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PH: 971.216.9913
4160 SE International Way, Suite D-205
Milwaukie, OR 97222

PATIENT HEALTH HISTORY

Personal Information

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home:_____ Cell: _____

At what number may I leave a message?_____

Email Address:_____

☐ I would like to receive occasional email updates with health tips and other updates relating to An Sheng Acupuncture & Healing Arts.

Driver's License #:_____ Gender (circle one): M F Non-Binary Other:_____

Number of children you have: _____ Ages:_____

Marital status (circle one): Single Married Partnership Separated Divorced

Emergency Contact Name:_____

Relationship: _____ Telephone number: _____

Your Occupation: _____ Hours per week: _____

Business Address:_____

Business Phone:_____

Do you enjoy your job?_____

How did you hear about my clinic? (check one)

Referral ☐ Google ad ☐ Google search ☐ Google maps ☐ Facebook ☐ LinkedIn ☐ Yelp ☐

Insurance directory ☐ Health-profs.com ☐ Print ad ☐ Print directory ☐ Other: _____

Chief Health Concerns

What are your most important health concerns and what treatments have you used in the past?

1. Health concern: _____ past treatment: _____

2. Health concern: _____ past treatment: _____

3. Health concern: _____ past treatment: _____

With what results? _____

Any other concerns:_____

_____

_____

Please list any physicians, therapists, or other practitioners you are seeing. May we contact them? Y / N

_____

_____

Are you aware of any allergies to food, drugs, or environmental allergens (cats, mold, dust)? If yes, please explain: _____

_____

SELF AND FAMILY HISTORY

Hospitalizations, Surgeries and Procedures

What hospitalizations and/or surgeries have you had, and dates? Please include any childhood hospitalizations or surgeries:_____

_____

_____

Serious Illnesses, Accidents and Injuries

Please list any serious illnesses, accidents or injuries you have had with dates, including childhood illnesses, accidents and injuries:_____

_____

_____

Do You Suffer From Any Medically Diagnosed Auto-Immune Disorders?

_____

What diagnostic imaging studies or other testing have you had and dates?

__Bone density scan __Mammogram __Electrocardiogram __Electroencephalogram __X-rays

__CT scan __MRI __Colonoscopy __Endoscopy __CBC __Stool test __Urine test

__Allergy test Other:_____

Medications and/or Supplements

Do you take or use any of the following?

__ Pain relievers (aspirin, ibuprofen) __ Antacids __ Laxatives

__ Diet pills, appetite suppressants __ Birth control __ Antibiotics

__ Cortisone (cream or pills) __ Sleeping pills __ Medical Marijuana

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking: _____

_____

General

Height: _____ Weight: _____lbs. Weight one year ago: _____lbs.

Maximum weight: _____lbs. When? _____

Overall rate your energy level on a scale of 1-10? _____

Blood Pressure and Date Last Checked:_____

Family History

Is your father still living? Yes; his age _____ No; age at time of death _____

Cause of death: _____

Is your mother still living? Yes; her age _____ No; age at time of death _____

Cause of death:_____

Do you have a family history of any of the following (please circle):

Anemia	Diabetes	Hay fever/hives	Liver disease
Arthritis	Epilepsy	Heart disease	Mental illness
Asthma	Gall bladder disease	Heart murmur	Stroke
Cancer	Glaucoma	High blood pressure	Tuberculosis
Cataracts	Menstrual problems	Kidney disease	Goiter

Others, Please list:_____

_____

Health Habits and Life-Style

Please describe your exercise routine: _____

_____

How many 8oz servings of nonalcoholic beverages do you drink each day? ____ What are they?_____

Servings of caffeinated beverages each day?____ Alcoholic beverages each day?_____ week?_____

Do you smoke or chew? _____ If yes, how much per day? ____ Have you ever tried quitting? _____

Would you like to quit?_____

Please describe your typical diet and how many meals you eat each day: _____

_____

_____

What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are there any foods you crave? _____If yes, what are they?_____

Do you use any recreational drugs? If yes, which ones and how often? _____

_____

Rate your stress level on a scale of 1-10: ____ What are your sources of stress? _____

