HEALTH HISTORY QUESTIONNAIRE

Ann M Coffey, Acupuncture Detoxification Specialist

Personal & Contact Information

Last Name: ______________________ First Name: __________________ M.I. ___ Today's Date: ___/___/____
Address: ____
City: ____________________ State: ______ Zip: _______ May we contact you via e-mail? ____Y ____N
If so, what is your e-mail address? ____
(e-mail address will not be shared and used only for correspondence from this clinic)

Home Phone: ____________________
Cell Phone: ____________________ Sex: ____M ____F Marital Status: _________
Work Phone: _____________________ Date of Birth:___/___/___ Age: ______ Height: _____ Weight: _______
Occupation: _______________________________ Employer: _____________________________________
Referred By: ______________________________ Family Physician: ______________________________
Emergency Contact: _________________________ Relationship to you: ____________________________
Emergency Contact Phone: ___________________

Main Complaint & Lifestyle History

Have you ever been treated by acupuncture before? _____Y _____ N
What health issues brought you in for treatment today and how long have they been going on?
Main: ____ Since: _____________
Secondary: ____ Since: _____________
Other: ____ Since: _____________
Has an M.D. for this/these problems given you a diagnosis? ____Y ____ N
If so, what were the diagnoses? ____
____
What types of treatment have you tried? ____
____
Medications/Vitamins/Supplements taken in the last 2 months:
____
____
Do you have high blood pressure? ___Y ___N Do you have a pacemaker? ___Y ___N
Please describe your average daily diet:
Morning: ____
Afternoon: ____
Evening: ____
How many cups of coffee, tea, and/or cola do you drink per week? _______
Current drug use: ____
How many alcoholic beverages do you drink per week? ______ Do you smoke? ___Y ___N
Do you have a regular exercise program? ___Y ___N if so, please describe:
____

INFORMATION AND CONSENT FORM

Treatment Description
Acudetox is a specialized form of acupuncture and is performed by placing five thin, sterile, single-use needles into each ear. The treatment takes 45 minutes. Acudetox is done individually or in a group setting. An Acudetox Specialist (ADS) or a professional acupuncture practitioner provides treatments.

Voluntary
I hereby voluntarily consent to be treated with acudetox. I understand that I may be treated with acupuncture needles and/or with the application of acupressure to the skin. I have not been guaranteed any specific outcomes concerning the uses and effects of acudetox. I understand that I am free to discontinue acudetox treatment at any time. However, I further understand that choosing to discontinue treatment may have an effect on my program status.

Possible Side Effects/Healing Reactions
I understand that acudetox may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Conventional medicine therapy also may be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed health care practitioner.

Medical Referral
I understand that if there is a worsening of an ailment or condition, or if a new ailment or condition arises, I should consult a licensed physician. I also understand that if I am currently under a physician's care, I should continue as long as my physician and I deem it necessary. This program does not recommend altering medications or other therapies without first consulting my personal physician or health care provider.

Infectious Disease/Clean Needle Procedures
I understand that there are infectious diseases that have the potential to be carried through the air, through physical contact, and through body fluids. I understand that acudetox practitioners follow the prescribed standards of Universal Precautions to guard against the spread of infection through the use of sterilized, prepackaged, disposable single-use needles.

______________________	______________________	__________
Client Name	Client Signature	Date
______________________	______________________	__________
Witness Name	Witness Signature	Date

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