Life Essentials TCM Center, Jing Shen, L.Ac., O.M.D. & Julian Zhu, L.Ac., O.M.
17269 Wild Horse Creek Road, Suite 140, Chesterfield, MO 63005

Health History Questionnaire

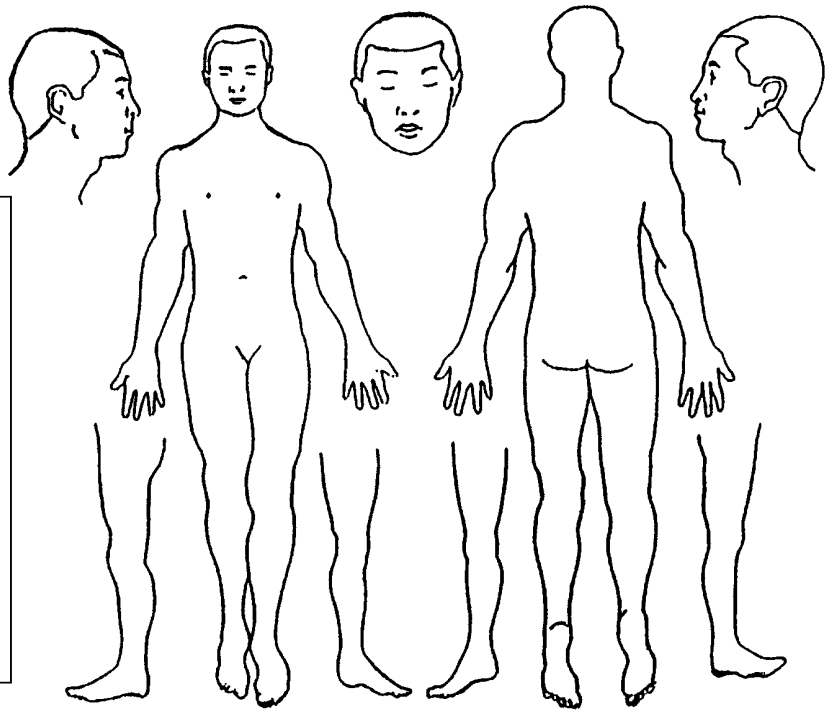
Name:			Today's Date:		
Address:			e-mail:		
City:	State:		Phone (Mobile):		
Zip:			Phone (Home):		
Age:	DOB:	Sex:		Wt:	Ht:
Marital Status:			Occupation:		
Place of Birth:			Date of Birth:		
Family Physician:			Address:		
In Emergency Notify:			Phone Number:		
Referred By:					
How/Where did you find us :			HealthProfs	Yelp	Google
Have you been treated by acupuncture or Oriental medicine before?					

Responsible Party Signature: _____ Relationship: _____ Date: _____

Main problem(s) you would like us to help you with: _____
_____
How long ago did this problem begin (be specific)? _____
_____
To what extent does this problem interfere with your daily activities (work, sleep, sex)?_____
_____
Have you been given a diagnosis for this problem? If so, what? _____
_____
What kinds of treatment have you tried? _____
_____
Past medical history (please include dates): _____
_____
Significant Illnesses: Cancer Diabetes Hepatitis High Blood Pressure Seizures
Heart Disease Rheumatic Fever Thyroid Disease Venereal Disease
Other_____
Surgeries: _____

Significant Trauma (auto accidents, falls, etc.): _____
_____
Allergies (drugs, chemicals, foods): _____
_____
Family Medical History:
Medicines taken within the last two months (vitamins, drugs, herbs, etc.):
_____
_____

Indicate painful or distressed areas:



Symbols	
Pain/pressure	X
Swelling	⌒
Tension	+
Weakness	–
Pulsing	✳
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑

Occupation: _____ Occupational stress (chemical, physical, psychological, etc.):

_____

Do you have a regular exercise program? _____ Please describe:
Have you ever been on a restricted diet? _____ What kind?
Do you smoke? _____ How many packs of cigarettes do you smoke a day? _____
How much coffee, tea, or cola do you drink per week? _____
How much alcohol do you drink per week? _____
Please describe any use of drugs for non-medical purposes: _____

Please check if you have had (in the last three months):

General

[] Poor Appetite [] Poor Sleeping [] Fatigue [] Fevers [] Chills
[] Night Sweats [] Sweat Easily [] Tremors [] Cravings
[] Localized Weakness [] Poor Balance [] Change in Appetite [] Bleed or Bruise Easily
[] Weight Loss [] Weight Gain [] Peculiar Tastes or Smells [] Strong Thirst

Skin and Hair

[] Rashes [] Ulcerations [] Hives [] Itching [] Eczema [] Pimples
[] Dandruff [] Loss of Hair [] Recent moles [] Change in hair or skin texture
Any hair or skin problems?

Head, Eyes, Ears, Nose, and Throat

[] Dizziness [] Concussions [] Migraines [] Blurry Vision
[] Poor Vision [] Night Blindness [] Earaches [] Spots in Front of Eyes
[] Ringing in Ears [] Poor Hearing [] Facial Pain [] Grinding Teeth
[] Sinus Problems [] Nose Bleeds [] Jaw clicks [] Recurrent Sore Throats
Headaches (Where and when?)
Any other head or neck problems?

