You can move between fields using the tab key. Please click on boxes to check them. Print as a pdf in your name (ie KristaEssler.pdf) and

email to KristaEsslerLAc@gmail.com HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS

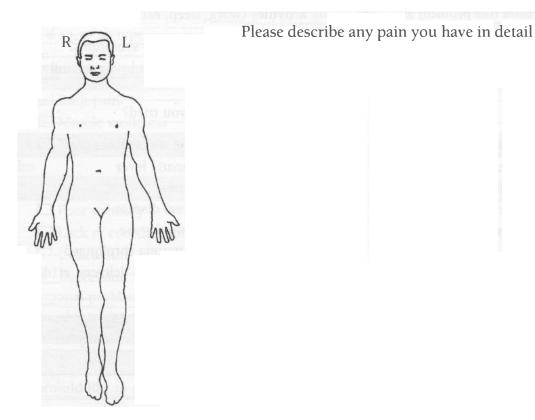
Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **COMMENTS** section. Thank you!

	and the second	and the second se
Street:	City:	State: Zip:
Age: Height:	Weight: E-	mail:
Home Phone:	Cell Phone:	
Date of Birth:	Place of Birth:	
Occupation:		Marital Status:
Emergency Contact and Pho	one Number:	
Referred by:		
Family Physician Contact:	ni isi dan apple datamin'nang m	
Have you tried acupunctur	e or Chinese herbal medicine before?	and the standard and the set
MAIN PROBLEM(S) YOU W	OULD LIKE TO ADDRESS	
What is your chief complain	t?	
		the second s
Fo what extent does this p	roblem affect your daily activities (wor	k, sleep, eating, etc.)?
1 Silungers		Alt of the second se
	you first noticed any symptoms?	(Clabor bod bot
	nosis for the problem by your family	physician?
If so, what is it?		Contemporation of the
What kinds of treatment or	therapy have you tried?	A list of a list of a
PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)	A STATE STATE
Allergies:	□Rheumatic fever	Other significant illness
Cancer	□Surgeries	and the set
Diabetes	□Venereal disease	Calevellary 2015(ptr)
Hepatitis	□Thyroid disease	e Chillend Brussen
□High blood pressure	□Birth trauma (prolonged	□Accidents or significant
□Heart disease	labor, forceps delivery, etc)	trauma (describe)
Seizures	and a second sec	
OTHER RELEVANT MEDICA	AL HISTORY	
Month Martin		and the second

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FAMILY MEDICAL HISTORY		
□ Allergies	□ Cancer	□ Seizures
□ Diabetes	□ Heart disease	□ Stroke
□ Asthma	☐ High blood pressure	□ Other
Occupation		
Describe your job:		
LIFESTYLE		
Your exercise program:		
Your average daily diet:		
Please check any of the follow	ing habits that apply. How m	uch and how often do you use them?
□ Cigarette smoking	\Box Coffee, tea or cola	□ Alcoholic beverages
List medications taken within	the last two months (vitaming	s, drugs, herbs, etc.):

Please describe any use of drugs for non-medical purposes:



L R The Aller Please put a check next to any conditions you have experienced within the last three months. Indicate the length of time you have had this condition.

GENERAL		
Poor appetite	🗆 Weight gain	□ Night sweats
🗆 Insomnia	□ Weight loss	Fever
□ Disturbed sleep	□ Changes in appetite	Chills
Localized weakness	□ Sweating easily	Sudden energy drop
□ Cravings	□ Tremors	Time of day:
□ Strong thirst	□ Bleeding or bruising easily	Poor balance
Other unusual or abnormal cond	itions you have noticed in your g	eneral sense of health
elision e miserio El		
Skin and hair		
□ Rashes	🗆 Eczema	□ Recent moles
□ Ulcerations	Pimples	□ Changes in hair or skin
Hives	Dandruff	and the second sec
□ Itching	🗆 Hair loss	
Any other hair or skin problems	and the second data and	
HEAD, EYES, EARS, NOSE, THE	ROAT	
Dizziness	Color blindness	□ Recurrent sore throats
□ Concussions	□ Cataracts	□ Nose bleeds
□ Migraines	□ Blurry vision	Grinding teeth
Glasses	Earaches	□ Sores on lips or tongue
□ Spots in front of eyes	□ Ringing in ears	🗆 Facial pain
🗆 Eye pain	Poor hearing	□ Teeth problems
Poor vision	🗆 Eye strain	□ Headaches (where? when?)
□ Night blindness	□ Sinus problems	□ Jaw clicks
Any other head or neck problem	S	
CARDIOVASCULAR		Service Charles Mail and
Dizziness	□ High blood pressure	□ Swelling of feet
□ Low blood pressure	□ Fainting	□ Blood clots
Chest pain -	□ Cold hands or feet	□ Difficulty in breathing
🗖 Irregular heartbeat	□ Swelling of hands	🗆 Phlebitis
Any other heart or blood vessel j	problems	Live and story been transit for a
RESPIRATORY		and the state of the state of the
Cough	Bronchitis	Difficulty breathing when
□ Coughing up blood	□ Pain with deep inhalation	lying down
□ Asthma	🗖 Pneumonia	□ Excessive phlegm
Any other lung problems		

