HISTORY QUESTIONNAIRE

NOTE: Many factors must be considered in designing a complete health-building program. Treating the whole person requires attention to all symptoms and conditions. Often minor symptoms are major clues to delicate biochemical, energetic or somatic imbalances. Please complete the questionnaire as carefully as you can. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME_____DATE_____ CASE NO _____
ADDRESS_____ RES. PHONE _____
CELL PHONE_____ EMAIL ADDRESS:_____
EMPLOYER_____ BUS. PHONE _____
PRIMARY CARE PHYSICIAN & PHONE _____
OCCUPATION_____REFERRED BY:_____
AGE ___ BIRTH DATE_____ ☐ M ☐ F ☐ M ☐ S ☐ D ☐ W ☐ SPOUSE ☐ CHILD

Is your condition due to ☐ an accident ☐ an illness ☐ Other _____
Did your accident occur while at work? ☐ Yes ☐ No When _____
Were you involved in an automobile accident? ☐ Yes ☐ No When_____
STATE your present complaint, injury or illness:_____
_____
_____
When did it begin? (Date)_____ Describe what caused it: _____
_____
_____
What makes it better?_____
What makes it worse?_____
Is it getting worse? ☐ Yes ☐ No Does it interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other
Explain: _____
Who have you previously consulted about your present problems?_____
_____
Secondary Complaints: _____
Previous Medical Care:_____
Operations: Please indicate all surgeries, type and year _____
_____
Have you ever been advised to have any surgery which was not done?_____
Have you been hospitalized for anything other than surgery? _____

TREATMENT FOR OTHER CONDITIONS:_____
_____

PERSONAL HISTORY: Have you ever had/do you currently have:
☐ Scarlet Fever ☐ Jaundice ☐ Rheumatic Fever ☐ Gonorrhea/Syphilis ☐ Pneumonia ☐ Anemia
☐ Rectal Disease ☐ Gallbladder Disease ☐ Pleurisy ☐ Epilepsy ☐ Bladder Disease ☐ Diabetes
☐ Polio/Meningitis ☐ Nephritis ☐ Cancer ☐ Nervous Breakdown ☐ Food/Drug Poisoning
☐ TB/Angina ☐ Hay Fever/Asthma ☐ Boils/Infections ☐ Heart Disease ☐ Hepatitis ☐ Alcoholism
☐ High Blood Pressure ☐ Miscarriage ☐ Mental disorder ☐ Drug problem ☐ A.I.D.S.

FAMILY HISTORY: Has your father or mother ever had:
☐ Cancer ☐ Stroke ☐ Scoliosis ☐ Kidney Disease ☐ Glaucoma ☐ TB ☐ Epilepsy ☐ Diabetes
☐ Mental Disorder ☐ Heart Trouble ☐ Asthma ☐ Ulcers ☐ Arthritis ☐ Alcoholism
☐ High Blood Pressure ☐ Drug problem ☐ Allergies ☐ Other _____
Is there any familial disease tendency of which you are aware:_____

INJURIES: (Auto accidents, falls, etc.) _____
☐ Broken Bones ☐ Concussion or Head Injury ☐ Dislocations ☐ Sprains ☐ Loss of Consciousness

Name: _____ Date: _____

PAST MEDICAL HISTORY

Birth: Anything significant about your birth?

Vaccination history: Any reaction that you remember?

Childhood illnesses: Any surgery or accidents? List in chronological order and indicate length of illness or injury.

