    Hepatitis B or C    Hemorrhoids  
Belching    Abdominal Pain    Constipation    Diarrhea

Any abnormal color, blood, smell, consistency, mucus, frequency, quality or quantity?    Y / N

If yes please explain: \_\_\_\_\_

19. **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    Kidney Stones  
Impaired Urination    Blood in Urine    Frequent Urination at Night

Any abnormal color, smell, urgency, blood, foam, cloudy, frequency, quality or quantity?    Y / N

If yes please explain: \_\_\_\_\_

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

Irregular Cycles    Breast Lumps/Tenderness    Nipple Discharge    Heavy Flow    Vaginal Discharge/Dryness  
Clotting    Premenstrual Problems    Painful Periods    Menopausal Symptoms    Difficulty Conceiving  
Sexual Function/Pain    Bleeding Between Cycles

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**21. Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_ 5. Birth Control Type: \_\_\_\_\_ 8. # of Abortions: \_\_\_\_\_  
2. # of Days of Menses: \_\_\_\_\_ 6. # of Pregnancies: \_\_\_\_\_ 9. # of Live Births: \_\_\_\_\_  
3. Length of Cycle: \_\_\_\_\_ 7. # of Miscarriages: \_\_\_\_\_ 10. Age of Menopause: \_\_\_\_\_  
4. Date of last PAP smear: \_\_\_\_\_ Any abnormalities? \_\_\_\_\_

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

Sexual Difficulties/Pain    Prostate Problems    Testicular Pain/Swelling    Discharge

**23. 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): \_\_\_\_\_

**24. Neurologic:** (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

**25. 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

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

Rash    Itching    Eczema    Psoriasis Acne    Herpes I    Herpes II    Shingles

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

Anemia    Cancer    Cold Hands/Feet    Dry Skin    Dry Hair    Dry Mouth    Dry Eyes    Hair Loss

28. Any chronic or continuing illnesses or conditions? \_\_\_\_\_

29. Any contagious diseases? \_\_\_\_\_

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

**31. Lifestyle:**

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

Typical breakfast: \_\_\_\_\_

Typical lunch: \_\_\_\_\_

Typical dinner: \_\_\_\_\_

Are you Vegetarian? Y / N    Do you eat fish? Y / N    Eggs? Y / N    Dairy? Y / N

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

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

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d. How is your sleep? \_\_\_\_\_ How many hours per night do you sleep? \_\_\_\_\_

Do you wake up often? Y / N Do you wake feeling rested? Y / N

e. Level of education completed: High School Bachelors Masters Doctorate Other

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

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

g. Nicotine (how much): \_\_\_\_\_

Caffeine (what & how much): \_\_\_\_\_

Alcohol (how much): \_\_\_\_\_

Drugs (what & how much): \_\_\_\_\_

Soda (how much): \_\_\_\_\_

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

\_\_\_\_\_

i. Approximately how many ounces of water do you drink per day? \_\_\_\_\_ oz.

j. Television habits: \_\_\_\_\_ Reading habits: \_\_\_\_\_

k. Interests and hobbies: \_\_\_\_\_

l. Energy Level: Low Medium High Does it change throughout the day? \_\_\_\_\_

m. What are your goals with our treatment? \_\_\_\_\_

Are there things that you would like to be able to do but are unable to do right now due to your chief complaint? (i.e. exercise, activities, work, family, etc.): \_\_\_\_\_

\_\_\_\_\_

o. What are your top three priorities? \_\_\_\_\_

p. What are your goals for the year? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

FINANCIAL POLICIES

Acupuncture initial visit \$105 (1.5 hours)  
Acupuncture follow up \$75 (1 hour)  
Massage \$105 (1.5 hours) / \$75 (1 hour) / \$40 (30 minutes)

HOW IT WORKS...

- \* All payments are due at the time of service.
- \* If you have insurance that covers acupuncture we will gladly provide you with the necessary forms for you to bill your insurance so your insurance will reimburse you directly.
- \* Please be on time, if you are late that time will be deducted from your treatment time and you will be charged the full amount. Please show up 5-10 minutes early to allow time to park, etc.
- \* Most conditions require an average of 4-8 treatments, although some will respond within 2-4 visits and others may require a longer series. This depends on the severity, the chronic nature of the chief complaint and your body's health and ability to heal itself.
- \* We accept CASH & CHECKS ONLY.
- \* Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you may be charged the full appointment fee. Insurance will not pay for a missed appointment.
- \* A \$25 fee will be charged for all returned checks.

Please indicate your understanding and acceptance of these policies by signing below.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with Chinese Medicine by a licensed acupuncturist at Yoga Pearl. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

ACUPUNCTURE/MOXIBUSTION: I understand that acupuncture is performed by the insertion of needles through the skin at certain points in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Moxa is the application of heat to help regulate the physiology & function of the body. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, burning/scarring (moxa), fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

HERBS/VITAMINS & SUPPLEMENTS: I understand that herbal medicine as well as vitamins and supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and contact the prescribing practitioner.

ACUPRESSURE/TUI-NA/CUPPING/GUA SHA: I understand that I may also be given one or more of these as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment at any time if it is too uncomfortable.

ELECTRO-ACUPUNCTURE: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment at any time.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINTED NAME: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

PRIVACY POLICIES / HIPAA FORM

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 consent to the use or disclosure of my identifiable health information by Uma Dawn Osha Tupper, L.Ac., for the purposes of diagnosis, providing treatment, obtaining payment for my health care bills and to conduct health care operations. I understand that my diagnosis and/or treatment may be conditioned upon my consent as evidenced by my signature on this document. Uma reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

I understand that this information serves as:

- 1) A basis for planning my care and treatment.
- 2) A means of communication among the healthcare professionals who contribute to my care.
- 3) A source of information for applying my diagnosis and surgical information to my bill.
- 4) A means by which a third-party payer can verify that services billed were actually provided.
- 5) 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:

- 1) To object to the use of my health information for directory purposes.
- 2) 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.
- 3) 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 disclosure of my health information:

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINTED NAME: \_\_\_\_\_

**MESSAGE INTAKE FORM**

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_  
(STREET) (CITY/STATE) (ZIP CODE)

Phone Number: (CELL) \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had professional massage before?

Do you wear contact lenses?

Are you under medical supervision?

Are you currently taking any medication?

Please check below any condition listed below that applies to you:

- Stress
  - Headaches
  - Contagious skin condition
  - Easy bruising
  - Current fever
  - Swollen glands
  - Allergies
  - Heart conditions
  - High or low blood pressure
  - Joint disorders
  - Osteoporosis
  - Epilepsy
  - Cancer
  - Diabetes
  - Decreased sensation
- Recent accident or injury \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Recent Surgery \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

I understand that massage sessions are for general wellness purposes and that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. Also, that it is my responsibility to keep my massage practitioner informed of any changes in my health and any medications that I may begin to take in the future.

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

CONSENT TO CUPPING: By signing below I do hereby voluntarily consent to utilize cupping as a modality during my massage. I am aware that certain side effects may result from this treatment. These include but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop treatment at any time if it is too uncomfortable.

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