HEALTH HISTORY QUESTIONNAIRE
INFORMATION FOR YOUR ACUPUNCTURIST

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

GENERAL PATIENT INFORMATION

Name: _____ Date:_____
Address:_____City, State, Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Age:_____ Date of Birth:_____ Email:_____
Legal Guardian: (if under 18 years of age)_____
Emergency Contact: (name and phone number)_____
Gender:____ M____ F Height: ____'____" Weight: _____lbs
Occupation:_____Employer:_____
Medical Doctor: _____Do we have your permission to update your medical doctor regarding your care at this office? Yes No
How did you hear about us?_____

MAJOR COMPLAINTS, IN ORDER OF IMPORTANCE

1._____
2._____
3._____
4._____
5._____
6._____

How do these conditions impair your daily activities?

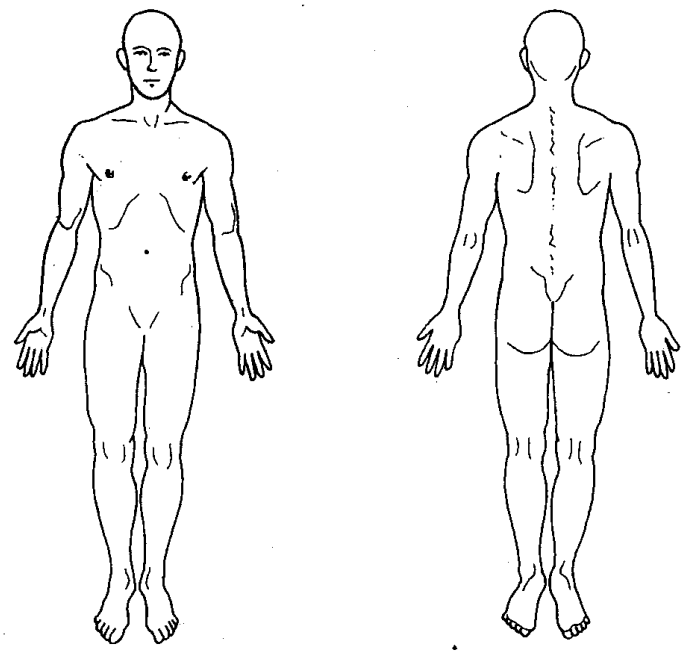
_____

Check any that you have had in the past:

- o Diabetes
- o Heart Disease
- o Asthma
- o Jaundice
- o Syphilis
- o Meningitis
- o Epilepsy
- o Paralysis
- o Other Lung Illness
- o Allergies
- o CVA (stroke)
- o Pneumonia
- o Gonorrhea
- o Measles
- o HIV
- o High Fever
- o Cancer
- o Other Liver Illness
- o Glaucoma
- o Vein Condition
- o Tuberculosis
- o Mumps
- o Chicken Pox
- o Polio
- o Hepatitis
- o Migraines
- o Other Heart Illness
- o Rheumatic Fever
- o Thyroid Disorder
- o Emphysema
- o Bleeding Tendency
- o Nervous Disorder
- o Mononucleosis
- o Multiple Sclerosis
- o High Blood Pressure
- o Other Kidney Illness
- o Other _____

- Surgeries:_____
  _____

Please mark areas of concern:



Do the following improve the pain?

- Pressure
- Exercise
- Cold
- Heat
- Other:

Do the following worsen the pain?

- Pressure
- Exercise
- Cold
- Heat
- Other:

Please check the following that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function):

Overall Temperature (Kidney Function)

- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration
- Take water to bed

Overall energy (Lung, Kidney function)

- Shortness of breath
- Low energy
- Difficulty keeping eyes open in the daytime
- Feel worse after exercise
- General weakness
- Easily catch colds

Overall Blood (Liver, Spleen, Heart function)

- Dizziness
- See floating black spots

Heart function

- Frequent dreams
- Wake unrefreshed
- Mental confusion
- Chest pain traveling to shoulder
- Sores on the tip of the tongue
- Restlessness
- Palpitations
- Anxiety
- Drink coffee (# of cups per week:_____)

