Acupuncture northwest

Acupuncture, Herbal Medicine
1328 9TH Ave.
Longview, WA 98632
(360) 636-0991
Fax (360) 636-5255

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______________________________

Acupuncture Northwest

Acupuncture, Herbal Medicine
1328 9th Ave.
Longview, WA 98632
(360) 636-0991
FAX (360) 636-5255

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:_____________

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 diangnosis?___________________________
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 ________Veneral 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:

_______Loose Stool ____Blood in Stool _____Diarrhea
_______Undigested food in Stool ____Stool with Bad Smell _____Hemorrhoids
_______Constipation ____Anus Itch _____Mucous in Stool
_______Colon Problems ____Burning Anus _____Black Stool
_______Small Amount of Stool ____Hard Stool _____Intestinal Worms
_______Pain or Cramps ____Laxatives Used _____Normal
Other: ____

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

_____Frequent ____Burning _____Bladder Infections
_____Urgency ____Nighttime _____Blood
_____Incontinence ____Profuse _____Pus
_____Kidney Stones/Infections ____Strong Smell _____Painful
_____Cloudy ____Scanty _____Not Normal Color
_____Normal Other_____________

Thirst:

_____Less than Normal ____Excessive_____Prefer Cold Drinks
_____Thirsty but do not Drink ____Prefer Hot Drinks _____Normal

Sleep:

_____Difficulty Falling Asleep _____Lots of Dreams _____Awaken Easily
_____Sleep too Much _____Tired on Rising in A.M. _____Nightmares
_____Restless _____Difficulty going back to Sleep _____Insomnia
_____Vivid Dreams _____Normal _____Hours of sleep

Headaches/Dizziness:

____Headaches ______Vertigo _____Dizzy on Standing _____Dizziness
____Motion Sickness ______Poor Balance ______Faint Easily _____Migraines
____Poor Memory ______Normal Other:__________________________________

Skin:

____Dry ______Hives _____Clammy Skin ______Shingles
____Oily ______Pimples _____Bruise Easily ______Dry Scalp
____Rashes ______Moles _____Cuts Heal Slowly ______Cysts
____Itching ______Warts _____Yellow Skin ______Tumors
____Eczemza ______Boils _____Ulcers ______Body Odor
____Herpes Simplex ______Normal Other: ______________________________

Hair:

____Dry ____Oily ____Dandruff ____Early Grey ___Thinning or loss ____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
___Tonsilitis ___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:

___Diagnosed Heart Problems ___Palpitations ___Bleed Easily
___Broken Vessels/Capillaries ___Low Blood Pressure ___High Blood pressure
___Purple Vessels/Capillaries ___Murmur ___Varicose Veins
___Ankle Swelling ___History of Anemia ___Chest pain
___Facial Swelling ___Slow Heartbeat ___Bruise Easily
___Hand Swelling ___Fast Heartbeat ___Irregular Heartbeat
___Numbness of Extremities ___ Normal Other: _______________

Pain:

___Low Back ___Neck ___Shoulder
___Sciatica ___Spine ___Hands or wrists
___Mid Back ___Knees ___Hips
___Upper Back ___Foot or Ankle ___Arthritis
___Fullness below ribs ___Weak Legs/Knees ___Nerve Pain
___Muscle Weakness ___Muscle Cramps ___Flank Area
___Muscle twitching or spasm ___Damp Weather Bothers You
Other:____

Miscellaneous:

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

Males Only: Please check or explain as applicable.

___Reduced Sex Drive____
___Premature Ejaculation____
___Seminal Emission____
___Impotence____
___Discharge____
___Genital Pain____
___Prostate Problems____
___Painful or Burning Urine____
___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:

Acupuncture Northwest

Acupuncture, Herbal Medicine,
1328-9th Ave. Longview, WA 98632
(360) 636-0991 FAX (360) 636-5255
Patty Kuchar, L.Ac.

INSURANCE FORM Name____

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_________________

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_________________________________