_____

When under stress, do you tend towards any emotional state such as worry, depression, fear, frustration, or anger?_____

_____

What practices do you have for stress management (for example exercise, meditation, yoga, qi gong, etc.):

_____

How many hours of sleep do you get on average in a night?_____

What time do you usually go to bed? _____

Please list your interests and hobbies:

_____

_____

REVIEW OF SYSTEMS

Please mark a "x" next to any conditions you currently have, a 'check' next to any conditions you've had in the past, and if you're unsure about a condition use a "?":

Head
__ Headaches
__ Head injury
__ Migraines
__ Jaw/TMJ problems

__ Sinus problems
__ Frequent colds

Ears
__ Ringing
__ Earaches
__ Dizziness
__ Impaired hearing
__ Itching

Mouth/Neck/Throat
__ Lumps
__ Goiter
__ Frequent sore/dry throat
__ Painful or stiff neck
__ Gum problems __ Dental cavities
Do you still have your tonsils? Y / N
Did you have your adenoids removed as a child? Y / N

Nose/Sinuses
__ Stuffiness
__ Hay fever
__ Loss of smell
__ Nose bleeds

Eyes
__ Blurred vision
__ Glasses/contacts
__ Spots in eyes
__ Cataracts __ Glaucoma
__ Tearing/dryness

Musculoskeletal
__ Joint pain; where _____
__ Arthritis
__ Muscle spasms/pain _____
__ Sciatica

Skin
__ Rashes
__ Lumps
__ Color changes

__ Psoriasis
__ Acne/pimples
__ Itching

__ Eczema/hives
__ Boils
__ Loss of hair

Urinary
__ Incontinence
__ Kidney stones
__ Frequent UTIs
__ Frequent urination in day
__ Frequent urination at night
__ Painful urination

Neurological
__ Seizures
__ Paralysis
__ Loss of memory
__ Numbness/tingling
__ Muscle weakness
__ Shooting pains

Blood/Peripheral Vascular
__ Anemia
__ Leg pain
__ Cold hands/feet
__ Easy bruising
__ Thrombophlebitis
__ Varicose veins

Respiratory
__ Asthma
__ Cough
__ Wheezing
__ Pleurisy
__ Bronchitis
__ Pneumonia

__ Emphysema
__ Spitting up blood
__ Tuberculosis
__ Sleep apnea

Cardiovascular
__ Chest pain /tightness
__ Murmur
__ Fainting
__ Pressure in the chest
__ Heart disease
__ Ankle swelling

__ Myocarditis
__ Low blood pressure
__ High blood pressure

__ Pace maker
__ Palpitations

Gastrointestinal
__ Diarrhea or loose stools
__ Constipation
__ Ulcers
__ Black stools
__ Hemorrhoids
__ Gall bladder removed
__ Appendix removed
__ Heartburn/Reflux/GERD
__ Abdominal pain
__ Liver disease
__ Excessive gas
__ Abdominal bloating
__ Nausea/vomiting

Mental/Emotional

__ Mood swings
__ Nervousness
__ Anxiety
__ Depression
__ Excessive anger
__ Frequent crying
__ Excessive worry
__ Eating disorders
__ Panic attacks
__ Diagnosis of Bipolar Disorder
__ Insomnia, hard time falling asleep or staying asleep

Endocrine

__ Hypothyroid
__ Hyperthyroid
__ Excessive thirst
__ Excessive hunger
__ Cold intolerance
__ Heat intolerance
__ Diabetes
__ Night sweats

Men's Health

__ Hernias
__ Prostate problems
__Venereal disease;
If yes, which_____
__ Impotence
__ Discharge or sores
__ Testicular masses/pain
__ Painful urination
__ Dribbling urination

Women's Health

Menstrual Cycle Regular? Y/N If no, please elaborate_____

____ Age of first menses _____ Age of last menses (if menopausal)
____ Length of cycle _____ Date of last annual exam/PAP
____ Duration of menses _____Pregnant? If yes, which trimester are you in?
____ History of Miscarriages? If yes how many?_____
____ History of Abortions? If yes, how many?_____

Do you use any form of birth control? If yes, what kind of birth control and for how long?