GASTROINTESTINAL	ette de la constante de la cons				
🗆 Nausea	□ Belching	□ Rectal pain			
□ Vomiting	\square Black stools	☐ Hemorrhoids			
□ Diarrhea	□ Blood in stools	□ Abdominal pain or cramps			
Constipation	□ Indigestion	Chronic laxative use			
Gas	□ Bad breath				
Any other problems with st	omach or intestines	i			
GENITOURINARY					
Pain on urination	Urgency to urinate	Decrease in flow			
□ Frequent urination	□ Unable to hold urine`	Impotence			
□ Blood in urine	□ Kidney stones	□ Sores on genitals			
Do you wake up at night to	urinate? If so, how often	1?			
Any particular color to your	r urine?	1 March 199			
Any other genital or urinary	y problems	Sud tons offers of specific problem.			
REPRODUCTIVE AND GYNE	ECOLOGIC				
Premenstrual changes	□ Heavy menstrual flow	Premature births			
Menstrual clots	□ Light menstrual flow	□ Miscarriages			
Painful menses	□ Irregular menses	□ Abortions			
□ Unusual menses	□ Other problems				
Age at first menses	Age at menopause Nun	nber of pregnancies			
Time between cycles	Duration of bleeding First	t day of last menses			
Do you practice birth contro	ol? If so, what type?	For how long?			
Any other gynecologic prob	lems	1 Alland			
MUSCULOSKELETAL					
🗖 Neck pain	🗖 Back pain	□ Hand/wrist pains			
□ Muscle pains	□ Muscle weakness	□ Shoulder pains			
🗖 Knee pain	☐ Foot/ankle pains	🗆 Hip pain			
Any other joint or bone pro	blems				
NEUROPSYCHOLOGICAL					
□ Seizures	Poor memory	Anxiety			
Dizziness	□ Lack of coordination	□ Bad temper			
□ Loss of balance	Concussion	Easily susceptible to str			
□ Areas of numbness					
Have you ever been treated	for emotional problems?				
Have you ever considered or	r attempted suicide?	English English English			
Any other neurological or p	sychological problems				
7 0 1					
Comments					

Metabolic Assessment Form

3._____ 4._____

Name: ______ Age: ____ Sex: ___ Date: _____

PART I

Please list the 5 major health concerns in your order of importance: 1._____ 2._____

5._____

PART II	Please circle the appropriate number "0 - 3" on all questions below. <u>0 as the least/never</u> to <u>3 as the most/always</u> .
~	

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	Õ	1	2	3
Pass large amount of foul smelling gas	Ŏ	1	2	3
More than 3 bowel movements daily	Ő	1	2	3
use laxatives frequently	Ő	1	$\frac{2}{2}$	3
use faxatives frequently	U	I	4	3
Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	Ŏ	1	$\overline{2}$	3
Offensive breath	Ő	1	$\frac{1}{2}$	3
Difficult bowel movements	0	1	$\frac{2}{2}$	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables;				
undigested foods found in stools	0	1	2	3
Category III				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids?	Ő	1	$\frac{2}{2}$	3
	0	1	2	3
Feeling hungry an hour or two after eating	•	-		-
Heartburn when lying down or bending forward Temporary relief from antacids, food,	0	1	2	3
	•	1	•	2
milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus,				
peppers, alcohol, and caffeine	0	1	2	3
Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4	v		-	5
hours after eating	0	1	2	3
	U	T	4	3
Pain, tenderness, soreness on left side	•		•	2
under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling,				
mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	Õ	1	2	3
······································	, v	-	-	2

