ONeill Acupuncture

4974 Transit Rd, Depew, NY 14043 (716) 685-9631 www.ONeillAcupuncture.com

Confidential Health History Questionnaire

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask.

Name: _____ Date_____

Name Preferred to be Called _____

Best phone to reach you: _____ may we leave a message? ☐ yes ☐ no

email: _____ may we send newsletters/ emails? ☐ yes ☐ no

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Relationship Status: _____ Referred by: _____

Occupation: _____

In Emergency Notify: _____
(please include name, phone and relationship)

Main Health Concern (symptoms, Western Diagnosis, duration of condition, etc.)	History/ Origin of Complaint

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

_____

What kinds of treatment have you tried? _____

_____

What has helped? _____

Significant Trauma (auto accident, falls, etc.): _____

Surgeries: _____

Allergies (drugs, food, chemical, environmental): _____

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

Exercise: Days per week: _____ Length of workout: _____ Type of Activity: _____

Diet per day: Meals:_____Snacks:_____Water:_____Coffee:_____Tea:_____Alcohol:_____Soft Drinks:____

Current medications, herbal medicine, nutritional supplements or vitamins: _____

_____

Please describe any use of drugs for non-medical purposes:

Personal History **Please check any conditions or symptoms you have now.**

☐ Arthritis	☐ Liver/Gall Bladder Disease	☐ Stroke	☐ Heart Disease
☐ High/Low Blood Pressure	☐ Hypo/Hyperglycemia	☐ Kidney Disease	☐ Elevated Blood Cholesterol
☐ Cancer	☐ Diabetes	☐ Food Allergies/Intolerance	☐ Diverticulitis/IBS
☐ Ulcer	☐ Seizures	☐ Hepatitis	☐ Raynaud's Disease
☐ Chronic Fatigue	☐ Anemia	☐ Thyroid Imbalance	☐ Allergies
☐ Fibromyalgia/Polymyalgia	☐ Lyme Disease	☐ Chronic Pain Condition	☐ Impotence
☐ Gastritis	☐ Asthma	☐ Infertility	☐ Emphysema

Family Medical History **Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.**

☐ Diabetes ___	☐ Seizures ___	☐ Heart Disease ___	☐ Stroke ___
☐ High Blood Pressure ___	☐ Allergies ___	☐ Cancer ___	☐ Asthma ___

☐ Other_____

Please check if you have had any of these items listed below in the last 3 months.

General

☐ Poor Appetite	☐ Poor Sleeping	☐ Fatigue	☐ Fevers
☐ Chills	☐ Night Sweats	☐ Sweats Easily	☐ Tremors
☐ Cravings	☐ Localized Weakness	☐ Poor Balance	☐ Change in appetite
☐ Bleed/Bruise easily	☐ Weight loss/gain	☐ Peculiar tastes/smells	☐ Dental/gum problems
☐ Muscle weakness/fatigue	☐ Sudden energy drop	☐ Strong thirst (hot or cold drinks)	

Skin and Hair

☐ Rashes	☐ Ulcerations	☐ Hives/Allergic Dermatitis	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Loss of hair	☐ Recent moles
☐ Skin discoloration	☐ Acne	☐ Change in skin/hair texture	☐ Face flushing

☐ Other skin/hair problems_____

Head, Eyes, Ears, Nose and Throat

☐ Dizziness	☐ Difficulty swallowing	☐ Migraines	☐ Glasses
☐ Eye Strain	☐ Eye pain	☐ Poor vision	☐ Night Blindness
☐ Color Blindness	☐ Cataracts	☐ Blurred vision	☐ Earaches
☐ Ringing in ears	☐ Poor hearing	☐ Spots in front of eyes	☐ Sinus problems
☐ Nose bleeds	☐ Recurrent sore throats/colds	☐ Grinding teeth	☐ Facial pain
☐ Sores on lips/tongue	☐ Dental problems	☐ Jaw clicks/locks	☐ Headaches

