# Luna Sparks Acupuncture Health History Questionnaire

*Important:* Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.
*All information is strictly confidential.*

## Personal and Confidential Patient Information

**Office Policies Concerning Confidentiality**
The confidentiality of your personal information is very important to us. We attempt to meet or exceed HIPAA guidelines concerning your personal and healthcare information. Please read the HIPAA information that we provided to you for more detail on our policies. We respect your right to refuse to give us any personal information, but the more information that we have the easier it is for us to help you. Thank You for your assistance.

**Please fill out this information completely and legibly: Circle Yes / No**

Full Legal Name:______________________________
Name or nickname that you would like to be called by us:______________________________
Home Address: Street:______________________________
City:______________________________State:______________Zip:__________
Current Occupation:______________________________
Employer:______________________________
Social Security Number:______________________________
Age:________Date of Birth:____________________Place of Birth: ______________________
Home Telephone:______________________________ ok to leave detailed message? Yes / No
Work Telephone:______________________________ ok to leave detailed message? Yes / No
Cell Phone:______________________________ ok to leave detailed message? Yes / No
Best phone to call you for appointment reminders or important information: Home / Work / Cell
Email: ______________________________Do you want our free email newsletter? Yes / No
Your Personal Medical Doctor:______________________________
Phone:_________________________Address:______________________________
Other Health Care Provider: ______________________________
Phone: _________________________Address:______________________________
In Emergency Notify: ______________________________
Relationship to You:______________________________Phone:_____________
How did you find out about this practice? (Please circle all that apply)
Personal Referral / Professional Referral (M.D., DC, etc.) / Flyer / Seminar
Wellness Event / Tai Qi or Qi Gong Class
Internet: Yelp / Google / Other: ______________________________
Who referred you? ______________________________
May I send this person a "Thank You Card" for referring you? Yes / No
Have you tried Acupuncture before? Yes / No Providers Name:__________________________
Have you tried Chinese Herbal Treatments? Yes / No Have you tried Acupressure? Yes / No

Patient Signature:______________________________Date:______________

Patient Printed Name: ______________________________

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**Patient Name:______________________________ Date:_____________________**

**Gender: Female ____ Male ____ Trans ____ Fill in the blank _______________________**

## Lifestyle and Medications

***List vitamins and supplements that you take both regularly and occasionally***

| Name | Purpose | How long | Dosage | Frequency | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

***List all pharmaceutical drugs that you currently take, regularly & as needed (eg. Nose sprays)***

| Name | Purpose | How long | Dosage | Frequency | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

***List all other pharmaceutical drugs taken within the past six months***

| Name | Purpose | How long | Dosage | Frequency | Last Dose |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Do you NOW follow a regular exercise program? □ Yes □ No Describe:____________________

________________________________________________________________

What did you eat in the last 24 hours?

Breakfast ________________________________________________

Lunch ________________________________________________

Dinner ________________________________________________

Other ________________________________________________

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## Patient Medical History

**Major Complaint(s) in order of significance to you:**

**1.** ______________________ **4.** ______________________

**2.** ______________________ **5.** ______________________

**3.** ______________________ **Additional:** ______________________

**How do these conditions impair your daily activities:**

______________________________________________

______________________________________________

**How was your childhood health?** ______________________

**Hospital Visits/Stays:** ______________________

**Recent tests: (please indicate test results and date below)**

| | | | |
|---|---|---|---|
| □ **Physical** | □ **Cholesterol** | □ **Prostate** | □ **Blood (which?)** |
| □ **HIV/STD** | □ **Pap Smear** | □ **Mammography** | □ **Other:** ____________ |

**Test results and date:** ______________________

______________________________________________

**Check any you have had in the past:**

| | | | |
|---|---|---|---|
| □ **Diabetes** | □ **Allergies** | □ **Glaucoma** | □ **Rheumatic fever** |
| □ **Heart disease** | □ **CVA (stroke)** | □ **Vein condition** | □ **Thyroid disorder** |
| □ **Asthma** | □ **Pneumonia** | □ **Tuberculosis** | □ **Emphysema** |
| □ **Jaundice** | □ **Gonorrhea** | □ **Mumps** | □ **Bleeding tendency** |
| □ **Syphilis** | □ **Measles** | □ **Chicken pox** | □ **Nervous disorder** |
| □ **Meningitis** | □ **HIV** | □ **Polio** | □ **Mononucleosis** |
| □ **Epilepsy** | □ **High fever** | □ **Hepatitis** | □ **Multiple sclerosis** |
| □ **Paralysis** | □ **Pap Smear** | □ **Migraines** | □ **High blood pressure** |
| □ **other lung illness** | □ **other liver illness** | □ **other heart illness** | □ **other kidney illness** |

