Jennifer Scheible Acupuncture

First Name:	Last Name:	Gender:
Address:		Pronouns:
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:		
Emergency contact:	Relationship:	Phone:
Referred by:		

Please describe the main reason for your visit today:

____

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Please indicate if you have, or suspect you may have, any of of the following conditions:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Pregnancy
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____________________

List all major childhood and adult illnesses:

____

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Have you had any surgeries, major accidents or injuries, please explain:

____

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Please list any major disease or illness in your immediate family and indicate family member:

Please list all medications or supplements, including herbs and vitamins you are currently taking (please use the back of this page if needed):

Occupation:

Do you have a regular exercise program? Please describe.

Are you utilizing a specific diet?

How much sugar do you eat per week?

How much dairy do you eat per week?

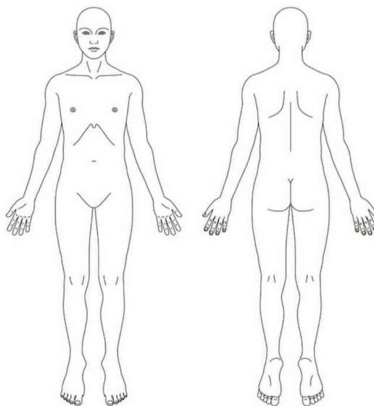
How many packs of cigarettes do you smoke per week?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Do you use drugs? How much per week?

Indicate painful areas. Rate on pain scale 1(none)to 10(worst).



PLEASE CHECK ALL SYMPTOMS THAT PERTAIN TO YOU AT THIS TIME.

☐ Cold hands/feet
☐ Fatigue
☐ Feverish in the afternoon or flushes
☐ Heat sensation in hands, feet, chest
☐ Night sweats
☐ Catch colds easily
☐ Sweats easily during daytime
☐ Dizziness
☐ See floating black spots

____

☐ Palpitations
☐ Sore on tongue
☐ Restlessness
☐ Anxiety
☐ Chest pain
☐ Insomnia

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☐ Cough
☐ Sinus congestion
☐ Dry mouth, throat, nose, or skin
☐ Allergies seasonal or food
☐ Chills and fever
☐ Stiff neck/shoulders
☐ Sore throat
☐ Difficult breathing

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☐ Low appetite
☐ Loose stools
☐ Constipation
☐ Abdominal bloating or gas after eating
☐ Feeling tired after eating
☐ Prolapsed organs (previously diagnosed)
☐ Bruises easily
☐ General feeling of heaviness in body
☐ Mental heaviness or fogginess
☐ Swollen hands/feet
☐ Burning sensation after eating
☐ Bad breath
☐ Large appetite

☐ Mouth, canker or cold sores
☐ Bleeding, swollen or painful gums
☐ Heartburn/belching
☐ Stomach pain
☐ Vomiting/nausea
☐ Diarrhea alternating with constipation
☐ Tight/suffocating feeling in chest
☐ Bitter taste in mouth
☐ Blood shoot eyes/dry eyes
☐ Anger easily
☐ Skin rashes
☐ Headache

☐ Numbness of hands and feet
☐ Muscle spasms, twitching, cramping
☐ Seizures/convulsions
☐ Sore, cold or weak knees
☐ Low back pain
☐ Frequent urination
☐ Get up more than once a night to urinate
☐ Lack of bladder control
☐ Memory problems
☐ Hair loss
☐ Ringing in ears

Urine is:
☐ Normal color ☐ Clear
☐ Dark yellow ☐ Reddish
☐ Cloudy ☐ Scanty
☐ Bad odor
☐ Burning ☐ Painful
☐ Difficult ☐ Urgent

Libido (sex drive) is:
☐ Normal ☐ Low ☐ High

WOMEN'S HEALTH

1. Are you pregnant now?
☐ Yes ☐ No

2. Number of children:___________

3. Number of pregnancies:_______

4. Age of first period:____________

5. Age of menopause if applicable:__________________

6. Is your menses cycle regular?
☐ Yes ☐ No

A. Average number of days in flow:____

B. The flow is:
☐ Normal ☐ Heavy ☐ Light

C. The color is:
☐ red ☐ dark ☐ purple
☐ light brown ☐ brown

D. Do you have the following menstruation related symptoms?

☐ Blood clots
☐ Cramps
☐ Nausea
☐ Breast distension
☐ PMS
☐ Bleeding between periods
☐ Heavy vaginal discharge between periods

E. Birth control:_______________________

MEN'S HEALTH

☐ Discharge

☐ Pain or swelling of testicles

☐ Ejaculatory problems

☐ Impotence/erectile dysfunction

OTHER:

NOTICE OF PRIVACY POLICIES

Our office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways;

- Information we receive.
- Information we receive from other healthcare providers.
- Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment, and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminders, by calls or email.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

- Upon written request you have the right to access, review or receive copies of your healthcare records.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have a right to receive all notices in writing.

If you have questions, complaints or want more information please contact Jennifer Scheible. at 415-424-5318.

You may also send a written complaint to:

The U.S. Department of Health and Human Services DHHS (Office of Civil Rights)

200 Independence Ave S.W. Room 509 F HHH Building Washington DC 20201

PATIENT SIGNATURE________________________________

DATE____