Category V				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating				
several hours after eating	0	1	2	3
Bitter metallic taste in mouth,				
especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored				
to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0 0	1 1	2 2	3 3
History of gallbladder attacks or stones		-	_	•
Have you had your gallbladder removed	Ye	s	Γ	lo
Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	Ő	1	$\frac{1}{2}$	3
Depend on coffee to keep yourself going or started	Ŏ	1	2	3
Get lightheaded if meals are missed	Ŏ	1	2	3
Eating relieves fatigue	Õ	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII	•		•	•
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0 0	1 1	2 2	3 3
Must have sweets after meals Waist girth is equal or larger than hip girth	0	1	$\frac{2}{2}$	3 3
Frequent urination	0	1	$\frac{2}{2}$	3 3
Increased thirst & appetite	0	1	$\frac{2}{2}$	3
Difficulty losing weight	Ő	1	$\frac{2}{2}$	3
Difficulty robing worght	Ū	•	-	U
Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1		3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.

For nutritional purposes only.

Canado fall asleep 0 1 2 3 Urdnich fall asleep 0 1 2 3 Urdnich fall asleep 0 1 2 3 Urdnich fall asleep 0 1 2 3 Weight gain when under stress 0 1 2 3 Wake up tired over after 6 or more hours of sleep 1 2 3 Excessive perspiration or perspiration or starting 0 1 2 3 Category X Tited, slegsish 0 1 2 3 Regure coccessive anounts of sleep to 1 2 3 More another on the own of sleep to 1 2 3 Opersoin, lack of morivation 0 1 2 3 Musted opersoin anound anound chest and hips 0 1 2 Difficult, infrequent lower 0 1 2 3 Musted opersoin anound chest and hips 0 1 2 3 Moring headaches that wear off 1 2 3 Musted opersoin anound chest and hips 0 1 2 3 Depressoi	Catagory IX					Catagory XIV				
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Do you smoke? If yes, how many times a day:										
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Rate your stress levels on a scale of 1-10 during the average week:										
Please list any medications you currently take and for what conditions:										

Please list any natural supplements you currently take and for what conditions:

Acupuncture and Holistic Care

for Wellness and Pain Management 570-728-3438 Krista J Essler LAC 2205 West Market Street, Pottsville PA 17901

Please describe your health history in detail:



Krista J Essler, LAc, Dipl Ac, MTCM Cert Homeo, CTFL, BAE

St Pottsville, PA 17901 570-728-3438 www.ACU17901.com

No-show, Cancellation and, Late Policies

Please be on time for your appointment. If you are going to be late, text or call. More than10 minutes of lateness is equivalent to a no-show.

If you need to cancel, please do so within 48 hours of your appointment. Otherwise, the appointment is equivalent to a no-show.

If you don't show up for your appointment without making contact and for non-emergency reasons, such as your day got busy, you forgot, etc, then penalties may be applied as follows:

First no-show – 50% of current price, payable before rescheduling. Second no-show – 75% of current price, payable before rescheduling. Third no-show – Full price, payable before rescheduling. Pandemic fee – additional \$20, payable before rescheduling.

Penalties can be avoided by rescheduling and showing up for your appointment the same calendar week.

By signing below, I understand that less than 48 hours notice of cancellation, lateness, and not showing up for an appointment can result in penalties.

Print name

Signature (type name)

Date

Office signature



Krista J Essler, LAc, Dipl Ac, MTCM Cert Homeo, CTFL, BAE

2205 West Maket St Pottsville, PA 17901 570-728-3438 www.ACU17901.com

Electronic Contact Consent

I agree to allow Krista J Essler, LAc and *Acupuncture and Holistic Care for Wellness and Pain Management* to contact me via the following e-mail address and mobile number (both voice and text messaging) for the purpose of appointment reminders, general practice updates, and to answer specific questions regarding my treatment.

Further, contact can be made for the purpose of invoicing and billing and may contain specific treatment information.

e-mail

mobile number

name

signature (type name)

date

PATIENT NAME: This form is read only, please fill out and sign in office

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. ______. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

	. (Date)
X	This form is read only, please fill out and sign in office
	(Indicate relationship if signing for patient)
	(Date)
X	
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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbress or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of treat largos. 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 the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 naused, gas, stomachache, vomiting, headache, dianhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and even all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed

I understand the clinical and administrative staff may review my patient 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, the above consent to treatment, have been 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(s) for which I seek treatment.

ACUPUNCTURIST NAME: (Date) This form is read only, please fill out and sign in office Х PATIENT SIGNATURE (Or Patient Representative) (Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

ALLO SIGN THE INFORMED CONSENT ON REVEALS

NG UP YOUR RIGHT TO A JURY OR COURT TRIAL SEE