# Dr and D's Acupuncture and Yoga

**@ ClubSport Green Valley, 2100 Olympic Ave, Henderson, NV 89014**
**702-858-2125 • www.LasVegasAcupunctureDr.com**

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank you.

## Personal Information

Name______________________________________________________Date ________ / _______ / 20____

Address_______________________________________________________________________________

City____________________________________________ State___________________ Zip___________

Cell Phone__________________ Day Phone___________________Evening Phone___________________

Email address___________________________________________Occupation_______________________

Birthdate___________________If under 18, person responsible for your account_______________________

Emergency Contact: ______________________________________ Contact Phone:___________________

Age_____________ Sex: □ Male □ Female Height:_________________ Weight:_________________

How did you hear about us? *Please circle one and write the name.*

□ Current Patient ____________________________ □ Doctor ___________________________________

□ Friend_______________________ □ Advertisement _________________________________________

Have you had acupuncture before? □ No □ Yes When? _______________ With Whom?______________

Any concerns or fears about the needles? □ No □ Yes If yes, what? ______________________________

## Health History

**Please indicate if any of the following pertain to you: (marking "yes" does not make you ineligible for treatment, however, it may restrict some of our treatment modalities):**
□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Pregnancy
□ Blood-Thinning Medication

**Chief complaint:**______________________________________________________________________
Onset of condition:______________________________________________________________________
Frequency of condition?__________________________________________________________________
What caused this (accident, lifestyle, drug, etc.)?_______________________________________________
Describe the worst it can be: ______________________________________________________________
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?_______________
_______________________________________________________________________________________
Get temporary relief? Fixes problem? Causes side effects?_______________________________________
_______________________________________________________________________________________
How does this affect your life?_____________________________________________________________
Affect your family?_______________________________________________________________________
Affect your sleep?________________________________________________________________________
Affect your work? _______________________________________________________________________
Affect your hobbies?______________________________________________________________________

**Complaint #2:**______________________________________________________________
Onset of condition:______________________________________________________________
Frequency of condition?__________________________________________________________
What caused this (accident, lifestyle, drug, etc.)?__________________________________________
Describe the worst it can be: ______________________________________________________
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?____________________
______________________________________________________________________________
Get temporary relief? Fixes problem? Causes side effects?___________________________________________
______________________________________________________________________________
How does this affect your life?_______________________________________________________
Affect your family?_______________________________________________________________
Affect your sleep?_______________________________________________________________
Affect your work? ______________________________________________________________
Affect your hobbies?______________________________________________________________

**Other complaints:**
3)___________________________________________________________________________
4)___________________________________________________________________________
5)___________________________________________________________________________

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better________________________
What are your goals of your acupuncture visits?
1)___________________________________________________________________________
2)___________________________________________________________________________
3)___________________________________________________________________________

**Medications – Please list all prescription medications you use.** Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays.
*NOTE: If you need more space please use the other side of this page.*

| Medication | Purpose | How Long | Dose | How Often | Last Dose |
|---|---|---|---|---|---|
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| **Medical Conditions** - Please list all conditions and the year diagnosed, and surgeries with year performed. | | **Allergies** – Medications, Seasons, Environmental, Food |
|---|---|---|
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**Symptoms according to Chinese Medicine** - ***Note***: Please put a checkmark beside each symptom you currently have. In addition, circle the conditions you would rate as being most severe.

**Liver/Gallbladder**
□ Irritability / Anger
□ Depression / Stress
□ Headaches / Migraines
□ Visual Problems
□ Red / Dry / Itchy Eyes
□ Gall Stones
□ Dizziness
□ Blurred Vision
□ Feeling of Lump in Throat
□ Clenching of Teeth at Night
□ Muscle Cramping / Twitching
□ Tension
□ Joints / Neck / Shoulder Pain / Tight
□ Poor Circulation
□ Soft / Brittle Nails
□ Emotional Eater
□ PMS

**Heart / Small Intestine**
□ Heart Palpitations
□ Chest Pain
□ Insomnia / Sleep Problems
□ Easily Startled
□ Restlessness / Agitation
□ Vivid Dreams
□ Lack of Joy in Life

**Lung / Large Intestine**
□ Dry Cough
□ Cough with Sputum
□ Nasal Discharge
□ Post-Nasal Drip
□ Sinus Infection / Congestion
□ Itchy, Red or Painful Throat
□ Dry Mouth / Throat / Nose
□ Skin Rashes / Hives
□ Snoring
□ Grief / Sadness
□ Shortness of Breath
□ Allergies / Asthma
□ Low Resistance to Colds or Flu
□ Sneezing
□ Mild Fever Comes and Goes
□ Smoke Cigarettes

