

Acupuncture northwest

Acupuncture, Herbal Medicine
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Patty Kuchar, L.Ac.

Welcome to Acupuncture Northwest. Acupuncture is a safe and effective way to achieve and maintain health. Your first visit as an acupuncture patient will include a complete medical history, an acupuncture treatment, and an herbal consult (optional depending on reason for the visit and patient preference). Please feel free to ask any questions regarding your treatment. Many of the procedures may be a new experience for you and it is important for you to be able to relax during the treatment and afterward as well. Thank you for choosing Acupuncture Northwest for your health care needs.

1. **Payment for Services Rendered:** You are responsible for all services received at this office and are expected to pay in full at the time of service. Once insurance has been verified the co-payment will be due at the time of service. Frequently, insurance companies make up their own rules and redefine 'Usual and customary' charges which means you may have to pay more than your anticipated co-pay. You are expected to pay any unpaid balance in a timely manner. This applies in a legal case, motor vehicle accidents, insurance disputes, and with children of divorced parents.

Any supplements or herbs that you receive are to be paid for at the time you receive them. If you are experiencing financial difficulty, please talk with one of us at the front desk.

2. **Cancellations:** Cancellations made with less than 24 hours notice will be charged the full fee. In case of emergency it is up to the clinician as to whether or not you will be charged.

3. **Supplements/herbs:** Please give us 2-3 days notice if you need refills.

I agree to all of the above conditions:

Signature _____ Date _____

Patty Kuchar, L.Ac.

PATIENT INTAKE FORM

Name _____ Phone Home () _____ Work() _____ E-Mail _____

Street _____ City: _____ State: _____ Zip _____

Date of Birth _____ Age: _____ Height: _____ Occupation: _____

Marital Status: _____ Number of children: _____ Referred By: _____

Social Security # _____ Physician: _____ Date of last exam: _____

Emergency Contact: _____ Relationship: _____ Phone() _____

Health History Questionnaire

Successful health care and preventive medicine are only possible when the healthcare practitioner has a complete understanding of the patient physically, mentally and emotionally. To assist me in best serving you, please complete this questionnaire as thoroughly as possible. Print all information and mark anything you do not understand with a question. Thank you.

What is your primary concern, condition, injury or illness? _____

Date it began: _____

Describe what caused it or how it started: _____

How does this condition affect you? _____

Have you had this condition or similar condition before? _____

Have you received treatment for this condition? _____ If yes, When? _____

From Whom? _____ what was the diagnosis? _____

Results? _____

Is the condition: _____ Better _____ Worse _____ about the same

Patient Name _____

Date _____

What makes the condition better? _____

What makes the condition worse? _____

What do you think is happening? And why? _____

What are your most important health concerns? List as many as you can in order of importance.

1] _____

2] _____

3] _____

4] _____

Family Medical History: [this refers to your extended family]

_____ Cancer	_____ Diabetes	_____ Allergies
_____ High-Low Blood Pressure	_____ TB	_____ Asthma
_____ Heart Disease	_____ Epilepsy	_____ Hives
_____ Kidney Disease	_____ Ulcers	_____ Sinus Problems
_____ Liver Disease	_____ Arthritis	_____ Alcoholism
_____ Eye Disease	_____ Stroke	_____ Hayfever
_____ Mental Disorders	_____ Anemia	_____ Drug Addiction
_____ Spinal Problems	_____ Other	_____

Age Parents Died and Cause of Death: Mother _____

Father _____

Personal Medical History: [Include Date]:

Major Surgeries: _____

Illnesses: _____

Diseases: _____

Accidents: _____

Childhood Illnesses: [Circle Yes or No]

Y N Scarlet Fever Y N Diphtheria Y N Mumps

Y N Rheumatic Fever Y N German Measles Y N Measles

Allergies:

Are you hypersensitive or allergic to: Any
drugs? _____

Any Foods? _____

Patient Name _____

Date _____

Current Medications: Do you take or use:

Laxatives	Y N	Pain Relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite Suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid Medication	Y N	Sleeping Pills	Y N

Please list any prescription medications, over the counter medications, vitamin, and other supplements you are taking.