□ **Other:** ______________________

**Immunizations:** ______________________

**Surgeries:** ______________________

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## Patient Profile

***Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you have a problem with that organ's function):***

### Overall Temperature (TCM kidney function)

| | | |
|---|---|---|
| □ **Cold hands** | □ **Cold feet** | □ **Hot body temperature (sensation)** |
| □ **Cold fingers** | □ **Cold toes** | □ **Cold body temperature (sensation)** |
| □ **Sweaty hands** | □ **Sweaty feet** | □ **Afternoon flushes or night sweats** |
| □ **Perspire easily** | □ **Thirsty** | □ **Hot flashes any time of day** |
| □ **Lack of perspiration** | □ **Take water to bed** | □ **Heat in the hands, feet & Chest** |

### Overall Energy (TCM lung/kidney function)

| | | |
|---|---|---|
| □ **Shortness of breath** | □ **General weakness** | □ **Difficulty keeping eyes open** |
| □ **Catch colds easily** | □ **Low energy** | □ **Feel worse after exercise** |

### Overall Blood (TCM liver, spleen, heart function)

| | | |
|---|---|---|
| □ **Dizziness** | □ **See floating black spots** | |

### Overall TCM heart function

| | | |
|---|---|---|
| □ **Palpitations** | □ **Anxiety** | □ **Sores on tip of tongue** |
| □ **Restlessness** | □ **Mental confusion** | □ **Chest pain traveling to shoulder** |
| □ **Frequent dreams** | □ **Wake un-refreshed** | □ **Drink coffee # cups/week______________** |

### Overall TCM lung function

| | | |
|---|---|---|
| □ **Cough** | □ **Nose bleeds** | □ **Nasal discharge, color________________** |
| □ **Sinus congestion** | □ **Sneezing** | □ **Allergies, to what____________________** |
| □ **Dry mouth** | □ **Sore throat** | □ **Headache, location___________________** |
| □ **Dry nose** | □ **Stiff neck** | □ **Alternating chills and fever** |
| □ **Dry throat** | □ **Stiff shoulders** | □ **Overall achy feeling in body** |
| □ **Dry skin** | □ **Difficulty breathing** | □ **Smoke cigarettes, #/day_______________** |
| □ **Dry throat** | □ **Sadness** | □ **Melancholy** |

### Overall TCM spleen function

| | | |
|---|---|---|
| □ **Low appetite** | □ **Abdominal gas** | □ **Gurgling noises in the stomach** |
| □ **Abrupt weight gain** | □ **Abdominal bloating** | □ **Fatigue after eating** |
| □ **Abrupt weight loss** | □ **Easily bruised** | □ **Prolapsed organs, which______________** |
| □ **Pensive** | □ **Over-thinking** | □ **Hemorrhoids** |
| □ **Worry** | | |

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## Overall TCM spleen, stomach, large intestine, small intestine function

| | | |
|---|---|---|
| □ **Loose stools** | □ **Constipated** | □ **Incomplete defecation** |
| □ **Diarrhea** | □ **Blood in stools** | □ **Mucous in stools** |
| | | □ **Undigested food in stools** |

## Overall TCM dampness trapped in body

| | | |
|---|---|---|
| □ **Snoring** | □ **Nausea** | □ **General sensation of heaviness in body** |
| □ **Mental heaviness** | □ **Mental sluggishness** | □ **Mental fogginess** |
| □ **Swollen hands** | □ **Swollen feet** | □ **Swollen joints** |
| □ **Chest congestion** | □ **Excess fat** | □ **Heavy limbs** |

## Overall TCM stomach function

| | | |
|---|---|---|
| □ **Large appetite** | □ **Bad breath** | □ **Burning sensation after eating** |
| □ **Mouth sores (canker)** | □ **Heartburn** | □ **Bleeding, swollen, painful gums** |
| □ **Acid regurgitation** | □ **Ulcer (diagnosed)** | □ **Belching** |
| □ **Hiccoughs** | □ **Stomach pain** | □ **Vomiting** |