Lung function

- Nasal Discharge (Color:_____)
- Allergies (To what?_____)
- Headache (Location:_____)
- Smoke cigarettes (# of cigarettes a day:____)
- Alternating fever and chills
- Coughs
- Nose Bleeds
- Difficulty breathing
- Sneezing
- Achy feeling
- Sinus Congestion
- Dry Mouth
- Sadness
- Dry throat
- Dry nose
- Dry skin
- Sore throat
- Stiff neck
- Stiff shoulders
- Melancholy

Spleen Function

- Worry
- Over-thinking
- Easily bruised
- Hemorrhoids
- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating

Spleen, stomach, large intestine, small intestine function

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools
- Dampness trapped in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess
- General sensation of heaviness in the body
- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach function

- Belching
- Hiccups
- Stomach pain
- Vomiting
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Bleeding, swollen or painful gums
- Large appetite
- Bad breath
- Mouth (canker) sores
- Burning sensation after eating

Liver, gall bladder function

- Alternating diarrhea and constipation
- Headache at the top of the head
- Tight sensation in the chest
- Bitter taste in the mouth
- High-pitched ringing in the ears
- Gall stones (history or current)
- Limited Range-of-Motion, neck
- Limited Range-of-Motion, shoulder
- Tingling sensation
- Chest pain
- Lump in the throat
- Anger easily
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures
- Frustration
- Depression
- Irritability
- Skin rashes
- Neck/Shoulder tension
- Convulsions
- Drink alcohol

Eyes (Liver function)

- Far-sighted
- Blurry vision
- Decreased night vision
- Near-sighted
- Dry
- Watery
- Itchy
- Bloodshot
- Hot

Kidney, urinary bladder function

- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing the ears
- Kidney stones
- Bladder infections
- Wake during the night twice to urinate
- Lack of bladder control
- Fear
- Easily startled

Urination

- Painful
- Discharge
- Difficult
- Urgent
- Frequent
- Strong color
- Burning
- Cloudy
- Normal color
- Dark yellow
- Clear

Women Only

- Breast swelling
- Breast tenderness
- Other emotions
- Water retention
- Migraines
- Anxiety
- Sharp pain, Where?_____
- Vomiting
- Headaches
- Irritability
- Nausea
- Food cravings
- Depression
- Dull pain, Where?_____

crossroads chiropractic & acupuncture

9320 Olde Eight Road
Northfield Center, Oh 44067
www.crossroads-chiro.com

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name**:_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____ /_____

Crossroads Chiropractic & Acupuncture
9320 Olde Eight Road, Northfield Center, OH 44067
(330) 467-0508 (p) ~ (330) 467-0140 (f)

Patient Name: _____ **Date: _____**

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Crossroads Chiropractic & Acupuncture, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.

Any massage appointment that is not canceled **24 hours prior** to scheduled appointment will be charged $35.

Outstanding Balances:

There will be an **annual 18% interest fee** charged to any balance **30 or more days outstanding**.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____ No one: _____
May we leave messages regarding your personal healthcare information on any answering device? Yes [ ] No [ ]
May we contact you via email? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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Patient Name: _____ **Date: _____**

Terms of Acceptance(Update – September 30, 2017)

Thank you for choosing our office for your chiropractic care. We realize that you have a choice in medical providers and are pleased that you have chosen to seek care with us. Our goal is to provide quality chiropractic care in a timely manner and to limit the inconvenience other patients may face in certain situations. Thank you for your consideration in reading and acknowledging the following office policies.

Effective immediately, we have implemented two new policies with regard to missed/canceled appointments, most specifically massage appointments, and outstanding account balances.

(1) MISSED/CANCELED MASSAGE APPOINTMENTS:

Effective immediately, any patient whose massage appointment is not canceled 24 hours prior to the scheduled appointment will be charged a $35 fee. In addition, a patient who fails to present at the time of his/her massage appointment will be assessed the $35 fee and will have the appointment recorded in his/her medical record as a "no show."

Patients will be notified and alerted to missed appointments and/or late cancelations.

Three (3) late cancelations or "no-shows" within one (1) calendar year will result in a suspension of services.

**Please note that Late Cancelation/No-Show charges are the patient's responsibility and will not be billed to your insurance company.

(2) OUTSTANDING BALANCES:

There will be an **annual 18% interest fee** charged to any balance **30 or more days outstanding**.

Acknowledgement

I have read and fully understand the above statements.

Print Name: _____

Signature: _____ Date: _____