1] _____ 4] _____
 2] _____ 5] _____
 3] _____ 6] _____

Contagious Diseases: Check if you have ever had any of the following:

_____ Hepatitis	_____ Herpes	_____ Venereal disease
_____ HIV+	_____ AIDS	_____ Other _____

Lifestyle:

Habits: please mark box with 'P' for past use and with "C" for current use.

_____ Cigarettes	_____ Soft Drinks	_____ Salt
_____ Coffee	_____ Alcohol	_____ Recreational Drugs
_____ Black Tea	_____ Sugar	_____ Stress

Have you ever been treated for alcoholism or drug dependence? Y N

Exercise:

___ None ___ Little ___ Moderate ___ Heavy

What exercise do you regularly do and how often? _____

Do you do any form of realization regularly? ___ Yoga ___ Tai Chi
 ___ Meditation ___ Qi Gong ___ Guided Relaxation ___ Breathwork

emotions: Check all that apply. Put 2 check by the two most predominant ones in your life

___ Happy	___ Easily Irritable	___ Restless	___ Angry
___ Cry Easily	___ Hurry to do things	___ Depression	___ Stressed
___ Anxious	___ Other _____		

Do you have a history of physical or emotional abuse? Y N

Have you experienced any major traumas? Y N More than 2 in 1 yr.? Y N
[i.e. divorce, change of residence, injury, loss of job, death in family, bankruptcy, etc.]

Patient Name _____

Date _____

Do you enjoy your work? Y N
Do you have a supportive relationship? Y N

Diet: Check which you eat typically.

Beef Eggs Cheese Grains Tofu Pork
 Bread Margarine Fried Foods Yogurt Poultry Milk
 Butter Sweets Fish Salads Vegetables
 Ice cream Health foods Hot Spicy Food

Other: _____ Cravings: _____

Do you eat 3 meals per day? Y N Do you eat at regular times? Y N

Appetite:

Up & Down Poor Good Hungry A Lot Loss of Taste

Weight:

Normal Underweight Overweight Recent Gain Recent Loss

energy:

Up & Down Low Normal Excess Low after Eating
 Tired in Afternoon

General Symptoms: Put check mark if experiencing any of these symptoms now

Warm Natured Flush Face Feel Warmer Late Afternoon & Night
 Cold Natures Warm Palms Alternate Chills & Fever
 Cold Hands & Feet Warm Soles Normal
 Aversion to Cold Aversion to Heat Aversion to Wind

Other: _____

perspiration:

Very Little Easily Nightsweats Profuse
 Palms Bad Smell Without exertion Feet
 Normal Other: _____

Digestion:

Indigestion Nervous Stomach Bloating
 Heartburn Nausea/Vomit Belch/Burp
 Gall Stones Stomach Noises Bad Breath
 Gas Abdominal Pain/Cramps Weight Problem
 Bitter Taste Full Feeling/Distention Normal
 Difficulty Digesting Fatty/Oily Foods Other: _____

Patient Name _____ Date _____

Bowels:

- | | | |
|---|---|---|
| <input type="checkbox"/> Loose Stool | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Undigested food in Stool | <input type="checkbox"/> Stool with Bad Smell | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Anus Itch | <input type="checkbox"/> Mucous in Stool |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Burning Anus | <input type="checkbox"/> Black Stool |
| <input type="checkbox"/> Small Amount of Stool | <input type="checkbox"/> Hard Stool | <input type="checkbox"/> Intestinal Worms |
| <input type="checkbox"/> Pain or Cramps | <input type="checkbox"/> Laxatives Used | <input type="checkbox"/> Normal |

Other: _____

Urination: [3-4 times per day is normal]

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Frequent | <input type="checkbox"/> Burning | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Nighttime | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Profuse | <input type="checkbox"/> Pus |
| <input type="checkbox"/> Kidney Stones/Infections | <input type="checkbox"/> Strong Smell | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Scanty | <input type="checkbox"/> Not Normal Color |
| <input type="checkbox"/> Normal | Other _____ | |

Thirst:

- | | | |
|---|--|---|
| <input type="checkbox"/> Less than Normal | <input type="checkbox"/> Excessive | <input type="checkbox"/> Prefer Cold Drinks |
| <input type="checkbox"/> Thirsty but do not Drink | <input type="checkbox"/> Prefer Hot Drinks | <input type="checkbox"/> Normal |

Sleep:

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Lots of Dreams | <input type="checkbox"/> Awaken Easily |
| <input type="checkbox"/> Sleep too Much | <input type="checkbox"/> Tired on Rising in A.M. | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Restless | <input type="checkbox"/> Difficulty going back to Sleep | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Vivid Dreams | <input type="checkbox"/> Normal | <input type="checkbox"/> Hours of sleep |

Headaches/Dizziness:

- | | | | |
|--|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Dizzy on Standing | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Faint Easily | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Normal | Other: _____ | |

Skin:

- | | | | |
|---|----------------------------------|---|------------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Hives | <input type="checkbox"/> Clammy Skin | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Oily | <input type="checkbox"/> Pimples | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Dry Scalp |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Moles | <input type="checkbox"/> Cuts Heal Slowly | <input type="checkbox"/> Cysts |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Warts | <input type="checkbox"/> Yellow Skin | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Eczemza | <input type="checkbox"/> Boils | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Body Odor |
| <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Normal | Other: _____ | |

Hair:

- | | | | | | |
|------------------------------|-------------------------------|-----------------------------------|-------------------------------------|---|---------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Oily | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Early Grey | <input type="checkbox"/> Thinning or loss | <input type="checkbox"/> Normal |
|------------------------------|-------------------------------|-----------------------------------|-------------------------------------|---|---------------------------------|

Patient Name _____

Date _____

Nails:

- Soft Spots Grow Slow Grow Fast
- Pale Break Easily Ridges & Lines Purple
- Normal Other: _____

Eyes:

- Wear Glasses of contacts Eyelids Swollen Cataracts
- Spots or Lines in vision Inflammation Glaucoma
- Pale Under Eyelids Yellow Sclera Blink
- Poor Night Vision Failing Vision Itch
- Sensitive to Light Sty History Twitch
- Color Blindness Blurry Vision Pain
- Dark Under the Eyes Tear Easily Other: _____

Nose:

- Stuffy Nose Hayfever Sneeze a lot Rhinitis
- Mucous Bleeding Loss of smell Sinusitis
- Blow Nose a Lot Normal Environmental Sensitivity
- Other: _____

Mouth & throat:

- Dry Gum Problems Hoarseness
- Frequent Sore Throats Sores in Mouth/Tongue Frequent Colds
- Difficulty Swallowing Dry Cracked Lips TMJ Syndrome
- Thyroid Problem Hiccups Drool A Lot
- Swollen Glands Grind Teeth Teeth Problems
- Bitter Taste in Mouth Feel Lump in Throat Loose Teeth
- Tonsillitis Normal Other: _____

Ears:

- Hearing Loss Sensitive to Cold Sensitive to Noise
- Ringing in Ears-High Pitch Ringing -Low Pitch Normal
- Other: _____

Respiratory:

- Shortness of Breath Difficulty Inhaling Sigh a Lot
- Chest Pain Difficulty Exhaling Dry Cough
- Asthma Shallow Breathing Cough with Phlegm
- Bronchitis Cough A Lot Cough with Blood
- Tightness in Chest Difficulty Breathing when Lying Down
- Normal Other: _____

Patient Name _____

Date _____

Cardiovascular-circulation:

- | | | |
|---|---|--|
| <input type="checkbox"/> Diagnosed Heart Problems | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Bleed Easily |
| <input type="checkbox"/> Broken Vessels/Capillaries | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Blood pressure |
| <input type="checkbox"/> Purple Vessels/Capillaries | <input type="checkbox"/> Murmur | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> History of Anemia | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Facial Swelling | <input type="checkbox"/> Slow Heartbeat | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Hand Swelling | <input type="checkbox"/> Fast Heartbeat | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Numbness of Extremities | <input type="checkbox"/> Normal | Other: _____ |

Pain:

- | | | |
|--|---|--|
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Spine | <input type="checkbox"/> Hands or wrists |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Knees | <input type="checkbox"/> Hips |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Foot or Ankle | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Fullness below ribs | <input type="checkbox"/> Weak Legs/Knees | <input type="checkbox"/> Nerve Pain |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Flank Area |
| <input type="checkbox"/> Muscle twitching or spasm | <input type="checkbox"/> Damp Weather Bothers You | |
- Other: _____

Miscellaneous:

Are there any other problems you would like to discuss? _____

Males Only: Please check or explain as applicable.