## Overall TCM liver and gallbladder function

| | | |
|---|---|---|
| □ **Chest pain** | □ **Flank pain** | □ **Alternating diarrhea & constipation** |
| □ **Easily angered** | □ **Easily frustrated** | □ **Tight sensation in chest, constraint** |
| □ **Easily irritated** | □ **Easily depressed** | □ **Headaches, one-sided temporal** |
| □ **Skin rashes** | □ **Bitter taste in mouth** | □ **Headaches, top of head** |
| □ **Muscle spasms** | □ **Numbness** | □ **Frequently unable to adapt to stress** |
| □ **Muscle twitching** | □ **Tingling sensation** | □ **Sensation of lump in throat** |
| □ **Muscle cramping** | □ **Neck tension** | □ **Limited range of motion, neck** |
| □ **Seizures** | □ **Shoulder tension** | □ **Limited range of motion, shoulder** |
| □ **Convulsions** | □ **Drink alcohol** | □ **Gallstones (history or current)** |
| | | □ **High-pitched ringing in ears** |

□ **Recreational drugs** **Which:** ______________________________

______________________________

**Frequency:** ______________________________

______________________________

□ **Sexually transmitted diseases** **Which:**

## Overall Eyes (TCM liver function)

| | | |
|---|---|---|
| □ **Itchy** | □ **Bloodshot** | □ **Hot** |
| □ **Dry** | □ **Watery** | □ **Gritty** |
| □ **Blurry vision** | □ **Near-sighted** | □ **Far-sighted** |
| | | □ **Decreased night vision** |

## Overall TCM kidney, urinary bladder function

| | | |
|---|---|---|
| □ **Frequent cavities** | □ **Sore knees** | □ **Cold sensation in knees** |
| □ **Low back pain** | □ **Weak knees** | □ **Memory problems** |
| □ **Excessive hair loss** | □ **Kidney stones** | □ **Lack of bladder control** |
| □ **Bladder infections** | □ **Easily broken bones** | □ **Low-pitched ringing in the ears** |
| □ **Fear** | □ **Easily startled** | □ **Wake during the night to urinate** |

## Overall Urination

| | | |
|---|---|---|
| □ **Color: normal** | □ **Color: dark yellow** | □ **Color: clear** |
| □ **Color: reddish** | □ **Color: cloudy** | □ **Discharge** |
| □ **Volume: profuse** | □ **Odor: Strong** | □ **Burning** |
| □ **Volume: scanty** | □ **Odor: None** | □ **Urgent** |
| □ **Frequent** | □ **Incontinence or loss** | □ **Painful** |

## Overall Libido

| | | |
|---|---|---|
| □ **Normal** | □ **Low** | □ **High** |

## Men only:

| | | |
|---|---|---|
| □ **Swollen testes** | □ **Testicular pain** | □ **Impotence** |
| □ **Feeling of cold or numbness in external genitalia** | | □ **Premature ejaculation** |
| □ **Other:** | | |

## Women only:

**Regular menstrual cycle?** □ **yes** □ **no**

**Pregnant?** □ **yes** □ **no**

**Number of children:** ____________________

**Number of pregnancies:** ____________________

**Age of first menstruation:** ____________________

**Age of menopause:** ____________________

**Average number of days of flow:**

**Averages number of days of cycle:**

**Vaginal discharge?** □ **yes** □ **no**

**Bleeding between periods?** □ **yes** □ **no**

**Do you experience any of the following pre-menstrual syndromes?**

| | | |
|---|---|---|
| □ **Nausea** | □ **Vomiting** | □ **Water retention** |
| □ **Breast swelling** | □ **Food cravings** | □ **Migraines** |
| □ **Breast tenderness** | □ **Depression** | □ **Irritability** |

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□ **Anxiety**

□ **Other emotions:** ____________________

□ **Sharp pain, where?** ____________________

□ **Dull pain, where?** ____________________

| Menstrual Chart: | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 |
|---|---|---|---|---|---|---|---|
| Color (normal, bright red, pale, brown, rust, dark, purple, other) | | | | | | | |
| Amount of flow (normal, heavy, light) | | | | | | | |
| Pain/Cramps (location, dull, sharp, other) | | | | | | | |
| Clots (large, small, black, purple, red, other) | | | | | | | |
| Vomiting (check if yes) | | | | | | | |
| Nausea (check if yes) | | | | | | | |
| Other | | | | | | | |

**All please fill out:**

**Other comments:** ____________________

**Patient Signature:** ____________________

**Acupuncturist Signature:** ____________________

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## INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to treatment with acupuncture and other Oriental Medicine procedure modalities on me by John Luna-Sparks and/or other licensed acupuncturists who now or in the future treat me while employed by, working, or associated with, or serving as back-up for John Luna-Sparks, including those working at this office or any other office or clinic.

