Health History and Insurance Coverage Questionnaire

Please complete this document as thoroughly as possible. Some questions may seem unrelated to your condition but may play a role in diagnosis and treatment. If you have insurance coverage, the information you provide will help us submit claims for you. *All information is strictly confidential*.

General Information Date: ___/___/____

Name: _____

Address: _____ City_____ State____ Zip____

Best Phone (C/W/H) : (_____)_____-_____ Alternate # (W/C/H): (____)_____-_____

Email:_____

Date of Birth: ____/____/_____ Age:_____ Place of Birth: _____

Height: ___ ft. ____ inches Weight: _____ lbs. Sex @ birth _____ Gender: _____

Marital status: _____ Name of Partner/Spouse_____# of Years: _____

Children: _____ Pets:_____

Occupation:_____ Employer:_____

How did you hear about us?_____

Medical History

Major Complaint(s) in order of significance to you:

	Severe	Moderate	Slight	
1.	❑	❑	❑	_____
2.	❑	❑	❑	_____
3.	❑	❑	❑	_____
4.	❑	❑	❑	_____
5.	❑	❑	❑	_____
6.	❑	❑	❑	_____
7.	❑	❑	❑	_____
8.	❑	❑	❑	_____

How do these conditions impair your daily activities?_____

Which treatments have you tried for these conditions?_____

What results have you experienced? _____

How would you describe your childhood health? _____

Did you get standard childhood immunizations? ❑ Yes ❑ N

Have you had any unusual immunizations or reactions to immunizations? _____

_____

Surgeries/Hospitalizations: _____

_____

Trauma (Physical/Emotional): _____

_____

Any test results you would like us to know about? _____

_____

Past Medical History

- ❑ Allergies
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Emphysema
- ❑ Diabetes
- ❑ Thyroid Disorder
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Hepatitis
- ❑ Pancreatitis
- ❑ HIV
- ❑ STD's
- ❑ Lyme Disease
- ❑ Epilepsy
- ❑ Paralysis/Bell's Palsy
- ❑ Stroke
- ❑ Migraine
- ❑ Vein Condition
- ❑ Frequent infections
- ❑ Recurring fevers
- ❑ Fibromyalgia /CFIDS
- ❑ Measles
- ❑ Mumps
- ❑ Mononucleosis
- ❑ Polio
- ❑ Tuberculosis
- ❑ Rheumatic Fever
- ❑ Lupus
- ❑ Cancer: _____
- ❑ Autoimmune disorder
- ❑ Glaucoma
- ❑ Ulcerative Colitis
- ❑ Crohn's Disease
- ❑ Kidney Stones
- ❑ Gall Stones
- ❑ Other Neurologic
- ❑ Other Hormone Disorder
- ❑ Other Kidney Disorder
- ❑ Other Lung Disorder
- ❑ Other Liver Disorder
- ❑ Other Digestive

Other: _____

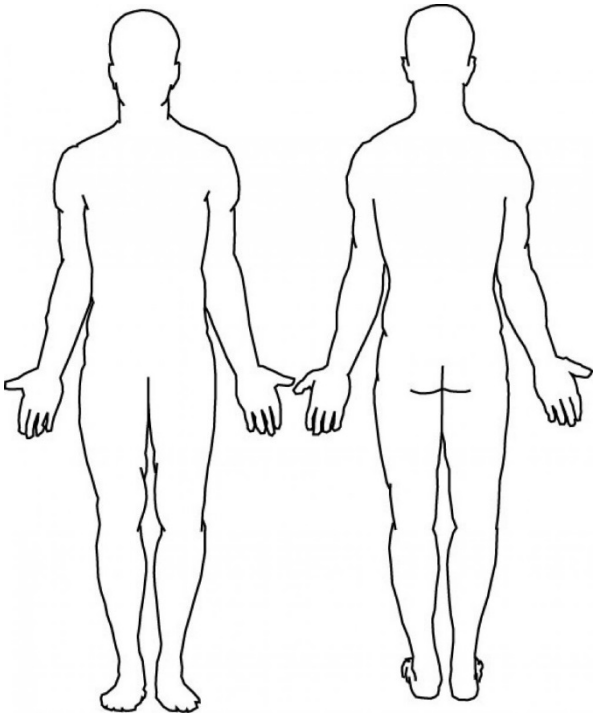
_____

Family History

	Age	Living	Deceased	Health History
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				
Child				
Child				
Child				

Patient Profile

Please mark any areas of pain (xxx) or scars (---)
Rate your pain next to areas of pain:
0….1….2….3....4....5….6….7....8….9….10
None Discomfort Moderate Severe



Is the pain:

- ❑ Constant
- ❑ Frequent
- ❑ Daily
- ❑ Occasional
- ❑ Weekly
- ❑ Infrequent
- ❑ Rare
- ❑ Sharp
- ❑ Dull
- ❑ Moving
- ❑ Burning
- ❑ Aching
- ❑ Tingling
- ❑ Other:

Does the following reduce the pain?

