Stephanie Petix Willard, L.Ac.
1033 SW Yamhill Street, Suite 100 Portland, OR 97205
503-227-8781 www.acupetix.com

PERSONAL HISTORY QUESTIONNAIRE

Today's Date:________________________________

Name: ____Date of Birth: _____________Age:_________

Address:____

City:____State:____________Zip_______________

Phone: Home______________________Work______________________Mobile_______________________

Can we leave a message at any of these numbers for you?____

Email Address____

Occupation:____________________________________Employer_________________________________

Who should we contact in case of emergency?

Name____

Phone_____________________________________Relationship____________________________________

Name of your current Physician?____

(circle one) MD DO ND Chiropractor Acupuncturist Other

How did you hear about our office:____

Have you ever experienced acupuncture or Chinese herbs before?__________________________________

What is the primary reason for your visit today?

____

____

____

How long has it been present:____

Secondary Complaints:____

____

Allergies:____

Height:_______________________________________Weight:______________________________________

Medications (**include** non-prescription, vitamins, supplements, etc.)

____

____

Previous Hospitalizations/Surgeries/Serious Illnesses When?

____ ______________________________

____ ______________________________

____ ______________________________

Please mark an 'X' next to any conditions you have had and a ' ' after conditions you currently have

Mental/Emotional
___Mood Swings/Depression
___Eating Disorder
___History of counseling
___Tension
___Anxiety or nervousness
___Considered/attempted suicide
___Seasonal Depression

Endocrine
___Thyroid problems
___Heat or Cold intolerance
___Fatigue
___Hypoglycemia
___Excess thirst or hunger
___Diabetes

Immune
___Chronic Fatigue Syndrome
___Chronically swollen glands
___Chronic infections
___Frequent colds
___Autoimmune disease
___Allergies or hay fever

Neurologic
___Seizures
___Vertigo or dizziness
___Paralysis
___Muscle weakness
___Numbness/tingling
___Loss of balance
___Loss of memory

Skin
___Rashes
___Color change
___Eczema
___Fungus
___Hair Loss
___Dry Skin
___Night Sweats

Head
___Headaches
___Migraines
___Head Injury
___Jaw/TMJ problems
___Faintness

Respiratory
___Cough
___Pain on breathing
___Wheezing or asthma
___Shortness of breath
___Bronchitis/Pneumonia
___Spitting up blood

Nose and Sinuses
___Stuffiness
___Nose bleeds
___Hay fever
___Sinus problems
___Loss of smell
___Sinus headaches

Ears
___Impaired Hearing
___Earaches
___Ringing
___Itching

Mouth and Throat
___Teeth grinding
___Hoarseness
___Copious saliva
___Dry Mouth
___Gum Problems
___Sore tongue or lips
___Frequent sore throat
___Mouth sores

Eyes
___Floaters or "spots"
___Cataracts
___Blurriness
___Double Vision
___Glaucoma
___Near/Far sightedness
___Tearing or dryness
___Eye pain/strain

Musculoskeletal
___Joint Pain
___Joint Stiffness
___Arthritis
___Weakness
___Sciatica
___Broken bones
___Muscle pain
___Osteoporosis

Urinary/Kidney
___Pain on urination
___Increases Frequency
___Frequency at night
___Kidney stones
___Infections
___Urine leakage

Cardiovascular
___Heart Disease
___Murmurs
___Chest Pain
___Poor circulation
___Blood clots
___Deep leg pain
___High/Low Blood Pressure
___Palpitations
___Easy bruising
___Anemia
___Varicose veins
___Fainting
___Swelling in ankles
___Body Temp (cold/hot)

Reproductive
___Pain with intercourse
___Chlamydia
___Herpes
___Genital warts
___Discharge or sores
___Sexual difficulties
___Trouble conceiving

Gastrointestinal
___Trouble swallowing
___Nausea
___Vomiting
___Diarrhea and or constipation
___Belching/Burping
___Passing gas
___Change in appetite
___Heartburn
___Ulcer
___Change in thirst
___Hemorrhoids
___Pain or cramping
___Black/Bloody stool
___Blood in toilet

