

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully and completely. All of your answers will be held absolutely confidential. If you have any questions please ask. Thank you.

Name			Date	
Address		City	State	Zip
Home Phone		Work Phone		
Date of Birth	Height	Weight	Marital Status	
Email Address		Appointment Reminder Preference (Circle one) Email Phone No Reminders		
Emergency Contact		Emergency Phone		
Insurance Company		Name of Primary Care Physician		
How did you hear about us? Circle one: Internet Search Physician Referral Friend Referral: _____ Word of Mouth Other: _____				

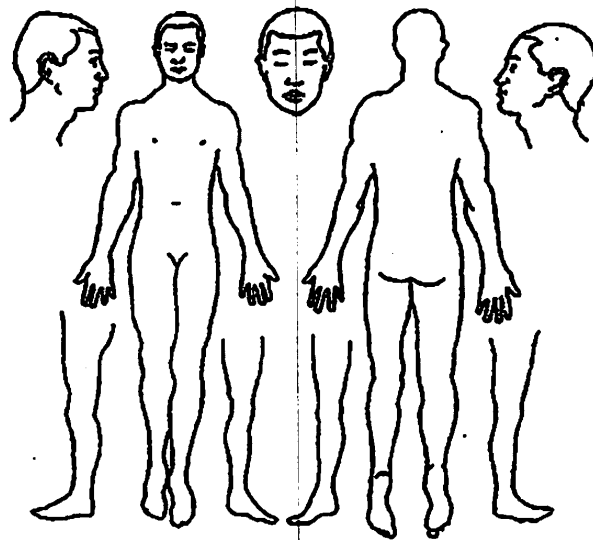
Have you been treated by acupuncture or oriental medicine before?
Main problem you would like us to help you with?
How long ago did this problem begin?
Did some event trigger this problem?
To what extent does this problem interfere with daily activities such as work and sleep?
Have you been diagnosed with this problem? If so, what?
What kinds of treatments have you tried?

Past Medical History (Please Include Date) <i>Significant Illnesses</i> Cancer Diabetes Heart Disease Hepatitis A B C High Blood Pressure Seizures HIV/AIDS Thyroid Disease Asthma Other:
Surgeries
Significant Trauma (Auto accidents. Falls, breaks)
Allergies

Family Medical History (Circle all that apply) Cancer Diabetes Heart Disease High Blood Pressure Stroke Seizures HIV/AIDS Thyroid Disease Asthma Other:
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Medicines Taken Within Last 3 Months
Occupational Stress (Chemical, Physical, Psychological, Etc.)
Are You On Any Kind Of Restricted Diet (Vegetarian, Vegan, Low Salt, Etc)?
Do You Have a Regular Exercise Program? Describe:
How Much Water Do You Drink Per Day?
How Much Caffeinated Coffee, Tea, or Soft Drinks Do you Drink Per Week?
Do You Smoke? If Yes, How Much?

INDICATE ANY PAINFUL OR DISTRESSED AREAS:



Are There Any Emergency Situations For Us To Be Aware Of? (Example: Seizures, Allergies Leading to Anaphylactic Shock, Etc.)

Note: Only complete this section if you are being seen for fertility, infertility, and women's health issues. Thank you

When was your last menstrual period?
Do you have regular periods? (circle one) YES NO
How many days between cycles? _____ Days
How long have you been trying to conceive?
Any previous pregnancies? (circle one) YES NO
Name of fertility Doctor/Clinic
Any family history of infertility? (circle one) YES NO UNSURE

Steve Mavros, L.OM
Julie Schwartz, L.Ac.
Matt Skahill, L.Ac.

The Healing Arts Center of Philadelphia
123 Chestnut Street, Ste. 204
Philadelphia, PA 19106
215-627-3782

I hereby request and consent to the performance of Acupuncture treatments and other procedures within the scope of the practice of Acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back up for the acupuncturist named above, including those working at the office listed above, and/or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, Acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant side effects accompanied with the consumption of the herbs.

I have been informed that Acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, as well as dizziness or fainting. Bruising is a common side effect of cupping. Highly unusual risks of Acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another minuscule risk, although the office and/or clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks associated with treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, or mineral sources) that may be recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of my treatment, based on expertise, instruction and my best interest. I understand recovery and results vary from individual to individual, and results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I indicate that I have read, or have had read to me, the above consent to treatment. I indicate I have been told the risks and benefits of Acupuncture and other procedures, and I have had an opportunity to ask questions. I intend this consent form to cover the entire course of my treatment for my present condition or any future conditions I may be treated for.

Patient (or Representative) Signature

Date

Relationship to Patient, if signed on their behalf



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Our Cancellation Policy

All providers kindly request **24-hour (one business day) notice** when canceling. If you need to cancel a Monday appointment, please contact our office by 2 p.m. Saturday.

Our **fees for canceling** without notice vary by provider due to their individual charge schedules. Please refer to your provider below:

Barry Silverman, DC	Chiropractic	\$35 flat fee
Steve Mavros, L.Ac.	Acupuncture & Herbal Medicine	50% of visit
Sheri McLellan-Krauss	Acupuncture	50% of visit
Julie Schwartz	Acupuncture	50% of visit
Matt Skahill	Acupuncture	50% of visit
Jerrold Friedman, MD	Physiatry/Medical Acupuncture	\$75 flat fee
Steven Rosenzweig, MD	Integrative Medicine	\$150/new patient \$75/established

If you have any questions about this policy, please feel free to ask a member of our staff. Due to the large number of clients we serve, exceptions to the policy will only be made under reasonable circumstances.

We do offer you the courtesy of a phone call or email one day prior to the visit to help remind you of your appointment. If you need to cancel and reschedule the appointment, you may do so at that time without incurring a charge.

By signing below, you are indicating that you have read and understood this policy.

Name

Date