_____

Have you ever been prescribed birth control pills or other hormonal therapy for managing problematic menstrual symptoms? Y / N

__ Painful menses
__ Heavy flow
__ Breast tenderness
__ Cycles irregular
__ Abnormal PAP
__ Breast lumps
__ Do self breast exams Y/N
__ Endometriosis
__ Fertility problems
__ Venereal disease;
If yes, which_____
__ PMS
__ Blood clots during menses
__ Low back pain during menses
__ Ovarian cysts
__ Cervical dysplasia
__ Bleeding or spotting between cycles
__ Sexual difficulty
__ Cramps
__ Nipple discharge
__ Vaginal discharge
__ Changes in bowel movements just before or during menses

Is There Anything Else You Would Like Me To Know To Better Serve You?

_____

_____

PATIENT (OR GUARDIAN) SIGNATURE AND DATE:

_____ _____
Signature Date

CONSENT TO TREAT

Susan Buhler, MSOM, LAc
An Sheng Acupuncture & Healing Arts
4160 SE International Way, Suite D-205
Milwaukie, OR 97222
Phone: 971.216.9913

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances by the above-named licensed acupuncturist. 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 my acupuncture treatment could include the insertion of needles through the skin, the application of heat to the skin, or both, at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects could result, including but not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning the use of acupuncture and Chinese herbs and their effects have been given to me, and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances 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 effects 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 herbal treatment. *Should I experience any problems that I associate with these substances, I should suspend taking them and call the above provider as soon as possible.*

Acupressure/Cupping: I understand that I may also be given acupressure/cupping 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 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.

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: _____ **DOB:** _____

Address: _____

City: _____ **State:** ____ **Zip Code:** _____ **Phone:** _____

Susan Buhler, MSOM, LAc
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NOTICE OF PRIVACY PRACTICES & CANCELLATION POLICY

Each time you receive an acupuncture treatment program, a record is made. Typically, this record contains your symptoms, examination observations, test results, notes, treatments given and plans for future treatment/goals. Understanding your health information and how it is used helps to ensure that it is accurately used and disclosed appropriately and that you make informed decisions when authorizing disclosure to others (whether to your primary care physician [PCP] or other healthcare providers/parties sharing in your treatment).

Per HIPAA (Health Insurance Portability & Accountability Act) guidelines, all clinics are required to provide their clients with a copy of their privacy practices. This describes how medical information about you may be used and disclosed and how you can get access to this information.

NO information about your condition will be given to your employers, friends or relatives without your permission (except if required by court of law). We want you to fully understand your condition and your treatment. If you do not understand something, please feel free to ask questions. Also, your suggestions or complaints are important to us because we are interested in ways that might improve our services.

By my signature below, I acknowledge (please check only one):

☐ I have been notified of the availability of the Privacy Practices, but decline a copy at this time, knowing it will be provided to me if requested.

☐ I would like to receive a full copy of the Privacy Practices.

OPTIONAL: Furthermore, I authorize my practitioner to discuss my health condition with the designated individual(s) below (i.e. guardian, spouse, or PCP):

Name/ relationship of allowed Individual(s):

Name	Relationship

Print Name _____ Signature _____ Date _____

24-Hour Cancellation Policy

I require a minimum of 24-hour notification of cancellation prior to the scheduled appointment time. Patients who cancel with less than 24 hours notice, or do not show up for their scheduled appointment will be charged a fee. **This fee is $75 for a missed appointment**.

I realize that emergencies do come up from time to time, so in the event of an illness, family emergency or other events out of your control, the cancellation fee will be waived. Forgetting appointments, changing your mind, etc., you will be charged. If there are any problems with this policy, then please discuss them directly with me. If you are ill, please call ahead of time to see if acupuncture is the best option for you. Thank you for your understanding.

By my signature below, I acknowledge this cancellation policy and the associated fees.

Signature _____ Date _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____