Bowel Movements: How Often?__________
Is this a change?___________
Stools: Hard_____ Soft:_____ Firm:_____ Loose:_____
Cramping?________

Female only

___Date of Last Period?
___Are cycles regular?
___Irregular Cycles
___PMS
___ Bleeding between cycles
___Heavy cycles
___Discharge ______Color
___Painful menses
___Endometriosis
___Menopausal symptoms
___Breast lumps or pain
___Nipple discharge
___Do you do self breast exams?
___Birth Control? Type:_______________________________________

___Length of Cycle(day 1 to day 1)
___Duration of flow
___Age of first menses
___Age of last menses
___Clotting
___Date of last Pap
___Abnormal paps
___Ovarian cysts
___# of pregnancies
___# of miscarriages
___# of live births
___# of abortions
____Could you be pregnant now?

Male Only

___Hernias
___Testicular mass
___Prostate disease
___Impotence
___Testicular pain
___Premature ejaculation
___Discharge or sores

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages(if living)							
Current Health							
Age at Death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer ________________________ High Blood Pressure ____________ Allergies _______________________
Stroke _________________________ Diabetes________________________ Asthma ________________________
Anemia ________________________ Epilepsy________________________ Mental Illness __________________
Kidney Disease ________________ Glaucoma_______________________ Arthritis ________________________
Heart Disease _________________ Tuberculosis____________________ Alzheimer's Dz _________________

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever ____ Diphtheria ____ Rheumatic fever ____ Mumps ____ Measles ____ German measles __

Have you had any immunizations? Yes No Negative Reactions? ________________________________

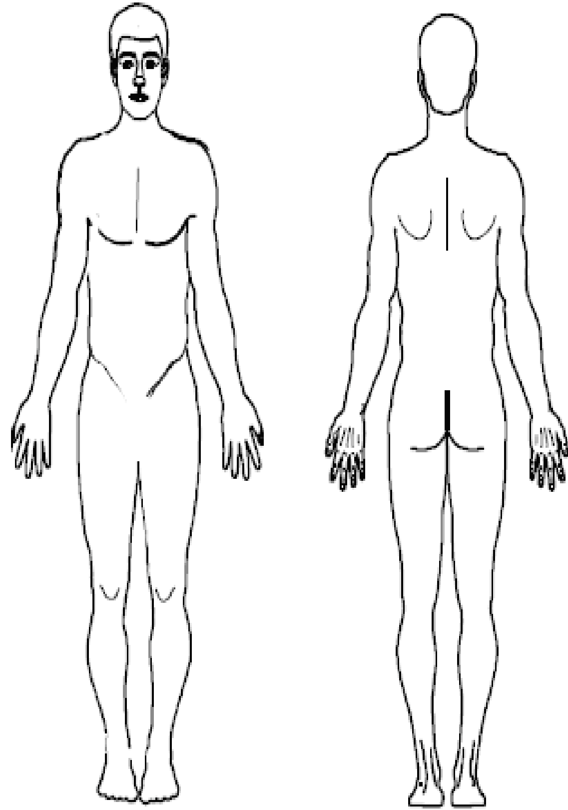
Typical:

Breakfast____
Lunch:____
Dinner:____
Snacks:____
Cravings?:____
Energy Dips (and when):____
How much water do you drink daily?____
Food intolerances (if known)-____

Lifestyle Habits

Main interest and hobbies?_____________
Exercise? How often?_________________
What kind?__________________________
__Y__N Have a religious/spiritual practice?
__Y __N Sleep well? Avg amount:________
__Y __N Have a supportive relationship
__Y __N History of abuse
__Y __N Major traumas
__Y __N Use recreational drugs
__Y __N Treated for drug dependence
__Y __N Drink coffee How Much?________
__Y __N Drink black/green tea How Much_____
__Y __N Drink cola/other soda How Much_____
__Y __N Add salt to you food
__Y __N Eat refined sugar
__Y __N Use alcoholic beverages # per wk?_____
__Y __N Treated for alcoholism
__Y __N Use tobacco currently How Much?_____
__Y __N Used tobacco in the past?
How many years?______ Packs per day?__
__Y __N Enjoy your work?
__Y __N Take vacations
__Y __N Spend time outside
__Y __N Watch TV? How much?______________
__Y __N Read? How often?__________________

Please shade in areas where you are experiencing pain on figures (if applicable)



A few final questions (thank you!)

