

# Stephanie Petix, L.Ac.

1033 SW Yamhill Street, Suite 100

Portland, OR 97205

503-227-8781

## 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?

\_\_\_\_\_

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How long has it been present:-----  
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Secondary  
Complaints:-----  
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Allergies:-----  
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Medications (include non-prescription, vitamins, supplements, etc.)-----  
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Previous Hospitalizations/Surgeries/Serious Illnesses

When?

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

**Mental/Emotional**

- \_\_\_Mood Swings/Depression Syndrome
- \_\_\_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
- \_\_\_Chronically swollen glands
- \_\_\_Chronic infections
- \_\_\_Frequent colds
- \_\_\_Autoimmune disease
- \_\_\_Allergies or hay fever

**Neurologic**

- \_\_\_Seizures
- \_\_\_Vertigo or dizziness
- \_\_\_Paralysis
- \_\_\_Muscle weakness
- \_\_\_Numbness/tingling

**Skin**

- \_\_\_Rashes
- \_\_\_Color change
- \_\_\_Eczema
- \_\_\_Fungus

**Head**

- \_\_\_Headaches
- \_\_\_Migraines
- \_\_\_Head Injury
- \_\_\_Jaw/TMJ problems

- \_\_\_ Loss of balance
- \_\_\_ Loss of memory

**Respiratory**

- \_\_\_ Cough
- \_\_\_ Pain on breathing
- \_\_\_ Wheezing or asthma
- \_\_\_ Shortness of breath
- \_\_\_ Bronchitis
- \_\_\_ Spitting up blood

**Mouth and Throat**

- \_\_\_ Teeth grinding
- \_\_\_ Hoarseness
- \_\_\_ Copious saliva
- \_\_\_ Dry Mouth
- \_\_\_ Gum Problems
- \_\_\_ Sore tongue or lips
- \_\_\_ Frequent sore throat
- \_\_\_ Mouth sores

**Urinary/Kidney**

- \_\_\_ Pain on urination
- \_\_\_ Increases Frequency
- \_\_\_ Frequency at night
- \_\_\_ Kidney stones
- \_\_\_ Infections
- \_\_\_ Urine leakage

**Reproductive**

- \_\_\_ Pain with intercourse
- \_\_\_ Chlamydia
- \_\_\_ Herpes
- \_\_\_ Genital warts
- \_\_\_ Discharge or sores
- \_\_\_ Sexual difficulties
- \_\_\_ Trouble conceiving

**Nose and Sinuses**

- \_\_\_ Stuffiness
- \_\_\_ Nose bleeds
- \_\_\_ Hay fever
- \_\_\_ Sinus problems
- \_\_\_ Loss of smell
- \_\_\_ Sinus headaches

**Eyes**

- \_\_\_ Floaters or "spots"
- \_\_\_ Cataracts
- \_\_\_ Blurriness
- \_\_\_ Double Vision
- \_\_\_ Glaucoma
- \_\_\_ Near/Far sightedness
- \_\_\_ Tearing or dryness
- \_\_\_ Eye pain/strain

**Cardiovascular**

- \_\_\_ Heart Disease
- \_\_\_ Murmurs
- \_\_\_ Chest Pain
- \_\_\_ Poor circulation
- \_\_\_ Blood clots
- \_\_\_ Deep leg pain

**Gastrointestinal**

- \_\_\_ Trouble swallowing
- \_\_\_ Nausea
- \_\_\_ Vomiting
- \_\_\_ Diarrhea
- \_\_\_ Belching
- \_\_\_ Passing gas
- \_\_\_ Change in appetite
- \_\_\_ Constipation

**Ears**

- \_\_\_ Impaired Hearing
- \_\_\_ Earaches
- \_\_\_ Ringing

**Musculoskeletal**

- \_\_\_ Joint Pain
- \_\_\_ Joint Stiffness
- \_\_\_ Arthritis
- \_\_\_ Weakness
- \_\_\_ Sciatica
- \_\_\_ Broken bones
- \_\_\_ Muscle pain
- \_\_\_ Osteoporosis

- \_\_\_ Palpitations
- \_\_\_ Easy bruising
- \_\_\_ Anemia
- \_\_\_ Varicose veins
- \_\_\_ Fainting
- \_\_\_ Swelling in ankles

- \_\_\_ Heartburn
- \_\_\_ Ulcer
- \_\_\_ Change in thirst
- \_\_\_ Hemorrhoids
- \_\_\_ Pain or cramping
- \_\_\_ Black stool
- \_\_\_ Blood in toilet

**Female only**

- \_\_\_ How many days of bleeding per cycle?
- \_\_\_ Are cycles regular?
- \_\_\_ PMS
- \_\_\_ Length of cycle (days)
- \_\_\_ Bleeding between cycles
- \_\_\_ Discharge
- \_\_\_ Painful menses
- \_\_\_ Endometriosis
- \_\_\_ Menopausal symptoms
- \_\_\_ Breast lumps or pain
- \_\_\_ Nipple discharge
- \_\_\_ Do you do self breast exams?