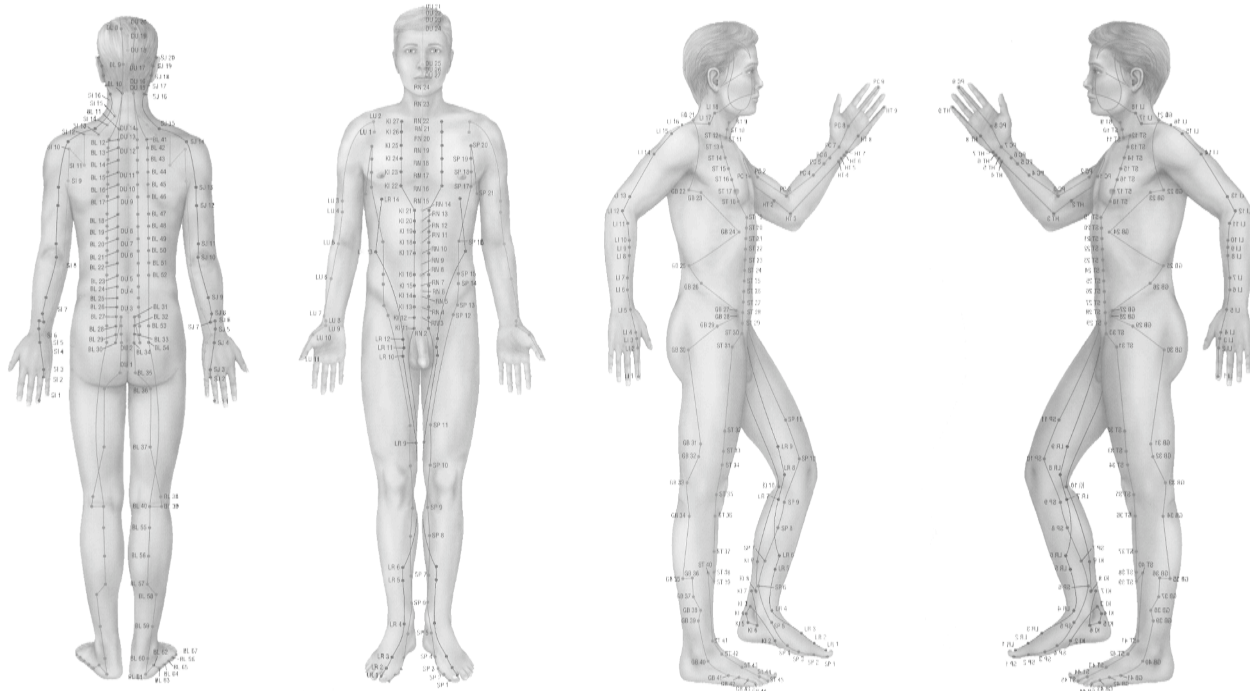
**Kidney / Urinary Bladder**
□ Urinary Problems
□ Bladder Infection
□ Urinary Frequency
□ Lack of Bladder Control
□ Weakness / Pain in Lower Back
□ Decrease Bone Density
□ Feel Cold Easily
□ Low Sex Drive
□ Excess Sexual Desire
□ Poor Memory
□ Loss of Hair
□ Hearing Problems
□ Cavities
□ Craving / Avoiding Salty Foods
□ Fear
□ Hot Flash / Night Sweating

**Spleen / Stomach**
□ Heaviness Anywhere in Body
□ Fatigue / Worse After Eating
□ Hard to Get up in Morning
□ Edema (Swelling)
□ Bloating after Eating
□ Muscles Feel Tired Often
□ Easily Bruising
□ Bad Breath
□ Decreased / Increased Appetite
□ Crave Sweets
□ Blood Sugar Fluctuations
□ Difficulty Digesting Oily Foods
□ Nausea / Vomiting
□ Gas / Belching
□ Acid Regurgitation
□ Insulin Sensitivity
□ Hemorrhoids
□ Constipation
□ Diarrhea
□ Abdominal Pain
□ Indigestion / Heartburn
□ Over-Thinking
□ Tendency to Gain Weight
□ Brain Foggy

**Exercise & Energy:**
How is your energy______________________________
What time of day is your energy: Highest?____________________ Lowest?______________
Do you fatigue easily?______________________________
What kind of exercise do you do?______________________________
How often do you exercise?______________________________

**Emotions & Sleep:**
How do you feel emotionally?______________________________
Do you have (check all that apply): □ Panic attacks □ Depression □ Anxiety □ Bad temper □ Nervousness
□ Poor memory □ Difficult concentration □ Mood swings
Are you in a relationship? Yes □ No □
How do you feel about your relationship?______________________________
How do you hold stress?______________________________
How do you relax?______________________________
How do you feel about your work?______________________________
How long do you normally sleep? _____________hours per night_____________
**I have difficulties with (check all that apply):** □ Falling asleep □ Staying asleep □ Dream-disturbed sleep
□ Waking up at about _____am/pm and not being able to fall asleep again

**Musculoskeletal:** Please circle on the figures below any areas of the body where you experience pain:



□ Muscle cramps - located:________________________________________________
□ Joint swelling - located:________________________________________________
□ Muscle Pain / Rheumatism - located:________________________________________
□ Tendonitis - located:___________________________________________________
□ Arthritis - located:____________________________________________________
□ Bursitis - located:____________________________________________________

How would you characterize your pain?
□ dull/achy □ sharp/stabbing □ burning □ tingling □ numbness □ electrical □ other____________