How does your health condition affect your life on an ongoing basis?_________________________________
____

How would your life be different if you did not have this condition?__________________________________

On a scale of 1-10, how committed are you to improving your state of health?__________________________

On a scale of 1-10, how much change are you willing to make at this time for improving your state of health?____

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?
____
____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive life style habits?____
____

What is going right in your life?____
____
____

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PERSONAL & WORK INFORMATION

Patient Name:____Date:_____________________ Date of Injury/Accident_______

Address:____City:_________________________State:_________ Zip:________

Home Phone:__________________________________ Cell Phone:_____________________________ Work Phone:_____________________

Birthdate:______________________ M F Single Married Other___________ Partner's Name:___________________________

Email:____ Occupation:_________________________ Employed by: _____________________

Business Address: ____ City:__________________________ State:_________ Zip: _______

FINANCIAL & INSURANCE INFORMATION

Please choose one: I will pay my balance in full at time of service **OR**

Do you have Medical Insurance that covers Acupuncture Yes No If yes, please check type of insurance : Group Insurance

Workman's Comp Personal Injury Other____

Insurance Co:____

Address:____

City:________________________________ State: ______ Zip:____________ Phone :____

Claim #(if **workman comp or auto injury**) : ____

Adjuster: ____Phone #:____

Attorney's Name:___________________________________ Phone#: _______________________________ PIP coverage:_______________

Group Insurance :ID/Policy #: ____ Group : _______________________________

Insured Name: self ___________________________________(please fill in) Insured Address (if diff.)_____________________________

City: _________________________________ State: __________ Zip :________________ Insured Phone#: ____________________________

Insured Social Sec. #: ____________________________ Insured Birthdate:_____/_____/_____ Insured Relationship to Patient: Spouse Child

Partner Insured M F Insured Employer: ____

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the **release of any information** relating to claims for benefits submitted. I further agree and authorize Stephanie Petix Willard, L.Ac. to submit claims for benefits, for services rendered, without obtaining my signature on each claim.

I (patient) ____ hereby authorize (Insurance Co.)____ to pay and hereby assign directly to Stephanie Petix Willard, L.Ac. all owed benefits. **I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company.** This authorization shall remain valid until written notice is given to me revoking said authorization.

Signature of Patient ____ Date _____________________________________

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Consent to Treatment

I, ____, hereby acknowledge that being treated with Oriental Medicine can include any of the following techniques:

1. Acupuncture – This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise (not painful). Various styles and sizes of acupuncture needles will be inserted into my body at various depths and locations.

2. Heat treatments using Artemesia vulgaris (moxibustion) 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 a needle or on top of a barrier (such as a slice of ginger or salt) which rests on the skin. When direct moxa is used, a very tiny amount of moxa is placed directly on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat, there is always risk of a burn.

3. Gua Sha is scraping on the skin using a smooth-edged instrument and may produce red or purple discoloration of the skin (similar to a bruise) which may remain for 1 to 7 days. There may also be a slight tenderness in the area treated.

4. A method called “cupping” involves placing glass cups over the skin to produce a vacuum and promote the circulation of “qi”, or energy, through the meridians. Cupping may also produce skin discoloration and tenderness 1 to 7 days after the treatment.

5. There is a technique called “bloodletting” which is rarely used, except for conditions with extreme heat, such as fever, sunburn, or swollen areas of the body. This treatment involves a slight prick at the fingers or toes to allow a few drops of blood to escape. This technique may also be used in cases of severe, local blood stagnation, such as in the case of surface varicose veins.

6. Electro-acupuncture may be performed in cases of pain or stagnation in order to facilitate the movement of qi and blood. This technique involves clipping a wire to the body of the needle in order to deliver a mild electrical current. I acknowledge that I may experience a slight buzzing or tingling sensation around the needle.

7. The practitioner may leave press-balls, press-tacks, press-seeds, intradermals, or magnets on my body. I will receive directions on how to care for, how to and when to dispose of the healing adjuncts.