- ❑ Pressure
- ❑ Heat
- ❑ Cold
- ❑ Exercise
- ❑ Rest
- ❑ Other:

Does the following worsen the pain?

- ❑ Pressure
- ❑ Heat
- ❑ Cold
- ❑ Exercise
- ❑ Rest
- ❑ Other:

Overall Energy (Lung, Kidney, Spleen Function)

- ❑ Fatigue during the day
- ❑ Tired when first wake up
- ❑ Tired at the end of the day
- ❑ General weakness
- ❑ Easily catch colds
- ❑ Shortness of breath
- ❑ Feel worse after exercise
- ❑ Prolonged recovery from illness
- ❑ Aversion to talking
- ❑ Pasty pale complexion
- ❑ Exercise: How often_____ How long_____ What_____

Heart Function

- ❑ Palpitations
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Emotional sensitivity
- ❑ Restlessness
- ❑ Easily startled
- ❑ Dull or glazed eyes
- ❑ Chest pain or discomfort
- ❑ Sores on tip of tongue
- ❑ Frequent dreams
- ❑ Fainting (ever?)

Lung Function

- ❑ Nasal discharge (Color:_____)
- ❑ Sinus congestion
- ❑ Allergies (To:_____)
- ❑ Nose bleeds
- ❑ Dry cough
- ❑ Productive cough (Color:_____)
- ❑ Dry mouth, nose, throat, skin

Lung Function cont'd

- ❑ Smoker or history # cigs / ppd_____
- ❑ Sore throat, History of Strep throat
- ❑ Overall achy feeling
- ❑ Alternating chills and feverish
- ❑ Asthma – difficulty exhaling
- ❑ Sadness, melancholy, grief
- ❑ Perfectionism

Overall temperature (Kidney Function)

- ❑ Cold hands/feet
- ❑ Sweaty hands/feet
- ❑ Feel generally more hot
- ❑ Feel generally more cold
- ❑ Afternoon flushes
- ❑ Red cheeks at times
- ❑ Hot flashes any time of day
- ❑ Heat in hands, feet, and chest

Overall temperature cont'd

- ❑ Night sweats
- ❑ Thirsty and drink in gulps
- ❑ Thirst but no desire to drink
- ❑ Thirst but take only sips
- ❑ Bring water to bed at night
- ❑ Perspire easily (where?:_____)
- ❑ Perspire with rest
- ❑ Lack of perspiration

Spleen Function

- ❑ Low appetite
- ❑ Never satisfied, tend to overeat
- ❑ Only want 'easy' foods, not inclined to cook
- ❑ Abrupt weight gain
- ❑ Abrupt weight loss
- ❑ Abdominal bloating
- ❑ Abdominal gas
- ❑ Gurgling noise in stomach
- ❑ Fatigue after eating
- ❑ Prolapsed organs (bladder, uterus)
- ❑ Hernia(s), Hemorrhoids
- ❑ Bruise easily
- ❑ Blood sugar variations
- ❑ Overthink, obsess, worry
- ❑ Difficulty focusing, distractible
- ❑ Overwhelmed by details
- ❑ Pensive

Stomach Function

- ❑ Large appetite, get hungry
- ❑ Small appetite
- ❑ Belching
- ❑ Bleeding, swollen, or painful gums
- ❑ Burning sensation after eating
- ❑ Heartburn, acid reflux (GERD)
- ❑ Hiccoughs
- ❑ Mouth (canker) sores
- ❑ Stomach Pain
- ❑ Ulcer (diagnosed)
- ❑ Aversion to strong odors or flavors
- ❑ Nausea/vomiting
- ❑ Anorexia
- ❑ Bulimia
- ❑ Headache over forehead
- ❑ Food aversions
- ❑ Bad breath