- | | |
|---|-------|
| <input type="checkbox"/> Reduced Sex Drive | _____ |
| <input type="checkbox"/> Premature Ejaculation | _____ |
| <input type="checkbox"/> Seminal Emission | _____ |
| <input type="checkbox"/> Impotence | _____ |
| <input type="checkbox"/> Discharge | _____ |
| <input type="checkbox"/> Genital Pain | _____ |
| <input type="checkbox"/> Prostate Problems | _____ |
| <input type="checkbox"/> Painful or Burning Urine | _____ |
| <input type="checkbox"/> Dribbling of Urine | _____ |

For Females Only:

Are you or might you be pregnant? Y N Maybe

If Yes, Approximate date of conception? _____

Are you experiencing reduced sex drive? Y N

Are you experiencing other difficulties? Y N

Explain: _____

Regular PAP tests? Y N How Regular? _____ Date of last PAP _____

Patient Name _____

Date _____

Do You have facial hair or excess body hair? ___Y ___N

Do you have or do yourself regular breast exams? ___Y ___N

How Regular? _____ -

Menstual cycle: Please check and explain as applicable.

Age started _____ Days of Flow _____ Age Stopped _____

How many days from the beginning of your period to the start of your next period? _____

___ Irregular _____

___ Painful _____

___ Heavy Flow _____

___ Scanty Flow _____

___ Dark Color Flow _____

___ Light Color Flow _____

___ Clotting _____

___ PMS _____

___ Water Retention _____

___ Abdominal Bloating _____

___ Painful or Tender Breasts _____

___ Emotional Changes _____

___ Spotting Between Periods _____

___ Lump in Throat Feeling _____

___ Constipation and/or Diarrhea _____

___ Tightness on Chest _____

___ Hormonal Problems _____

___ Backache _____

___ Sigh A Lot _____

Vaginal Discharges:

___ Yellow _____

___ Thick _____

___ Bad Odor _____

___ White _____

___ Clear _____

___ Other _____

Ovulation Symptoms _____

Menopause Problems _____

Pregnancies:

Total Number _____ Number of Miscarriages _____ Number of Children _____

Number of Abortions _____

Patient Name _____

Date _____

Pregnancy or Childbirth Complications

Gynecological History or Operations:

Ovaries _____
Uterus _____
Fallopian Tubes _____
Vagina _____
Breasts _____
Other _____

What method of birth control do you use now? _____

What methods of birth control have you used in the past? _____

Thank you for completing this questionnaire. Your answers will assist in planning the most appropriate treatment for your condition{s} based on your lifestyle and constitutional profile. If you have any questions, please ask.

Date:

Tongue:

Pulse:

Rate:

Left:

Right:

Diagnosis:

Treatment Plan:

Recommendations:

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Longview, WA 98632
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Patty Kuchar, L.Ac.

INSURANCE FORM

Name _____ SSN _____

Address _____ City _____ Zip _____

Home phone() _____ Work Phone () _____

Are You: () Married () Single () Widowed Date Of Birth _____

Employer Name _____ Address _____

Spouse's Name (if Married) _____

Spouse's Date of Birth _____ SSN _____

if insurance coverage is under spouse's employer, please furnish the following:

Employer Name _____ Address _____

Phone () _____ Work: () full-time () part-time () unemployed

INSURANCE INFORMATION

Insurance Company Name _____

Insurance ID # _____ Group # _____

Under Whose Name is coverage provided? _____

Address to send claims _____

Authorization for payment: I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the provider herein for services and treatment received by me.

Signature _____ Date _____