Cardiovascular

[] High Blood Pressure [] Low Blood Pressure [] Chest Pain [] Fainting
[] Irregular Heartbeat [] Dizziness [] Blood Clots [] Phlebitis
[] Cold Hands or Feet [] Swelling of Hands or Feet [] Difficulty in Breathing
Any other heart or blood vessel problems?

Respiratory

[] Cough [] Coughing Blood [] Asthma [] Pain With a Deep Breath
[] Bronchitis [] Pneumonia [] Difficulty in Breathing When Lying Down
[] Production of Phlegm (What color?)
Any other lung problems?

Gastrointestinal

[] Nausea [] Vomiting [] Diarrhea [] Abdominal Pain or Cramps
[] Constipation [] Gas [] Belching [] Bad Breath
[] Black Stools [] Blood in Stools [] Indigestion [] Hemorrhoids
Any other problems with your stomach or intestines?

Genito-Urinary

[] Pain When Urinating [] Frequent Urination [] Blood in Urine [] Kidney Stones
[] Urgency to Urinate [] Unable to Hold Urine [] Decrease in Flow [] Impotency
Do you wake up to urinate? How often?
Any particular color of your urine?
Any other problems with your genital or urinary system?

Pregnancy and Gynecology

__ Number of Pregnancies __ Number of Births __ Premature Births
__ Miscarriages __ Abortions __ Age at First Menses
__ Period Between Menses __ Duration __ First Date of Last Menses
[] Unusual Character (Heavy or Light) [] Irregular periods
[] Painful Periods [] Clots [] Last PAP
[] Vaginal Discharge [] Vaginal Sores [] Breast Lumps
[] Changes in Body/Psyche Prior to Menstruation
Do you use birth control? What type and for how long?

Musculoskeletal

[] Neck Pain [] Muscle Pains [] Knee Pain [] Hand/Wrist Pains [] Hip Pain
[] Back Pain [] Muscle Weakness [] Foot/Ankle Pains [] Shoulder Pain
Any other joint or bone problems?

Neuropsychological

[] Seizures [] Dizziness [] Loss of Balance
[] Areas of Numbness [] Lack of Coordination [] Poor Memory [] Bad Temper
[] Concussion [] Depression [] Anxiety [] Easily Susceptible to Stress
Have you ever been treated for emotional problems?
Have you ever considered or attempted suicide?
Any other neurological or psychological problems?

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Informed Consent For Treatment

I, _____, hereby authorize the private practitioners of life essentials TCM center to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special disposable needles through the skin into underlying tissues at specific points on the surface of the body.

Cupping: a technique used to relieve symptoms in which cups made of glass or other materials are placed on the skin with a vacuum created by heat or other device.

Heating Lamp or Pad: produces heat on the acupoints and meridians.

Electrical Acupuncture: use of electrical device to produce electrical stimulation on the acupuncture needles.

Herbs: may be given in the form of powders, or pills. We prepare customized herb formulas based on individual's condition and needs.

Dietary Advice: based on traditional Chinese Medical Theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential Risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of the symptoms prior to the acupuncture treatment.

Potential Benefits: natural drugless relief of present symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the present problem and the strengthening of the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by life essentials TCM center or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understood the life essentials TCM center's HIPAA Privacy Policies or which a copy can be requested in person at our office.

_____ _____

Signature of Patient, Patient Representative, or Guardian Date

Notice of Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to life essentials.

Legal Responsibilities of life essentials TCM center As mandated by Federal and State legal requirements, your protected health information must be protected. As part of these regulations, we are required to ensure you are aware of privacy policies, legal duties, and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice. This notice will be in effect until it is replaced.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing the notice will precede all significant modifications. A copy of this notice will be provided upon request.

Protected Health Information Use and Disclosure: Information regarding your health may be used and disclosed for the purpose of treatment, payment, and other healthcare operations. Examples cited below further explain the use and disclosure process.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provided providing treatment to you. However, this information will not be provided unless you have authorized it in writing.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: At any time, you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your protected healthcare information may be use and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved In Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information maybe used or disclosed to a family member, your personal representative, or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information, you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without your written authorization.

Required By Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect, domestic violence, or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances, the military may require disclosure of healthcare information for armed forces personnel. For the purpose of national security activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected healthcare information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected healthcare information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters. We may also write a thank you card to whomever referred you to our practice.

Patient Rights

Access: At all times, you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a format other than photocopies. If we are able to do so, we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a Protected Health Information Access Form by using the contact information at the end of this notice. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. You may also request access for submitting a letter using the information at the bottom of this notice. If you request copies, we will charge you $0.83 per page for the first 30 pages and $0.63 for every page after that plus $19.00 for staff time to locate and copy you protected health information. Postage will be included if you wish to have your information mailed. If you request a different format, we will charge a cost based fee for that format. An explanation of fees can be made available.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associated disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your healthcare information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions, we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or other locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject your request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative location, you have the right to bring this issue forward. You may make a complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources, we will not retaliate in any way. We are available to assist you with any questions, concerns, or complaints.

I have read and understood the HIPAA privacy policies of Life Essential TCM Center.

_____	_____	_____
Name	Date	Relationship to patient (if applicable)