Age 0-6:

Age 7-12:

Age 13-20:

Age 21-30:

Age 31-40:

Age 41 to present:

Family health history:

Name: _____ Date: _____

FEMALES ONLY

Are you or might you be pregnant? ☐ Yes ☐ No ☐ Maybe If yes, what month? _____
What method of birth control do you use? _____
Are you experiencing reduced sexual energies? ☐ Yes ☐ No Other difficulties? ☐ Yes ☐ No
Explain: _____
Do you have regular PAP tests? ☐ Yes ☐ No How regular? _____

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Menstrual Cycle
Age started: _____ Age stopped: _____

- ☐ Irregular _____
- ☐ Painful _____
- ☐ Excess blood _____
- ☐ Lack of blood _____
- ☐ Dark _____
- ☐ Light _____
- ☐ Heavy clotting _____
- ☐ Water retention _____
- ☐ Painful breast _____

Vaginal Discharge:

- ☐ Liquid _____
- ☐ Yellow _____
- ☐ Thick _____
- ☐ Bad odor _____
- ☐ White _____
- ☐ Other _____

Gynecological History or Operations:

- ☐ Ovaries _____
- ☐ Uterus _____
- ☐ Tubes _____
- ☐ Vagina _____
- ☐ Breast _____
- ☐ Other _____

Pregnancy:
Total Number: _____
Number of children: _____
Number of abortions: _____
Number of miscarriages: _____
Complications: _____

MALES ONLY

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

- ☐ Reduced sexual energies: _____
- ☐ Premature ejaculation: _____
- ☐ Seminal emission: _____
- ☐ Impotence: _____
- ☐ Discharges: _____
- ☐ Pain associated with genitals: _____
- ☐ Other: _____

Name:_____ Date:_____

PATIENT PROFILE

It is very important to know how long a patient has experienced his/her symptoms. Thus, it is essential to indicate time on the symptoms.

Indicate with one check any condition that you sometimes experience; use two checks for those which often occur, and three checks for symptoms that are a major concern.

WATER ELEMENT

- ❑ Hearing loss
- ❑ Dizziness
- ❑ Lower backache/neck pain
- ❑ Sinus congestion
- ❑ Edema
- ❑ Darkness under the eyes
- ❑ Emotional instability
- ❑ Aversion to cold
- ❑ Hair thinning or loss
- ❑ Premature aging
- ❑ Frequent urination
- ❑ Kidney stones
- ❑ Perspire very easily
- ❑ Weakness of legs/knees
- ❑ Asthmatic cough
- ❑ Rapid weight change
- ❑ Loose teeth
- ❑ Reduced sexual energy
- ❑ Thyroid problems
- ❑ Diabetes

WOOD ELEMENT

- ❑ Headaches
- ❑ Migraines
- ❑ Ringing in the ears
- ❑ Poor eyesight
- ❑ Eye infections
- ❑ Dry eyes
- ❑ Eczema
- ❑ Shingles
- ❑ Herpes simplex
- ❑ Warts
- ❑ Nervousness
- ❑ Convulsion, spasms
- ❑ Irritability
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Ulcer
- ❑ Vomiting
- ❑ Gallstones
- ❑ Indecisive
- ❑ Fullness below ribs
- ❑ Shoulder/neck tension
- ❑ Insomnia 11 P.M. - 3 A.M.

FIRE ELEMENT

- ❑ Dry scalp
- ❑ Skin eruptions, rashes
- ❑ Cysts, tumors
- ❑ Ear infections
- ❑ Sore throat, tonsillitis
- ❑ Lymphatic swelling
- ❑ Hot palms and soles
- ❑ Heart palpitations
- ❑ Aversion to heat
- ❑ Bitter taste in mouth
- ❑ Gum problems
- ❑ Nose bleed
- ❑ Facial redness
- ❑ Itching/burning skin
- ❑ Hot hands/feet
- ❑ Thirst
- ❑ Vivid dreaming
- ❑ Dark urine
- ❑ Night sweats

EARTH ELEMENT

- ❑ Indigestion
- ❑ Flatulence
- ❑ Food allergy
- ❑ Stomach ache/ulcer
- ❑ Diarrhea
- ❑ Anemia
- ❑ Halitosis
- ❑ Sores in mouth
- ❑ Heartburn
- ❑ Strong appetite
- ❑ Weak appetite
- ❑ Nausea
- ❑ Abdominal bloating
- ❑ Low body weight

