Lisa Lipson, M.P.H., Lic. Ac. M.Ac

Well Space Community Acupuncture

847 Washington Street Canton MA 02021

Health History Questionnaire

All information will be kept strictly confidential as part of your medical record

Name:	**DOB**
Address:	
Phone Numbers Home: **Cell:** **Work:**	
Emergency Contact Name:	**Phone:**
Referred By:	
Primary Care Physician:	**Date of Last Exam:**

HEALTH HISTORY

What are your main reasons for coming in for treatment?

1.
2.
3.

Please list serious illness, accidents, or surgeries:

Please check illnesses that have occurred in blood relatives:

☐Diabetes(Type I or II) ☐Cancer (Type) ☐ High blood pressure

☐ Kidney disease ☐Stroke ☐Other

Please List Medications, Herbs, and Supplements Taken Regularly:

Name of Medication/Herb/Supplement	Strength	Reason Taken

Any Allergies to Medications/Foods?

Name of Drug/Food	Reaction You Had

Health History Continued

Exercise:	☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.) ☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)
Diet:	Are you on a special diet? ☐ Yes ☐ No If yes, please describe:
Caffeine:	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day?
Alcohol:	Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? _____ Are you concerned about the amount you drink? ☐ Yes ☐ No
Tobacco:	Do you smoke tobacco? ☐ Yes ☐ No ☐ Cigarettes - Pks/day ☐ or Year Quit

Life Stressors:

Is stress/anxiety a major problem for you? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Please describe or explain any concerns:

WOMEN ONLY

Age at onset of menstruation: Date of last menstruation:

Period every days. Heavy periods, irregularity, spotting, pain, or discharge? (please circle) ☐ Yes ☐ No

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Have you had a D&C, hysterectomy, or Cesarean section? ☐ Yes ☐ No

Any urinary tract, bladder, or kidney infections within the last year? ☐ Yes ☐ No

Any hot flashes or sweating at night? ☐ Yes ☐ No

PMS, pain, bloating, irritability, or other issues near time of period? (please circle) ☐ Yes ☐ No

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No If yes, # of times ___

Do you feel pain or burning with urination? ☐ Yes ☐ No

Date of last prostate exam? _____

OTHER ISSUES

Check if you have any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Lungs	☐ Circulation
☐ Head/Neck	☐ Chest/Heart	☐ Recent change in weight
☐ Ears	☐ Back	☐ Energy Level
☐ Nose	☐ Bladder	☐ Ability to Sleep
☐ Throat	☐ Bowels	☐Other Pain/Discomfort:

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Informed Consent to Treatment

I hereby consent to acupuncture treatments and other procedures within the scope of practice of acupuncture by acupuncturist Lisa Lipson. Methods of treatment may include acupuncture, moxibustion, cupping, gua sha, herbal supplements or nutritional counseling based on the concept of Traditional Chinese Medicine.

Acupuncture involves the insertion of small sterile needles into particular points on the body. The purpose of this it to prevent or reduce pain and to help your body function better. I understand that acupuncture is a generally safe method of treatment, but there are some risks to treatment, including slight bleeding or bruising, weakness, soreness, fainting, or temporary aggravation of existing symptoms. We use only one-time use, sterile needles. There is little to no risk of infection.

We do not provide primary medical care. If you are pregnant, have a bleeding disorder, pacemaker, high blood pressure, seizure disorder, local infection, or are on blood thinning medications, by signing below you state that you have informed your acupuncturist of such conditions.

Signature:_____ Date:_____

Special Privacy Notice

Because clients are in such close proximity, it is important that we all make an effort to respect one another's privacy. We do this by refraining from much talking in the treatment room, and keeping our voices to a whisper when we do talk. I consent to receive acupuncture in a group setting. I understand that it is more difficult to maintain complete privacy in this setting. I understand that I may choose not to mention, or have my acupuncturist mention, any sensitive health information in the group treatment room. This information can be shared in private or in writing. I understand that my written health record will remain confidential.

Signature:_____ Date:_____

Financial Policy

Payment is due at time of treatment. Fees are $20-$40 per treatment. Please pay whatever amount you are comfortable each time you have a treatment. My mission to make acupuncture available to as many people as possible at the most affordable rates. I accept cash, check (made out to Lisa Lipson, Lic. Ac), or Venmo. You can also pay by credit card but there is a 2.75% processing fee. Please pay for each treatment at the time it is received. I will reserve an appointment time for you, and ask that you call if you cannot kept it at least 24 hours ahead of time. There is a $20 fee for appointments with less than 24 hours notice.
By signing, I agree to the above policy.

Signature:_____ Date:_____