(where/when?) _____ ☐ Other head or neck problems_____

Cardiovascular

☐ Chest pain or pressure	☐ Irregular heart beat	☐ Palpitations at rest	☐ Fainting
☐ Cold hands/feet	☐ Swelling of hands/feet	☐ Blood clots	☐ Phlebitis
☐ Shortness of breath	☐ Varicose/spider veins	☐ Pressure in chest	☐ High blood pressure
☐ Low blood pressure	☐ Other heart or blood vessel problems_____		

Respiratory

☐ Cough/Wheezing	☐ Coughing blood	☐ Asthma	☐ Bronchitis
☐ Pneumonia	☐ Pain with deep inhalation	☐ Tight sensation	☐ Difficult inhale/exhale
☐ Difficulty in breathing when lying down	☐ Production of phlegm, what color? _____		☐ Other: _____

Gastrointestinal

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Gas ☐Belching ☐Black stools ☐Blood in stool
☐Indigestion ☐Bad breath ☐Rectal pain ☐Hemorrhoids
☐Bloating/Edema ☐Chronic laxative use ☐Loose stools (>2 per day) ☐Abdominal pain/cramps
☐Changes in appetite ☐Acid reflux ☐Hernia ☐Poor appetite
☐Significant thirst ☐Other problems with your stomach/intestines?_____

Urogenital

☐Pain on urination ☐Frequent urination ☐Blood in urine ☐Urgent urination
☐Unable to hold urine ☐Kidney stones ☐Scanty flow ☐Copious flow
☐Impotence ☐Sores on genitals ☐Urinary tract infection ☐Burning urination
☐Premature ejaculation ☐Decreased libido ☐Prostatitis ☐Dribbling after urination
☐Nocturnal emission ☐Pain in testicles ☐Herpes ☐Infections
☐Night urination What time?_____ How often?_____ ☐Other: _____
color of urine_____

Gynecological/Reproductive

☐Breast lumps ☐Vaginal sores ☐Age of first menses_____
☐Difficult intercourse ☐Vaginal discharge ☐Date of last menses_____
☐Vaginal dryness ☐Fibroid tumors ☐Date of last PAP/Pelvic_____
☐Ovarian cysts ☐Fibrocystic breast tissue ☐Number of abortions_____
☐Infertility ☐Endometriosis ☐Number of pregnancies_____
☐Irregular menstruation ☐PMS/Painful menstruation ☐Number of births_____
☐Number of premature births_____
Do you practice birth control?_____ ☐Number of miscarriages_____
What type?_____ How long?_____
Are you pregnant? _____

Musculoskeletal

☐Neck pain ☐Shoulder pain ☐Hand/wrist pain ☐Carpal Tunnel
☐Knee pain ☐Sprains/Strains ☐Sciatica ☐Foot/ankle pain
☐Hip pain ☐Muscle pain ☐Muscle weakness ☐Tendonitis
☐Back pain Low___ Middle___ Upper___ ☐Bursitis ☐Rotator Cuff

Neuropsychological

☐Seizures ☐Loss of balance ☐Vertigo/Dizziness ☐Areas of numbness
☐Lack of coordination ☐Poor memory ☐Concussion ☐Depression
☐Anxiety/Panic attacks ☐Bad temper/irritable ☐Easily susceptible to stress ☐Seasonal affective disorder
☐Nervousness ☐Inappropriate or strong emotions ☐Other: _____

Have you ever been treated for emotional problems? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No
Have you ever been treated for substance abuse? ☐Yes ☐No

Do you smoke cigarettes? _____ If yes, how much? _____

Approximate number of times taken antibiotics? Almost Never Less than once/year 1-2/year 3 or more/year

Please describe anything else you wish to discuss during our session

Acupuncture Consent to Treatment

I have discussed the nature and purpose of my treatment and I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by Colleen O'Neill, licensed acupuncturist.

