Leslie Laya Raznick
Acupuncturist Holistic Health Coach
2201 NE 65th Street Seattle, WA 98115
206-349-8686

Thank you for taking the time to complete your medical history form. The information you provide enables us to evaluate, diagnose and treat your condition according to Acupuncture/East Asian Medicine diagnoses. All of your answers are completely confidential and will not be released to any person without your written authorization.

Health History Form

Today's Date:

Name	**Email**		
Address	**City**		**Zip Code**
Home phone	**Work phone**		**Cell Phone**
Date of Birth	**Age**	**Height**	**Weight**
Primary Care Physician		**Phone**	
Emergency contact		**Phone**	
Referred by:			

Your Main Reason for Coming for Acupuncture Treatment:

Exercise: (summarize all regular exercise and how often)

Medications & Dose: (Rx, OTC, vitamins, herbs. Use the back if needed)

Accidents, Traumas, Surgeries/Hospital Stays:

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Review of Systems: (check any symptoms you are currently experiencing)

General
- ☐ Chills
- ☐ Fever
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst
- ☐ Fatigue
- ☐ Body swelling
- ☐ Poor sleep
- ☐ Tremors (shaking)
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight gain
- ☐ Weight loss

Skin and Hair
- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives
- ☐ Acne
- ☐ Recent moles
- ☐ Hair loss
- ☐ Dandruff
- ☐ Fungal infections

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting

Respiratory
- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Pain with a deep breath
- ☐ Problems breathing when laying
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Sinus problems
- ☐ Excessive phlegm
- ☐ Recurrent sore throats
- ☐ Hoarseness

Gastrointestinal
- ☐ Vomiting
- ☐ Nausea
- ☐ Acid regurgitation
- ☐ Bad breath
- ☐ Hiccup
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Mucous in stools
- ☐ Abdominal pain or cramps
- ☐ Gas
- ☐ Rectal Pain
- ☐ Burning anus
- ☐ Itchy anus
- ☐ Hemorrhoids
- ☐ Anal fissures

Head, Eyes, Ears, Nose, Throat
- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
- ☐ Facial Pain
- ☐ Glasses
- ☐ Poor Vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Color blindness
- ☐ Blind field

Head, Eyes, Ears, Nose, Throat
- ☐ Eye dryness
- ☐ Excessive tears
- ☐ Discharge from eyes
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Hearing aid
- ☐ Earaches
- ☐ Discharge from ears
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Jaws Clicks
- ☐ Concussions
- ☐ Enlarged thyroid
- ☐ Swollen glands
- ☐ Sores on lips or tongue
- ☐ Gum problems
- ☐ Teeth problems

Genito-Urinary
- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Unable to hold urine
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Genital itching
- ☐ Sores on genitals
- ☐ Waking to urinate at night?

  How often? _____

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Pregnancy and Gynecology
- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ PMS
- ☐ Clots
- ☐ Vaginal discharge
- ☐ Bleeding after sex
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Musculoskeletal
- ☐ Neck Pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Myalgia

Neuropsychological
- ☐ Seizures
- ☐ Areas of numbness
- ☐ Tics
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Bad temper
- ☐ Irritability
- ☐ Depression
- ☐ Frustration
- ☐ Sadness
- ☐ Anxiety
- ☐ Easily susceptible to stress
- ☐ Vertigo
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Substance abuse
- ☐ Abuse survivor

Have you been ever been treated for emotional problems? ☐ Yes ☐ No

Have you ever considered or Attempted suicide? ☐ Yes ☐ No

*****ANY HEALTH ISSUES NOT MENTIONED ON THIS FORM:**

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Current/Past Medical History (circle all the apply now or in the past)

AIDS/HIV	Alcoholism	Allergies	Acne	Anxiety	Arthritis	Asthma
Anorexia	Back Pain	Bulimia	Cancer	Chicken Pox	COPD	Crohn's
Chem. Depend	Diverticulitis	Depression	Diabetes	Eczema	Emphysema	Epilepsy
Fibromyalgia	Goiter	Gout	Hepatitis	Herpes	Heart Disease	High/low BP
High Choles.	Headaches	IBS	Insomnia	Kidney Dis..	Lung Problem	Miscarriage
MS	Measles	Mumps	Menstrual Prob	Menopause	Migraines	PMS
Pacemaker	Pneumonia	Prostate	Psoriasis	Rashes	Rheumatic Fever	
Seizures	Stroke	Suicide Attempt	Tuberculosis	Thyroid Prob.	Ulcers	UTI
Vaginitis	Venereal Dis.	Whooping Cough				

Other (Specify):

Serious Allergies:

PATIENT NOTIFICATION OF QUALIFICATIONS AND SCOPE OF PRACTICE

Acupuncture (East Asian Medicine) means a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders. My qualifications include Bachelor of Science in Business Management, Masters of Acupuncture, Licensed Acupuncturist and Certified Holistic Health Practitioner.

The scope of practice for a Licensed Acupuncturist/East Asian medicine practitioner in the state of Washington includes the following: Acupuncture, including the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians; Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure; Cupping; dermal friction technique; Infrared; Sonopuncture; Laserpuncture; Point injection therapy (aquapuncture); Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements; Breathing, relaxation, and East Asian exercise techniques; Qi gong; East Asian massage and Tuina, which is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and Superficial heat and cold therapies.

Side effects may include, but are not limited to: Pain following treatment; Minor bruising; Infection; Needle sickness; and Broken needle. The patient must inform the East Asian medicine practitioner if the patient has a severe bleeding disorder or pace maker prior to any treatment.

NOTICE OF PRIVACY PRACTICES-HIPAA

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of healthcare operations include the business aspects of running our practice. In addition, we may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

In some limited situations, the law requires us to use and disclose your health information without your permission. These are when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices; disclosure to government authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws; disclosures in response to subpoenas or orders of the court; disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office; disclosure related to worker's compensation programs.

You have the following rights, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree, we must abide by it unless you agree in writing to remove it. The right to ask us to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request. The right to ask to see or to get photocopies of your health information. We charge a photocopy fee for records release. Please complete our written records request release form. The right to receive an accounting of disclosures of protected health information. The right to amend your protected health information. The right to obtain a paper copy of this notice from us upon request. This notice is effective as of January 1, 2005, and we are required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practices from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices:

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For more information on HIPAA or to file a complaint:
US Dept of Health & Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington DC 20201
877-696-6775 (toll free)

This notice has been issued and considered effective date signed. This copy shall be retained by this office for minimum of six (6) years.

_____

Patient signature **Date**