**Women only -** Please indicate

Hysterectomy - Ovaries removed? □ Yes □ No

How likely is it that you are pregnant now?
□ 100% certain yes □ not sure □ unlikely
□ highly unlikely □ 100% certain no

Are you trying to get pregnant? □ Yes □ No

Number of: ____ Pregnancies ____ Births
____ Miscarriages ____ Abortions

Birth control: □ None □ Spermicides □ IUD
□ Barriers □ Birth Control Pills

Post-menopausal bleeding? □ Yes □ No

When did your last period begin? _____________

Number of days for monthly cycle? ____________

Number of days bleeding lasts? ______________

Do You Suffer from:
□ Cramping *(Mark as appropriate):*
□ Severe □ Moderate □ Mild
□ Before Period □ During Period □ After Period

□ Clotting *(Mark as appropriate):*
□ Bright in Color □ Dark in Color

□ Premenstrual Syndrome *(Mark as appropriate):*
□ Fluid Retention □ Fluctuating Emotions
□ Tenderness in Breasts □ Fatigue
□ Cravings □ Irritability □ Depression

□ Bleeding Between Periods □ Infertility
□ Pelvic Inflam. Disease □ Ovarian Cysts
□ Endometriosis □ Hot Flashes
□ Mastitis □ Breast Cysts
□ Yeast Infection/ Vaginitis /
Other Discharge

**Men only -** Please indicate:
□ Impotence □ Discharge from penis □ Testicular pain or lump □ Premature ejaculation
□ weak erection □ prostate problems □ low sex drive

**Personal Medical and Family Health History**

Please indicate those that are current health problems for yourself and your family members with a “C” under the appropriate person's column. “P” should be used to indicate a past problem. Leave blank those that do not apply. Please use the backside of this form if you need more space.

| | You | Father | Mother | Spouse | Brother(s) | | Sister(s) | | Children | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ***age*** | | | | | | | | | | | |
| AIDS / HIV | | | | | | | | | | | |
| Alcohol Abuse | | | | | | | | | | | |
| Anxiety | | | | | | | | | | | |
| Arthritis | | | | | | | | | | | |
| Asthma / Allergy | | | | | | | | | | | |
| Back Trouble | | | | | | | | | | | |
| Bursitis | | | | | | | | | | | |
| Cancer | | | | | | | | | | | |
| Constipation | | | | | | | | | | | |
| Depression | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Digestive Trouble | | | | | | | | | | | |
| Headaches | | | | | | | | | | | |
| Heart Trouble | | | | | | | | | | | |
| Hepatitis | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| Immune Disorder | | | | | | | | | | | |
| Insomnia | | | | | | | | | | | |
| Kidney Trouble | | | | | | | | | | | |
| Liver Trouble | | | | | | | | | | | |
| Migraine | | | | | | | | | | | |
| Neck Pain | | | | | | | | | | | |
| Thyroid Disorder | | | | | | | | | | | |
| Tobacco Use | | | | | | | | | | | |
| Recreational Drug Use | | | | | | | | | | | |
| Weight Problem | | | | | | | | | | | |
| Emotional Problems: ____________________ | | | | | | | | | | | |
| Other:______________ | | | | | | | | | | | |

If any of the above family members are deceased, please list their age at death and the cause:

______________________________________________________________________________

## Nutrition / Diet

Please mark an “X” in the box indicating how often you consume the following foods and beverages:

| | More than 3x a day | 2-3x a day | 1x a day | 1x a week | A few days a month | A few times a year | Rarely | Never |
|---|---|---|---|---|---|---|---|---|
| white sugar / candy / chocolate | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| cookies / cake / pie / bakery items | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| bread / cereal / pasta | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| milk / whey protein | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| cheese | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| yogurt | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| ice cream | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| coffee / caffeine | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| alcohol | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| soda / sports drinks | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| fast food meals | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| restaurant food items | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| homemade meals | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| canned food items | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| frozen meals | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| red meat | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| poultry | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| eggs | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| fish | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| vegetarian protein source | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| cooked veggies from freezer bag | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| cooked vegetables | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| fresh dark leafy greens | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| fresh vegetables | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| fresh fruits | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| nuts / seeds | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| cold-pressed oils | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| organic food | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |
| uncooked veggies and fruits | > 3x / day | 2-3x/day | 1x / day | 1x / week | month | year | rarely | never |

| Supplement | Purpose | How Long | Supplement | Purpose | How Long |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.
In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

***Safeguards in place at our office include:***

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

***Types of information that we gather and use:***
In administering your health care, we gather and maintain information that may include non-public personal information.:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at 702-858-2125.

Yours truly,

Dr. Alyssa Wampole, O.M.D.

Dr and D’s Acupuncture and Yoga
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## CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

**NAME** ____________________________________________________

**BIRTHDATE** ________________________________________________

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 understand that this information serves as:**

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

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

______________________________________________________________________

______________________________________________________________________

**Patient:**

**X**_________________________________ __________ ___________________________

- **Patient Signature or Legal Representative** **Date** **Witness Signature**

Office Use Only:

☐ Accepted ___________________________ ___________ __________

☐ Denied Signature Title Date