8. There is a Japanese technique called “Manaka’s hammer” which involves a soft tapping on the skin with a small wooden hammer. This method is used to move the qi locally or in the channels and there are typically no side-effects from this treatment.

9. I may also receive herbal prescriptions or recommendations pertaining to nutrition, diet, exercise, or other life-style habits. I understand that I am not required to take these herbal

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, which I associate with these substances, I should suspend taking them and call the clinic as soon as possible.*

The acupuncture practitioner must be advised if the patient has a pacemaker or a bleeding disorder, might be pregnant, or has a contagious disease. If the patient has a potentially serious condition that is out of the practitioner's scope of practice, the patient will be referred to the emergency room or to a licensed physician with regard but not limited to : cardiac conditions including uncontrolled hypertension; acute, severe abdominal pain; acute undiagnosed neurological changes; unexplained weight loss or gain in a three month period; suspected fracture or dislocations suspected systemic infections; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history.

I have been informed that I have the right to refuse any form of treatment and that I have the right to terminate our treatments at any time. I understand the nature of the treatment, have been informed of the risks and possible consequence involved with this treatment, and was given the opportunity to ask questions pertaining to my treatment. I also understand that there is always the possibility of unexpected complication and I understand that no guarantee can be made concerning the results of the treatment. I am aware that acupuncture, oriental medicine, or alternative care does not substitute appropriate advice and care from a licensed medical doctor.

I have carefully read and understand all of the above information and am fully aware what I am signing, I give my permission and consent to treatment.

Printed Name: ____

Signature: ____

Date: _____________________________

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Patient Name: ______________________________ **Insurance ID**: ___________________

1. *Name of the Representative* I am speaking with: __________________ Date: ____________

2. When did my coverage begin_______________and when is it valid through_______________

3. Is Stephanie Petix Willard, Lac an *In-Network* or a *Preferred Provider* with my insurance company?
   Yes__________ No ________________

4. What are my benefits? ~*be sure to find out the details. There will be different benefits depending on whether I am In-Network or Out-Of-Network, and whether your plan includes Out-Of Network benefits.*

   % Covered________
   Copay____________
   Year Max - $______________ #of Visits____________

5. Are my alternative claims billed to American Specialty Health? ___________

6. What is my deductible for the year and has any or all of it been met?

   Deductible__________ Amount of Deductible met so far $________ Date_________

7. What year is my deductible based on? (When does it renew)___________________

Assignment of insurance benefits and verification acknowledgement

I acknowledge that the above listed coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Stephanie Petix Willard, Lac. I also understand that all out-of-network (non contracted) insurance billing services provided by Stephanie Petix Willard, Lac on my behalf are performed on a courtesy basis and can be discontinued by either myself or Stephanie Petix Willard, Lac, with a written notice at any time. I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to Stephanie Petix Willard, Lac. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Signature____

Date_______________________

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Notice of Privacy Practices

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Stephanie Petix Willard, LAc clinic and you may obtain one at any time. This Notice goes into effect February 3, 2008.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan.

Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Research.** For medical research – Such circumstances include taking steps to protect your privacy.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage

Patient Rights

Right to request restrictions on uses and disclosures: To request a restriction, please write a request to Portland Alternative Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.
Right to receive confidential communications: This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via Email than by regular mail. To verify or modify where or how you would like communication sent, contact Stephanie Petix Willard, LAc. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.
Right to inspect and copy. Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Stephanie Petix Willard, Lac, and we will respond to you within 30 days of receipt of your written request. We will charge you a reasonable copying fee for each page and mailing costs but will inform you of that fee in advance.
Right to amend: If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Stephanie Petix Willard, LAc. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.
Right to receive an accounting of disclosures. This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting (can be no longer than 6 years and may not include dates before April 14, 2003). The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.
Right to get a paper copy of this Notice. At any time even if you previously agreed to receive an electronic copy.
Right to file a complaint. If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Stephanie Petix Willard, LAc to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

Patient Name (Please print)____
Patient/Guardian Signature____ Date___________________

Relationship to Patient (if other than self):____
Note: if this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.