METAL ELEMENT

- ❑ Bronchitis
- ❑ Asthma
- ❑ Shallow breathing
- ❑ Cough
- ❑ Sinus congestion
- ❑ Nasal infections

OTHER

- ❑ Fatigue
- ❑ Arthralgia
- ❑ Sciatica/nerve pain
- ❑ Cold hands/feet
- ❑ Tendonitis
- ❑ Bursitis

PAIN

(please describe below)

_____

_____

_____

OTHER COMMENTS

_____

_____

_____

EMOTIONS AND PREFERENCES

Choose one or two EMOTIONS that seem predominant in your life (frequently experienced, difficult to express, or in some way influential): _____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic experience you have had (e.g., divorce, change of residence, injury, death in family, bankruptcy, etc.):

Date:	Event:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Preference:	Most Liked	Least Liked
Season:		
_____	_____	
Taste:		
_____	_____	
Climate:		
_____	_____	
Time of Day:		
_____	_____	
Temperature:		
_____	_____	
Color:		
_____	_____	

HABITS, DIET, MEDICINES, ALLERGIES

Name:_____ Date _____

LAST PHYSICAL: Date_____Practitioner:_____Results:_____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy	Moderate	Light	None	
☐	☐	☐	☐	Alcohol:
☐	☐	☐	☐	Coffee:
☐	☐	☐	☐	Tea:
☐	☐	☐	☐	Tobacco:
☐	☐	☐	☐	Exercise:
☐	☐	☐	☐	Sleep:
☐	☐	☐	☐	Appetite:
☐	☐	☐	☐	Energy:
☐	☐	☐	☐	Medication:
☐	☐	☐	☐	Vitamins:
☐	☐	☐	☐	Diet:
☐	☐	☐	☐	Teeth problems:
☐	☐	☐	☐	Drugs:
☐	☐	☐	☐	Salt:
☐	☐	☐	☐	Other:
☐	☐	☐	☐	Stress: _____ (Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

_____

_____

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs)

_____

_____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.)

_____

_____

Dakota Family / Jade Screen Clinic
1136 W. Divide Ave.
Bismarck, ND 58501
701-223-9632

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:
   a) Treatment – To give you medical treatment or other types of health services.
   b) Payment – To bill you or a third party for payment for services provided to you.
   c) Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

   a) To you
   b) As required by federal, state or local law
   c) If child abuse or neglect is suspected
   d) Public health risks (for public health activities to prevent and control spread of disease)
   e) Lawsuits and disputes (in response to a court or administrative order)
   f) Law enforcement (to help law enforcement officials respond to criminal activities)
   g) Coroners, medical examiners and funeral directors
   h) Organ or tissue donation facilities if you are an organ donor
   i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

   a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
   b) Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend or other person that you have named as being involved in your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

   a) Right to inspect your health record and to receive a copy of your health record upon request
   b) Right to amend information in your health record you believe is inaccurate or incomplete
   c) Right to know to whom we have disclosed your health information
   d) Right to ask for limits on the health information data we give out about you
   e) Right to receive communication from us about your health information in alternate ways
   f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICE of this practice.

Signature of patient or representative Date

Print patient name Patient Birth Date

Jade Screen Clinic

Informed Consent to Treatment

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Marilyn Sjaastad DOM.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui Na, Gua Sha, Chinese herbal medicine and Chinese nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable single-use needles, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and then consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Marilyn Sjaastad DOM of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Marilyn Sjaastad DOM if I am or become pregnant.

I do not expect Marilyn Sjaastad DOM to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named practitioner to exercise judgement during the course of treatment which she thinks at the time, based upon facts then known, is in my best interests.

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

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, have ben told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

Print Name of Patient (or representative)	**Print Name of Practitioner**
Signature of Patient (or representative)	**Marilyn Sjaastad DOM**