I understand that treatments may include, but not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), CranioSacral, herbal treatments, supplements, guasha, far infared heat lamps, nutritional counseling, and life style modifications.

I understand that I have the opportunity and am encouraged to discuss with the treating acupuncturist or clinic personnel the nature and purpose of acupuncture treatments and other procedures at any time.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain disease or dysfunctions of the body. I have been informed that acupuncture is generally a safe method of treatment, but there may be bruising or tingling near the needle sites that may last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. If you choose to have a cupping treatment, there will be bruising, which is normal for that modality.

The herbs and nutritional supplements are from plant, animal and mineral sources. I understand that some herbs may be inappropriate during pregnancy, while others do not combine well with the drug treatments. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist. It is important to inform the acupuncturist of all the pharmaceuticals, supplements, or other medications so that appropriate herbs can be selected. I agree to inform my acupuncturist of all changes in pharmaceutical usage.

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 at the time, based upon the facts then known, is in my best interest.

I understand the clinical, administrative staff, and medical consultants may review my medical records and lab reports, but all my records are confidential and are handled according to HIPAA regulations.

I understand lab reports to help assess my condition may be ordered. These are not a substitute for lab reports that my medical doctor may order. These test are for different diagnosis criteria and may not be evaluated in the same manner as a medical doctor and do not replace diagnosis or treatment by my Medical Doctor.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about it's 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 condition(s) for which I seek treatment. I understand that this is a general consent and it is always, at every treatment, my choice to accept, deny, or ask about any treatment offered to me.

---

**To be completed by the patient**

Patient's Name____________________

Patient's Signature_________________

Date Signed______________________

Are You Pregnant? Yes No

**To be completed by the patients representative**

Name of Patient________________________

Patients Representative__________________

Relationship of Authority of Patient_______

Witness______________________________

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## Policies and Office Procedures

**Office Policies:**
The purpose of these office policies is to create an environment that supports the balance and health of our patients. Please read the following information and sign and date the bottom of the form if you fully understand and agree to these policies. If you feel that you need more information, please speak to John Luna-Sparks for clarification.

**Professional Fees:**
All fees are subject to change without notice. A full listing of current fees can be found on the "Attending Practitioner's Statement." At the present time, my discounted fees for payment at the time of service are as follows:

New Patient Consultation and Treatment.................................................$ 250
Established Patient Follow-up Acupuncture Treatment..........................$85
Established Patient f/u Sports Acupuncture may include Electrostim.... $95
Herbal Formulas (if necessary)...............................................................$9-$60 each

**There is a full charge for missed appointments not cancelled with 24 hours' notice**
Missed appointments severely impact this practice. Maintaining this missed appointment policy allows me to serve my patients and keep patient fees as low as possible.

**Payment for Services:**
Payment is due at the time of service. I accept cash, check, MasterCard, Visa, American Express, Flexible Spending Account debit cards and Health Savings Account debit cards.

**Patient Comfort and Safety:**
Some of my patients are allergic to fragrances. To make their office visit a pleasant and healthy experience I ask that you not wear scented items into the office (perfume, colognes, lotions, etc.).

**Please turn off your cell phone in the office for the safety and harmony of yourself and others.**
If you expect to receive an urgent call, give my office number and I will alert you if called.

**Confidentiality:**
Clinic policies and conduct are designed to meet or exceed HIPAA requirements for confidentiality. Please read the HIPAA policies. Clinic walls are not completely soundproof, so in the interest of your confidentiality, the comfort of other patients, and to maintain a harmonious and healthy atmosphere, I ask that all conversations be kept at a low volume. Thank you!

**Urgent Care and Telephone Policy:**
I do NOT have 24-hour availability or phone access. For MEDICAL EMERGENCIES CALL 911 OR YOUR MEDICAL DOCTOR. For general inquiries, I will return calls, received Monday through Friday during business hours, within 24 hours. Any questions about your specific health care needs or problems can be addressed at your next appointment with John Luna-Sparks.

***If you suspect that herbs or supplements are causing unpleasant or unexpected results, discontinue them immediately and then call our office.***

*Prior to signing please read this form in its entirety*

Signature:____________________________Print Name:____________________Date:________