I understand that methods or treatments may include but are not limited to:

- ☯ Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture. Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment.
- ☯ Heat treatments using Arthemesa vulgaris (moxibustion, "moxa") or a conventional heat lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or formed into cones, which rests on the skin. The heat generated from moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat, there is a risk of burns.
- ☯ A massage technique called "gua sha" may produce redness on the skin, which may remain for up to 5 days. A slight bruising and tenderness may persist following the treatment.
- ☯ Cupping may be used to promote the circulation of qi (energy) through the meridians. Cups may produce a red/purple color on the area cupped, which may remain for up to 5 days.
- ☯ Electrical stimulation of needles may be used which produces a vibration/tapping sensation of the needles. Ion pumping cords may be attached to the needles.
- ☯ Microbleeding, alone or in conjunction with cupping, may be used to improve the circulation in specific meridians. Lancets are inserted into the skin and small amounts of blood are expressed from the puncture.
- ☯ Tui Na, a style of Chinese Massage.
- ☯ Shonishin, a non-insertive pediatric acupuncture technique.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify Colleen O'Neill, licensed acupuncturist, if I am, or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I understand that no guarantee can be made concerning the results of treatment. 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 it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

I agree to pay for the treatment at the time of my appointment. 24 hour minimum advance notice of appointment cancellations is required. I agree to pay the full charge for any missed or forgotten, or cancelled appointments without 24-hour notice of cancellation.

Patient's Name	**Patient's Signature**	**Date Signed**

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated. I assert that I am legally authorized to give consent for treatment.

Representative's Name	**Representative's Signature**	**Relationship to Patient**

PATIENT ADVISORY TO CONSULT A PHYSICIAN

Colleen O'Neill, Licensed Acupuncturist, is committed to your health and well being, and believes that while Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 821 1.1 (b) of NYS Education law, your signature below indicates that you have read and understand the following statement: We, the undersigned, do affirm that the patient and/or their legal representative has/ have been advised by, Colleen O'Neill, Licensed Acupuncturist, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture.

Patient's Name	**Patient's Signature**	**Date Signed**

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated. I assert that I am legally authorized to give consent for treatment.

Representative's Name	**Representative's Signature**	**Relationship to Patient**

Colleen O'Neill, M.Ac., L.Ac., Licensed Acupuncturist

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge receiving a copy of O'Neill Acupuncture Notice of Privacy Practices.

Patient's Name	**Patient's Signature**	**Date Signed**

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated. I assert that I am legally authorized to give consent for treatment.

Representative's Name	**Representative's Signature**	**Relationship to Patient**

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Dear ONeill Acupuncture patient,

I appreciate your business and confidence in the care I offer. The goal of ONeill Acupuncture is to provide the best possible care and accommodate your appointments in a timely fashion. Missed appointments and appointment cancelled with less than 24 hours notice, prevents others from being seen or scheduled in your appointment slot. I realize that emergencies occur, but it is your responsibility to call the office as soon as possible. A message can be left on voice mail, in the event you cannot speak with a receptionist or me.

In order to offer all my patients the best possible care, I am asking that the following expectations are adhered to:

1. You are on time for your appointment. If you are late for your appointment, please be aware your treatment time will be shortened and you will be charged for the full treatment. If possible, please call in advance if you know you are running late.

2. Please give as much notice as possible if you cannot keep an appointment. If you cancel your appointment with less than 24 hours advance notice you will be charged a late cancellation fee of thirty dollars ($30). I understand that sickness and emergencies can occur. Please call the office as soon as possible to cancel your appointment. If a problem arises with you consistently failing to show for your scheduled appointment I may not be able to reserve future appointments and will need you to call the day you would like an appointment to schedule something.

3. If you fail to show for your scheduled appointment you will be charged the full treatment fee, as the time was reserved for your care. If you call after your scheduled appointment to cancel, you will be considered to have missed your appointment without calling. If you have an emergency and could not keep your appointment, please call so we can discuss your situation.

4. Payments for services is expected at the time of your visit. I accept cash, check and many credit cards. There will be a forty dollar ($40) service charge on all returned checks.

Thank you for your cooperation in this matter.

Sincerely,

Colleen O'Neill
Licensed Acupuncturist

Please sign to acknowledge that you have been informed of these policies.

Patient's Name	**Patient's Signature**	**Date Signed**

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated. I assert that I am legally authorized to give consent for treatment.

Representative's Name	**Representative's Signature**	**Relationship to Patient**