2376 Main Street Suite 3
Ferndale, WA 98248

LondonHealthCenter
community natural medicine

(360) 384-2900

Acupuncture Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Thank you.

Name___________________________________ Date________________

Please identify the health concerns that brought you to the Clinic in order of importance below:
Condition For how long? Past treatment that helped this condition
1. ____
2. ____
3. ____
List any foods, drugs, or medications you are hypersensitive or allergic to:
____
List any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking and for
what condition they are being taken:
____
____
Height: ______Current weight: ____ **Blood Pressure:** Most recent blood pressure reading? ____/____
When was this reading taken? ________

Childhood & adulthood major illnesses, accidents, hospitalizations, surgeries:	
Date	Event

Family History			
ADOPTED?	□ YES	□ NO	If yes, please fill out information for biological relatives if known.

IF ANY IMMEDIATE FAMILY HAS HAD ANY OF THE FOLLOWING - PLEASE CHECK THE # AND INDICATE WHICH RELATIVE

□ 1. Allergies □ 2. Arteriosclerosis □ 3. Cancer (specify) □ 4. Heart Disease □ 5. Diabetes □ 6. Seizures	□ 7. Asthma □ 8. Stroke □ 9. Alcoholism □ 10. High Blood Pressure □ 11. Autoimmune disease □ 12. Mental Illness	
OTHER:		

LIfestyle

□ Do you typically eat at least three meals per day? Y N If no, how many? _____________
□ Exercise routine:____
□ Spiritual practice:____
□ How many hours per night do you sleep? ________ Do you wake rested? Y N
□ Level of education completed: High School Bachelors Masters Doctorate Other
□ Hours worked per Week:_________ Do you enjoy work? Y/N Why/Why not? ____________________
□ Nicotine/Alcohol/Caffeine Use: ____
□ Have you experienced any major traumas? Y N Explain: ________________________
□ How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____
□ Television habits: ______________________ Reading habits: ____________________
□ Interests and hobbies: ____
□ How did you hear about us? ____

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Name___________________________________ Date________________

SYMPTOM LIST **Please check symptoms you currently have or have experienced in the past.**

Endocrine Neurological Respiratory	Sleep/Energy/Skin/Kidneys Urinary Tract/Blood Sugar Regulation	Women	Men
□ Thyroid problems □ Diabetes Mellitus □ Hypoglycemia □ Feeling hot or cold □ Hypo adrenal □ Seizures/Epilepsy □ Nerve pain/inflammation □ Vertigo/Dizziness □ Paralysis □ Numbness/Tingling □ Loss of Balance □ Pneumonia □ Frequent colds & flu □ Wheezing □ Bronchitis □ Shortness of breath □ Persistent cough □ Pleurisy □ Asthma □ Tuberculosis □ Emphysema	□ Insomnia □ Light sleeper/wake easily □ Can't fall back to sleep □ Fatigue □ Tired during day but awake at night □ Can't relax □ Poor memory □ Fuzzy thinking □ Rashes □ Eczema □ Hives □ Dandruff □ Fungal infections □ Warts □ Psoriasis □ Sweat easily during day □ Sweat easily at night □ Never sweat □ Itchy skin □ Dry skin □ Bruise easily □ Kidney disease □ Painful urination □ Frequent urinary tract infection □ Frequent urination in general □ Frequent urination at night □ Lack of bladder control □ Kidney stones □ Impaired urination □ Blood in urine □ Emotional eating □ Excessive appetite □ Hungry between meals □ Irritable before meals □ Get shaky if hungry □ Afternoon headaches □ Crave sweets in afternoon □ Compulsive eating □ Frequent dieting □ Frequent overeating	□ PMS symptoms □ Irregular/missed periods □ Painful periods □ Short cycles (<26 days) □ Long cycles (>35 days) □ Clots in menstrual blood □ Fatigue after menses □ Spotting between periods □ Difficulty conceiving □ Pregnant now? __________ **Date of last period** ___**# Days of bleeding** **Color of blood:** bright dark pale **Type of blood:** light medium heavy □ Current or past sexual or physical abuse □ Sexually transmitted disease □ Pain with intercourse **Current method of birth control:** _____________________________ **Past methods of birth control:** _____________________________ ___# of Pregnancies ___# of Births ___# of Miscarriages ___# of Abortions Note any complications during pregnancies, births, postpartum: ________________________________ □ Vaginal discharge □ Vaginal infections □ Breast fibroids □ Breast lumps □ Nipple discharge □ Uterine fibroids □ Endometriosis □ Ovarian Cyst □ Hysterectomy, when: ________ Monthly breast exam? Y N Last Pap Smear:________________ Last mammogram:_______________ □ Cancer: ovarian uterine breast cervical □ Menopause symptoms □ Hormone Replacement □ Decreased sexual energy □ Increased sexual energy	Prostate hypertrophy (BPH) /cancer □ Testicular pain/swelling □ Difficulty conceiving □ Penile discharge □ Increased sexual energy □ Decreased sexual energy □ Sexual difficulties □ Current past sexual or physical abuse □ Sexually transmitted diseases □ Prostate hypertrophy (BPH) /cancer.

Please fill out both sides of this form.