- \_\_\_ Age of first menses
- \_\_\_ Clotting
- \_\_\_ Heavy cycles
- \_\_\_ Abnormal paps
- \_\_\_ Ovarian cysts
- \_\_\_ # of pregnancies
- \_\_\_ # of miscarriages
- \_\_\_ # of live births
- \_\_\_ # of abortions

**Male Only**

- \_\_\_ Hernias
- \_\_\_ Testicular mass
- \_\_\_ Prostate disease
- \_\_\_ Impotence
- \_\_\_ Testicular pain
- \_\_\_ Premature ejaculation

**Habits**

Do you exercise? \_\_\_\_\_ If yes, what kind and how often? \_\_\_\_\_

Do you have a spiritual practice? \_\_\_\_\_ If yes, what kind? \_\_\_\_\_

How many hours do you sleep? \_\_\_\_\_ Do you sleep well? \_\_\_\_\_

Drink coffee? \_\_\_\_\_ Drink cola? \_\_\_\_\_ Eat 3 meals a day? \_\_\_\_\_

Use tobacco? \_\_\_\_\_ Use alcoholic beverages? \_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_

Food intolerances (if known)-  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 is going right in your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as a 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 or treatment. I understand that this information serves as:

1. a basis for planning my care and treatment
2. a means of communication among the many health professionals who contribute to my care
3. a source of information for applying my diagnosis to my bill
4. a means by which a third-party payer can verify that services billed were actually provided
5. and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to review the *Notice of Information Practices* prior to signing this document. The *Notice of Information Practices* describes in detail the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Symmetry Health Alliance. I understand that Symmetry Health Alliance reserves the right to change their *Notice of Information Practices* at any time. I may obtain a revised *Notice of Information Practices* by requesting the most current notice during any office visit. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Signature: \_\_\_\_\_ Name of  
minor: \_\_\_\_\_  
Printed name: \_\_\_\_\_ Relationship:  
\_\_\_\_\_

Date:\_\_\_\_\_

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## Office Policies and Financial Agreement

### Office hours and appointments:

- 1) The office is open Monday through Saturday, by appointment only.
- 2) please call 24 hours in advance to cancel or change an appointment or you will be charged a \$50 fee. Insurance will not cover missed appointments, therefore patients who are billing their insurance are also required to give 24 hours notice or pay the cash cost for missed treatments.

### Insurance:

If your insurance policy is qualified and proven to cover our care, we will agree to bill your insurance company directly. This is with the understanding that your insurance policy is a contract between you and your insurance company – we cannot guarantee payment of your claims. If your insurance company pays only a portion of your bill or rejects your claim, you are still financially responsible for the remainder of your claim.

### Automobile Accident or Personal Injury

It is our office policy that your payment of fees, with the exception of reports, will be deferred until the case is settled, provided the following conditions are satisfied:

- 1) That a “Practitioner’s Lien Form” is signed by you and your attorney. This allows the acupuncturist’s fees to be paid from the final settlement.
- 2) That the “Irrevocable Assignment and Consent to Disbursement Form” is signed by you. This form states that you are financially responsible to pay the fees incurred if they are not paid in full from the final settlement.
- 3) That the merits of your case are established by your attorney and communicated to the acupuncturist.

### On the Job Injury:

Worker’s compensation coverage in lieu of payment at the time is accepted, provided we have an authorization signed by your employer or supervisor authorizing care, as well as an authorization from your worker’s compensation company.

The best care can only be provided on the basis of mutual understanding. We, therefore, encourage you to discuss any financial problems or questions that you have at this time. Thank you.

I, \_\_\_\_\_, understand and agree with this policy.

Patient's Signature \_\_\_\_\_

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:**

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-----

**Signature:**

-----  
-----

**Date:** -----

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## PERSONAL & WORK INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Date of

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work

Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_  M  F Social Security # \_\_\_\_\_  Single  Married

Divorced  Separated  Widowed

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employed

by: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

How did you learn about our practice?  Friend  Ad  Internet  Drive-by  health professional  other:

\_\_\_\_\_

## FINANCIAL & INSURANCE INFORMATION

Please choose one:  I will pay my balance in full at time of service  I prefer to make payment arrangements prior to services being rendered

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

Workman's Comp  Personal Injury  Other

Insurance Co: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone : \_\_\_\_\_ Adjuster: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_ Group or Plan or Program: \_\_\_\_\_

Insured Name:  self  \_\_\_\_\_ (please fill in below) Insured Address: \_\_\_\_\_

Insured City: \_\_\_\_\_ State: \_\_\_\_\_ Zip : \_\_\_\_\_ Insured Phone#: \_\_\_\_\_

Insured Social Sec. #: \_\_\_\_\_ Insured Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured Relationship to Patient:

Spouse  Child  Partner

Insured  M  F Insured Employer & Address:

\_\_\_\_\_

## **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, L.Ac. of Symmetry Health Alliance 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, 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 \_\_\_\_\_

\_\_\_\_\_