Daily Diet	Approximate Time	What do you typically eat?
Breakfast		
Snacks		
Lunch		
Snacks		
Dinner		
Snacks		

Cravings: _____

Special dietary regimens/diets: _____

Large and Small Intestine Function

- ❑ Bowel movements (#/day or /week____)
- ❑ Well formed
- ❑ Alternating diarrhea / constipation
- ❑ Shredded
- ❑ Pasty
- ❑ Loose stools
- ❑ Diarrhea
- ❑ Burning
- ❑ Incontinence (unable to control bowels)
- ❑ Constipation
- ❑ Hard, dry stool
- ❑ Incomplete bowel movement
- ❑ Blood in stool
- ❑ Mucus in stool
- ❑ Cramping pain
- ❑ Undigested food in stool
- ❑ Gas/flatulence
- ❑ Food sensitivity/intolerance:
  What:_____
- ❑ Obsessive compulsive tendencies
- ❑ Trouble sorting thoughts

Kidney and Bladder Function

- ❑ Kidney stones
- ❑ Urinary tract infections (UTI)
- ❑ Wake to void
- ❑ Low back pain
- ❑ Cold, weak, or sore knees
- ❑ Low pitch ringing in ears
- ❑ Hearing loss or trouble hearing
- ❑ Easily overwhelmed
- ❑ Take on more that you can handle
- ❑ Phobias or fears
- ❑ Asthma: trouble with inhaling
- ❑ Dark circles under eyes
- ❑ Frequent dental cavities
- ❑ Broken bones
- ❑ Memory problems
- ❑ Excess hair loss
- ❑ Early graying of hair
- ❑ Repeat miscarriage
- ❑ Need excessive sleep
- ❑ Apathy or decreased motivation
- ❑ Easily defeated or disgruntled
- ❑ Crave coffee and stimulants
  # cups caffeine/day_____ or /week____
- ❑ Water intake # ounces/day _____

Kidney and Bladder cont'd

- ❑ Urgency or frequent urination
- ❑ Difficult or incomplete urination
- ❑ Lack of bladder control
- ❑ Stress incontinence

Liver and Gall Bladder Function

- ❑ Tingling / Numbness
- ❑ Migraines
- ❑ Headaches on top or side of head
- ❑ Neck and shoulder tension
- ❑ Seizures or stroke
- ❑ Muscle spasm, twitching, cramping
- ❑ Tight sensation in chest under ribs
- ❑ Frequent sighing
- ❑ Eyes bloodshot, hot, dry, painful, gritty
- ❑ Watery eyes / discharge from eyes
- ❑ Blurred vision, decreased night vision
- ❑ Cataracts
- ❑ Macular degeneration
- ❑ Glasses (age started_____)
- ❑ Anger easily
- ❑ Frustration, irritability
- ❑ Depression
- ❑ Difficulty making decisions
- ❑ PMS
- ❑ High-pitched ringing in ears
- ❑ Bitter taste in mouth
- ❑ Lump in throat, trouble swallowing
- ❑ Itching, where:_____
- ❑ Alcohol (#drinks _____ day/week/month)
- ❑ Recreational drug history/current use:
  What:_____ Frequency:_____

Sexual Function

- ❑ Normal libido
- ❑ High libido
- ❑ Low libido
- ❑ Difficulty with arousal or orgasm

Dampness

- ❑ Mental heaviness, sluggish, foggy
- ❑ Swollen hands, feet, joints
- ❑ Chest or sinus congestion
- ❑ Nausea
- ❑ Snoring, if yes sleep study? _____
- ❑ General sensation of heaviness
- ❑ Yeast infections, damp rashes

Men Only

- ❑ Premature ejaculation
- ❑ Impotence (Erectile Dysfunction)
- ❑ Swollen testicles
- ❑ Testicular pain
- ❑ Feeling of coldness in genitals
- ❑ Prostate swelling or prostatitis
- ❑ Elevated PSH
- ❑ Urinary stream changes
- ❑ Excessive masturbation
- ❑ Lack of semen, infertility

