**Patient Health History**

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally.  Please complete this questionnaire as thoroughly as possible.  Print all information and indicate areas of confusion with a question mark.

**ALL INFORMATION IS CONFIDENTIAL**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Suburb\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mob\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Google \_\_\_   Other Online Search \_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (if different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone                                                         Relationship

Please describe the reason for your visit today (Chief Complaint)

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 If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction)

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Please list any current and past health issues (including hospitalisations, operations, broken bones, spinal problems, headaches, digestive issues):

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Please list family health issues (if known) and their relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

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Please comment on any difficulty with your sleep (quality, quantity, interruptions):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Female clients please list detailed menstruation, pregnancy, birth history:

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 Do you have any reason to believe you may be pregnant?                Y        N

If so, how far along are you and have you had any complications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any infectious diseases?        Y     N         If yes, please identify:    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE TICK ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST 6 MONTHS**

**KIDNEY YIN/JING DEFICIENCY**

Do you have lower back weakness, soreness or pain or knee problems?

Do you have ringing in your ears or dizziness?

Is your hair prematurely grey?

Do you have dark circles around or under your eyes?

Do you have night sweats or heat up at night?

Are you prone to hot flushes?

Do you experience fear in your life?

**KIDNEY YANG DEFICIENCY**

Is your lower back sore or weak?

Are your feet and hands cold?

Are you typically colder than those around you?

Is your libido low?

Do you wake at night/early in the morning because you have to urinate?

Do you urinate frequently and is the urine diluted?

Do you have early morning loose bowels?

**SPLEEN QI DEFICIENCY**

Are you often fatigued?

Is your energy lower after a meal?

Do you feel bloated after eating?

Do you crave sweets?

Do you have abdominal pain or digestive problems?

Are your hands and feet cold?

Is your nose cold?

Are you prone to heaviness or fogginess is the head?

Do you bruise easily?

Do you have poor circulation?

Do you have varicose veins?

Are you prone to worry?

Have you been diagnosed with low blood pressure?

Do you sweat a lot without exerting yourself?

Do you feel dizzy or light headed, or have visual changes when you stand up fast?

Are you often sick or do you have allergies?

Have you been diagnosed with anaemia?

Do you have haemorrhoids or polyps?

**BLOOD DEFICIENCY**

Do you have dry flaky skin?

Are you prone to getting chapped lips?

Are your fingernails or toenails brittle?

Are you losing hair on your head?

Is your hair brittle or dry?

Do you have diminished night-time vision?

Do you get dizzy or light headed?

Do you get shortness of breath?

Do you experience palpitations (feel your heart beat in your chest)?

**BLOOD STASIS**

Do you experience periodic numbness of your hand or feet?

Do you have varicose veins or spider veins?

Is your lower abdomen tender to palpation (touch)?

Do you have dark spots in your vision?

**LIVER QI STAGNATION**

Are you prone to emotional depression?

Are you prone to anger or rage?

Do you have difficulty falling asleep at night?

Do you experience heartburn or wake up with bitter taste in your mouth?

Do you have cold hands and/or feet?

**HEART DEFICIENCY**

Do you wake up early in the morning & have trouble getting back to sleep?

Do you have heart palpitations, especially when anxious?

Do you have nightmares?

Do you seem low in spirit or lacking in vitality?

Are you prone to agitation or extreme restlessness?

Do you fidget?

Do you sweat excessively, especially on your chest?

**EXCESS HEAT**

Is your pulse rate rapid?

Are your mouth and throat usually dry?

Are you thirsty for cold drinks most of the time?

Do you often feel warmer than those around you?

Do you wake up sweating or have hot flushes?

Do you break out with red acne?

**DAMPNESS**

Do you feel tired and sluggish after a meal?

Do you have cystic or pustular acne?

Do you have odema/swelling?

Do your joints ache, especially with movement?

Are you overweight?

Do you have damp, sticky, unformed stools?

**MUSCULOSKELETAL**

Is the injury better with movement?

Is the injury better with heat?

Is the injury better with rest?

Have you ice packed?

Is this injury as a result of an accident or trauma?

**IVF PATIENTS**

IVF: Clinic Name

IVF: DR:

IVF: Procedures performed? Y/N

IVF Medications:

IVF: Sperm Test performed? Test Sighted Y/N

IVF: History:

How long had you been trying to conceive for, before going to IVF? Months Years

**Renew Acupuncture Clinic Consent to Treatment Form**

I hereby request and consent to the performance of acupuncture and other treatments within the scope of practice of an acupuncturist to be performed by the staff of Renew Health & Acupuncture Clinic (RHAAC) on me (or, if the patient is a minor, on the patient named, for whom I am legally responsible).

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body’s physiological functions.  I am aware that certain adverse side effects may result.  These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort.  Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Direct Moxibustion, Heat Lamp and Cupping:** Although rare, burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. I understand that I may refuse this therapy.

**Massage:** I understand that I may also be given acupressure/tuina massage as part of my treatment to modify or prevent pain perception and to normalize the body’s physiological functions.  I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment.  I understand that I may stop the treatment if it is too uncomfortable. I acknowledge that I am encouraged to ask for additional information or to clarify things further

**Privacy:** Information provided by you is collected with a view to helping you with your health concerns. RHAAC uses an electronic health record management system ‘Jane’ whose data servers are based in the Australia. Jane uses the latest industry standards to safeguard the confidentiality of your personal information, such as firewalls and Secure Socket Layers (SSL Certificates) however it is important that you understand "perfect security" does not exist on the Internet. To keep you abreast of news, developments and activities at our office, you agree to be placed on our mailing list. This may include sending you newsletters, news items, notifications of changes to our practice hours, procedures, activities etc. You can unsubscribe from the newsletters by simply clicking on the “unsubscribe” link at the bottom of any email newsletter. Additionally, we may contact you in relation to your care.

**Cancellation and Late Policy:**RHAAC requires 24 hours for appointment cancellations. If less than the required notice is given RHAAC reserves the right to charge a 75% cancellation fee. If in the case I am likely to be late I will endeavour to contact RHAAC to advise when I will be attending the appointment. Arriving more than 15 minutes late could result in my appointment being cancelled or a shorter treatment time.

**Payment:**I understand and agree that all services rendered are charged directly to me and I am personally responsible for payment to RHAAC. Our policy requires payment for all services, at the time of visit. Payment for services is accepted in either cash or payment by card.Private health fund rebates are now available to clients who receive acupuncture treatments and have extras cover with their fund. Retain your receipts and forward them to your health fund for a rebate to be processed. Remember to check with your private health insurance provider to ensure Acupuncture treatments are covered in your policy.

I have read the above consent, or have had it read to me. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_