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Name_______________________________ Date______________

SYMPTOM LIST	Please check symptoms you currently have or have experienced in the past.			
Emotional/ Psychological	**Immune& Inflammation**	**Eyes, Ears, Nose, Throat & Head**	**Gastrointestinal**	**Cardiovascular & Blood**
□ Anxiety □ Depression □ Manic □ Bipolar □ Stress □ Frequent irritability □ Frequent anger □ Mood swings □ Anorexia □ Bulimia □ Frequent Worry □ Obsessive/Compulsive □ Chronic sadness/grief □ Overly fearful □ Addictions:(to what?):	□ Chronic Fatigue Sx □ Hashimoto's dz □ Grave's disease □ Arthritis: where? _____________ □ Lupus □ Colitis □ Crohn's disease □ Fibromyalgia □ Frequent illness □ Frequent infection □ Hay fever □ Frequent swollen glands □ Cancer_________ □ Hepatitis A, B or C □ Herpes □ Chicken pox □ HIV □ Cold sores □ Mononucleosis □ Raynaud's □ Connective tissue inflammation □ Food allergies □ Environmental allergies □ Seasonal allergies	□ Impaired vision □ Blurry vision □ Eye pain/strain □ Glaucoma □ Dry eyes □ Red & painful eyes □ Watery eyes □ Impaired hearing □ Ear ringing □ Earaches □ Nose bleeds □ Bleeding gums □ Runny nose □ Sinus problems □ Snoring □ Headaches □ Teeth grinding □ Teeth grinding □ Toothache □ TMJ/Jaw problems □ Sore throat □ Dry mouth □ Dry throat	□ Ulcers □ Increased appetite □ Decreased appetite □ Nausea/Vomiting □ Gas □ Abdominal pain □ Liver disease □ Heartburn/reflux □ Belching □ Rectal bleeding □ Hemorrhoids □ Indigestion □ Constipation □ Loose stools □ Diarrhea □ Irritable bowel □ Inflammatory bowel □ Polyps □ Leaky gut □ Greasy foods upset □ Bloating after meals □ Discomfort after eating □ Discomfort relieved by eating □ Gallstones	□ Irregular heartbeat □ Palpitations/Flutter □ Chest pain □ Anemia □ Dizziness □ TIA/Stroke □ Heart murmurs □ Rheumatic Fever □ High LDL cholesterol □ Low HDL cholesterol □ High blood pressure □ Low blood pressure □ Cold hands/feet □ Hands & feet go to sleep easily □ Chest pressure or tightness □ Fast pulse (over 100 beats/min) □ Slow pulse (under 60 beats/min) □ Swelling of ankles □ Heart disease □ Heart attack □ Numbness □ Varicose veins

Elimination	Bowel movements per day___#
	Please check type of BM: □ loose □ hard □ dry □ soft □ sticky (sticks to bowl) "normal"
	Color of BM: Please check all that apply: □ brown □ pale color □ green □ black □ bloody

Musculoskeletal:	
Note any current joint, muscle, tendon, or ligament problems. Include 1) Cause, 2) Diagnosis, 3) When problem started, 4) Treatment that's helped:	
Note any past major musculoskeletal problems or injuries:	

Is there anything else we should know?

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient or parent if minor _______________ Date

Thank You!!

Thank you for selecting London Health Center. To help us meet your health care needs. please fill out this form completely in ink. If you have any questions or need assistance, we will be happy to help you.

Personal Information

Legal Name: ____ Today's Date:______________

Wishes to be called: __________________________________ Date of birth: ________________

□ Married □ Significant Other □ Single □ Divorced □ Widowed □ Separated

Gender Identity: □ Female □ Male □ Neither □ Both □ Other

Gender Assigned at birth: □ Female □ Male □ Choose not to disclose

Contact Information Please check preferred phone number

□ Home Phone: _________________________ □ Work Phone:_________________________

□ Cell Phone:______________________ Email: _____________________________________

Automated text/email okay? □*Yes* □*No* *Is is okay to leave a message*? □Yes □No

Address: ____

City, State, Zip: ____

Employer: ___________________________ Occupation:______________________________

In case of emergency, who should we contact? Name: ______________________________

Relationship_________________________Work # ______________Home # ________________

Insurance Information We will make a photocopy of your insurance card

Primary Insurance__________________ Subscriber's Name_________________ DOB__________

Secondary Insurance________________ Subscriber's Name_________________ DOB__________

Authorization and Release

I hereby authorize the direct payment of medical benefits to London Health Center, Inc. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize London Health Center, Inc. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.
I understand that charts will be shared if I am seeing more than one provider at London Health Center and information may be discussed between providers in this clinic.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

X_______________________________________ _______________
Signature of patient or parent if minor Date

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NOTICE OF PRIVACY PRACTICE SUMMARY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

London Health Center, Inc. (the "Practice"), in accordance with applicable federal and state law, is committed to maintaining the privacy of you protected health information ("PHI"). In other words, information about your health condition and the care and treatment you receive from the Practice. We will use and disclose elements of your PHI in the following ways:

- Treatment
- Payment
- Health Care Operations
- When release is required by law, including judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in their duties.
- To organ, tissue and other donation organizations, upon or proximate to your death, if we have no indication on hand about your donation preferences.

Special Cases:

- Appointment reminders, treatment alternatives and other health related benefits and services
- Office newsletter
- Sponsor of your health plan

All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:

- **Restrictions**: To request access to all or part of your PHI. To do this, please make this request in writing. We are not required to grant your request.
- **Confidential communications**: To receive correspondence of confidential information by alternate means or location. To do this, please make your request in writing.
- **Access**: To inspect or receive copies of your PHI. To do this, please make your request in writing.
- Accounting: To recieve an accounting of the disclosures by us of your PHI in the six years prior to your request. To do this, please make your request in writing.
- This notice: to get updates or reissue of this notice at your request.
- Complaints: To complain to our office or the US Department of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, please submit this request in writing. The law forbids us from taking retaliatory action against you if you complain.

Our Duties: We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: To obtain more information on or have your questions about your rights answered: you may contact the Practice's Privacy Office, Dr. Angela London at London Health Center, Inc. 2376 Main Street, Ferndale, WA 98248.
Patient Acknowledgement: By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

______________________________	__________	____
Patient Signature	Date	Print Patient Name