Women Only

- ❑ Age at first menses:_____
- ❑ Regular menses
- ❑ How often (# days):_____
- ❑ Number of days of flow: _____
- ❑ Bleeding between periods
- ❑ Birth control method _____
- ❑ Number of pregnancies:
- ❑ Number of miscarriage/abortion:_____
- ❑ Complications with pregnancies
- ❑ Vaginal delivery (#_____)
- ❑ C-sections (#_____)
- ❑ Breast-fed
- ❑ Lack of breast milk
- ❑ Postpartum depression or weakness
- ❑ Endometriosis
- ❑ Fibroids
- ❑ Infertility
- ❑ Ovarian cysts
- ❑ Vaginal discharge (Color_____)
- ❑ PMS symptoms
  - ❑ Nausea
  - ❑ Vomiting
  - ❑ Headaches/migraines
  - ❑ Cramping
  - ❑ Breast tenderness/swelling
  - ❑ Irritability
  - ❑ Anxiety
  - ❑ Depression
  - ❑ Other: _____
- ❑ Fertility treatments:_ _____
  - ❑ IUI cycles: _____
  - ❑ IVF cycles: _____

Blood

- ❑ Dry eyes, hair, skin, nails
- ❑ Dry mucous membranes
- ❑ Thin hair
- ❑ Pale sallow complexion
- ❑ Restless fatigue, restless leg syndrome
- ❑ Anxious sleep
- ❑ Itchy skin, rashes, where? _____
- ❑ Muscle cramps, tight muscles
- ❑ Dry hard stool
- ❑ Anemia
- ❑ Infertility
- ❑ Scanty or light menses
- ❑ Decreased flexibility
- ❑ Poor skin healing
- ❑ See floating spots
- ❑ Feel invisible

Sleep

Describe your sleep:_____
Trouble falling asleep ❑ Yes ❑ No
Typical bedtime: _____
Typical wake time: _____
Wake with alarm? ❑ Yes ❑ No
Wake to urinate? ❑ Yes ❑ No
Fall back asleep easily? ❑ Yes ❑ No
Awake at other times? ❑ Yes ❑ No
Rested upon rising? ❑ Yes ❑ No
Take naps? ❑ Yes ❑ No
Sleep in on days off? ❑ Yes ❑ No

Medications, Supplements, Herbs

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Biologic females, if you are still menstruating, please complete the following chart:
Date of last menstrual cycle: _____

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (red, bright, pale, brown, rust, purple)							
Amount (heavy, moderate, light, spotting							
Pain/Cramps (dull, sharp)							
Clots (large, small, red, black)							
Vomiting (V) Nausea (N)							
Headache (H) Migraine (M)							
Other							

Additional comments:

Patient signature:_____

Date

Please turn to the next page for information and questions regarding your insurance coverage.

Simply ignore if your plan does not cover acupuncture, or you don't currently have insurance!

Health Insurance Information/Questionnaire

We are in-network providers with:

• Aetna	• Johns Hopkins EHP
• Blue Cross/Blue Shield	• Kennedy Krieger's Core Source
• Cigna	• United Health Care

We will submit claims for you *as an in-network provider*. You are responsible for any co-payment or co-insurance at the time of your appointment. ***Please be aware:***

- Medicaid and Medicare ***do not*** cover acupuncture.
- ***Some*** Medicare supplemental insurance plans provide coverage but ***most do not***.

Please confirm insurance coverage before arriving for your first appointment. If you are unclear about your insurance coverage, full payment will be expected at the time of service. Please use this chart to ask questions and record the information you receive.

Name of Insurance Provider: _____ Phone: (____)_____-_____

Representative with whom you spoke: _____ Reference # for call:_____

1.	Does my insurance cover acupuncture?	❑ Yes	❑ No	By a provider of my choosing?
2.	Is my acupuncture coverage limited to certain conditions or diagnosis?	❑ Yes	❑ No	Which ones?
3.	Is preauthorization required?	❑ Yes	❑ No	
4.	Are there exclusions to my acupuncture benefits?	❑ Yes	❑ No	What are they?
5.	Are there exclusions to who may provide acupuncture?	❑ Yes	❑ No	What are they?
6.	Do I have a deductible that must be met before my insurance covers my treatment?	❑ Yes	❑ No	How much is it? How much have I met?
7.	Do I have a co-payment?	❑ Yes	❑ No	How much is it?
8.	Do I have a co-insurance payment?	❑ Yes	❑ No	How much is it?
9.	Is there a limit to the number or dollar amount of acupuncture services I may receive?	❑ Yes	❑ No	How many/much?
10.	Does my benefit year follow the calendar year? (i.e. Jan 1-Dec 31)	❑ Yes	❑ No	If not what's the start date? (e.g., April 1, July 1)

10.	Are you the insured?	❑ Yes	❑ No	If not who is? DOB: Employer: