PATIENT INFORMATION

EMILY FARISH ACUPUNCTURE
400 S. Jefferson STE. 203
Spokane WA 99204
(509) 217-9262
Fax (509) 931-0448

Patient Name:_____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Preferred form of appointment reminder? Email_____ Text_____ Phone_____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Phone #: _____

How did you hear about us?: _____

I understand that I am financially responsible for all charges whether paid by my insurance. I am aware that some and perhaps all the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I authorize the release of medical information to my insurance company, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and request my insurance company to pay directly to AcuHealth Solutions, LLC., for those medical services. I understand that any outstanding account balances will be sent to collections after 90 days if payment has not been remitted.

An East Asian Medicine Practitioner in the State of Washington is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition has been diagnosed by your doctor and is not an emergency we will be happy to do so, as long as the condition has been diagnosed by your doctor and is not an emergency. If the patient decides to alter their pharmaceutical regime in any way, the patient must consult their doctor before doing so. I have read the above and I understand and accept these policies. Please understand we have a strict 24-hour cancellation policy. If within those 24 hours you decide to cancel or not show, you will be billed for 50% of the apt. fee/consult.

Patient Signature: _____ Date: _____

HEALTH HISTORY QUESTIONNAIRE

Major Complaint(s):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Primary Physician:_____

Other physicians/therapists:_____

Medication(s) you are currently taking:

Drug Name	Taking For	Taking Since

Supplements (vitamins, herbs, minerals, etc.):_____

_____

List all hospital stays, surgeries, accidents, traumas and major illnesses that you have had since birth	**Year Occurred**

Test	Year	Test Results
☐ Physical	_____	_____
☐ Cholesterol	_____	_____
☐ Prostate	_____	_____
☐ Mammogram	_____	_____
☐ Pap Smear	_____	_____
☐ Blood	_____	_____
☐ HIV/STD	_____	_____

Please check if you have or had any of the following conditions

☐ Diabetes	☐ Syphilis	☐ Mumps	☐ Jaundice
☐ Heart Disease	☐ CVA (Stroke)	☐ Rheumatic Fever	☐ Hepatitis
☐ Asthma	☐ Pneumonia	☐ Emphysema	☐ Vein Condition
☐ Allergies	☐ Gonorrhea	☐ Bleeding Tendency	☐ Tuberculosis
☐ Meningitis	☐ Measles	☐ High Blood Pressure	☐ Chicken Pox

- [ ] Epilepsy
- [ ] HIV
- [ ] Nervous Disorder
- [ ] Polio
- [ ] Paralysis
- [ ] High Fever
- [ ] Mononucleosis
- [ ] Migraines
- [ ] Glaucoma
- [ ] Cancer
- [ ] Multiple Sclerosis
- [ ] Anxiety

Family History of Disease (include relationship)

- [ ] Diabetes: _____
- [ ] Heart Disease: _____
- [ ] Thyroidism: _____
- [ ] COPD: _____
- [ ] Autoimmune: _____
- [ ] Smoking: _____
- [ ] Alcoholism: _____
- [ ] Hepatitis: _____
- [ ] Cancer: _____

Please check all the symptoms that you are currently experiencing or have experienced in the last 6 months.

Describe Your General Pain

- [ ] Sharp
- [ ] Fixed
- [ ] Burning
- [ ] Moving
- [ ] Cramping
- [ ] Aching
- [ ] Dull
- [ ] Other: _____

What makes the pain better?

- [ ] Soft pressure
- [ ] Hard pressure
- [ ] Cold
- [ ] Heat
- [ ] Exercise
- [ ] Rest
- [ ] Other (_____)

What makes the pain worse?

- [ ] Soft pressure
- [ ] Hard pressure
- [ ] Cold
- [ ] Heat
- [ ] Exercise
- [ ] Rest
- [ ] Other: _____

TOTAL BOXES CHECKED: _____

Please indicate pain location(s):

Lung & Kidney Function (Overall Temperature)

- ☐ Shortness of breath
- ☐ General weakness
- ☐ Daily chronic fatigue & malaise
- ☐ Low energy
- ☐ Difficulty keeping eyes open (daytime)
- ☐ Easily catch colds
- ☐ Feel worse after exercise

TOTAL BOXES CHECKED: _____

Liver, Spleen, Heart Function

- ☐ Dizziness
- ☐ See floating black spots

TOTAL BOXES CHECKED: _____

Heart Function

- ☐ Anxiety
- ☐ Sores on tip of tongue
- ☐ Restlessness
- ☐ Mental confusion
- ☐ Chest pain traveling to shoulder
- ☐ Frequent dreams
- ☐ Wake unrefreshed
- ☐ Trouble falling and/or staying asleep

TOTAL BOXES CHECKED: _____

Pancreas/Spleen Function

- ☐ Low appetite
- ☐ Abrupt weight gain
- ☐ Abrupt weight loss
- ☐ Abdominal bloating
- ☐ Abdominal gas
- ☐ Worry
- ☐ Gurgling noise in stomach
- ☐ Fatigue after eating
- ☐ Bruise easily
- ☐ Prolapsed organs: _____
- ☐ Overthinking

TOTAL BOXES CHECKED: _____

Small/Large Intestine Function

- ☐ Loose stools
- ☐ Constipated
- ☐ Incomplete stools
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Mucous in stools
- ☐ Undigested food in stools

TOTAL BOXES CHECKED: _____

Lung Function

- [ ] Nasal discharge (color: _____)
- [ ] Cough
- [ ] Nose bleeds
- [ ] Sinus congestion
- [ ] Allergies (type: _____)
- [ ] Alternation of chills/fever
- [ ] Dry mouth
- [ ] Dry throat
- [ ] Dry nose
- [ ] Dry skin
- [ ] Sneezing
- [ ] Headache (location: _____)
- [ ] Overall achy feeling in body
- [ ] Stiff neck
- [ ] Stiff shoulders
- [ ] Sore throat
- [ ] Difficulty breathing
- [ ] Smoke cigarettes (packs per day: _____)
- [ ] Sadness
- [ ] Melancholy

TOTAL BOXES CHECKED: _____

Stomach Function

- [ ] Burning sensation after eating
- [ ] Large appetite
- [ ] Bad Breath
- [ ] Canker sores (mouth)
- [ ] Bleeding, swollen or painful gums
- [ ] Heartburn
- [ ] Acid regurgitation
- [ ] Ulcer
- [ ] Belching
- [ ] Hiccups
- [ ] Stomach pain
- [ ] Vomiting

TOTAL BOXES CHECKED: _____

Dampness Trapped in the Body

- [ ] Bodily sensation of heaviness
- [ ] Mental heaviness
- [ ] Mental sluggishness
- [ ] Mental fogginess
- [ ] Swollen hands
- [ ] Swollen feet
- [ ] Swollen joints
- [ ] Chest congestion
- [ ] Nausea
- [ ] Snoring

TOTAL BOXES CHECKED: _____

Liver Function (Eyes)

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

TOTAL BOXES CHECKED: _____

Liver, Gall Bladder Function

- [ ] Alternating diarrhea & constipation
- [ ] Chest pain
- [ ] Tight sensation in chest
- [ ] Bitter taste in mouth
- [ ] Anger easily
- [ ] Depression
- [ ] Frustration
- [ ] Irritability
- [ ] Skin rashes
- [ ] Headache at the top of the head
- [ ] Tingling sensation
- [ ] Numbness
- [ ] Muscle twitching
- [ ] Muscle cramping
- [ ] Muscle spasms
- [ ] Seizures
- [ ] Convulsions
- [ ] Lump in the throat
- [ ] Neck tension
- [ ] Shoulder tension
- [ ] Limited range of motion in neck
- [ ] Limited range of motion in shoulder
- [ ] Alcohol consumption (per day: _____)
- [ ] Recreational drug use (which: _____)
- [ ] High-pitched ringing in ears
- [ ] Gallstones
- [ ] STD's (which: _____)
- [ ] Unable to adapt to stress

TOTAL BOXES CHECKED: _____

Kidney Function (Overall Temperature)

- [ ] Cold hands
- [ ] Cold fingers
- [ ] Cold feet
- [ ] Cold toes
- [ ] Sweaty hands
- [ ] Sweaty feet
- [ ] Hot body temp. sensation
- [ ] Cold body temp. sensation
- [ ] Afternoon flushes
- [ ] Night sweats
- [ ] Heat in the hands, feet & chest
- [ ] Hot flashes any time of the day
- [ ] Thirsty
- [ ] Perspire easily
- [ ] Lack of perspiration
- [ ] Do you take water to bed

TOTAL BOXES CHECKED: _____

Kidney (Urinary Bladder Function)

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

TOTAL BOXES CHECKED: _____

Urination (Bladder Function)

- ☐ Color: Pale ___ Dark Yellow ___ Clear ___
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ Profuse
- ☐ Strong odor
- ☐ Burning sensation
- ☐ Painful
- ☐ Discharge
- ☐ Difficult
- ☐ Urgent
- ☐ Frequent

TOTAL BOXES CHECKED: _____

Libido

- ☐ Low
- ☐ Normal
- ☐ High

WOMEN ONLY

Do you have a regular menstrual cycle?:	☐ Yes	☐ No
Are you pregnant?:	☐ Yes	☐ No
Do you have bleeding between periods?	☐ Yes	☐ No
Do you have a vaginal discharge?	☐ Yes	☐ No

Menstrual Cycle Symptoms

- ☐ Nausea
- ☐ Vomiting
- ☐ Food cravings
- ☐ Water retention
- ☐ Breast swelling
- ☐ Breast tenderness
- ☐ Headaches
- ☐ Migraines
- ☐ Dull pain
- ☐ Sharp pain
- ☐ Depression
- ☐ Irritability
- ☐ Anxiety
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

MEN ONLY

- ☐ Swollen testes
- ☐ Testicular pain
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Coldness or numbness external genitalia
- ☐ Other: _____

TOTAL BOXES CHECKED: _____

WELLNESS ASSESSMENT

Please take your time with each of the following questions. Our method of obtaining optimal results begins here. In order for us to offer you the best care it is essential that we ascertain your current state of overall health. As we go through this paperwork with you, we encourage any questions or thoughts you may have.

Name: _____ Date: _____

Chief Complaints:

1) _____ How long? _____
2) _____ How long? _____
3) _____ How long? _____

What have you tried doing to resolve this problem? Did it work?

_____
_____

Have you become discouraged about handling this problem?

_____
_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work:_____

Family:_____

Hobbies:_____

Life:_____

Do you know how this problem may have started?_____
_____

Are there any health conditions you are afraid these problems might turn into? Please check all that apply.

- Diminish future abilities
- Stress
- Weight gain
- Heart disease
- Depression
- Surgery
- Arthritis
- Cancer
- Diabetes
- Other: _____

What aspects of your life would be better without these problems? Please check all that apply.

- Less Stress
- Work
- More Energy
- Outlook on Life
- Self-Esteem
- Family
- Confidence
- Sleep

On a typical day, what do you eat and drink for:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Do you have any emotional eating habits? If so, what are they?_____

_____

How have you taken care of your health in the past? Please check all that apply.

- Medications
- Acupuncture
- Exercise
- Chiropractic
- Other: _____
- Routine medical
- Physical therapy
- Diet and nutrition
- Vitamins

How did the previous methods work for you?_____

_____

Would you like improvement with any of the following?

- Digestion: bloating, acid reflux, gas, constipation, diarrhea
- Sleep: Falling asleep or staying asleep
- Sense of well being

- Energy levels and focus
- Emotional Balance

Are you here visiting us to: Please check all that apply.

- Resolve an immediate problem
- Health rehabilitation to restore proper functions
- Other: _____

YOUR HEALTH GOALS

If we were to sit down and discuss your life 3 years from now and look back at today, what changes would you like to experience for you to be happy with your progress?

(Please take your time and include anything that is part of your happiness, include health, family, work, finances, travel, marriage, or personal goals.)

_____
_____
_____
_____
_____
_____

What potential barriers do you foresee that would prevent these things from happening?

_____
_____
_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____
_____
_____

How important is it for you to resolve your health concerns? (Rate on a scale of 1 to 10. 10 being extremely important) _____

We see excellent results because we take the time to evaluate your health conditions and personal goals. If we feel like our program can help you accomplish those goals, we will create an action plan for you during one of you first three visits with us.

- Please bring any lab work or pertinent medical information you have within the past 6 months.
- Because this is a lifestyle program, we ask that you bring your spouse/partner to your appointment if possible.

Emily Farish Acupuncture
EAMP., L.Ac

EMILY FARISH ACUPUNCTURE OFFICE POLICIES

Welcome to the Acupuncture office of Emily Farish. We want you to be comfortable and to receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES

The fees charged in this office are comparable to those charged by other healthcare providers in this ares, with similar qualifications. If you have Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note there is a $25.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE

Many insurance policies cover Acupuncture, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for
Acupuncture. We can verify coverage and submit your claim form for reimbursement, provided you sign financial agreement below.

Initial_____

RELEASE OF INFORMATION

Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS

As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $25.00 fee for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations

Initial_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance I understand I will be responsible for all “non covered” services and /or coinsurance/co-pays associated with my office visit. In addition I authorize insurance payment of medical benefits to Emily Farish Acupuncture.

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions. If I am electronically signing, this signature below reflects agreeing with the initials above unless otherwise stated in writing to provider.

Patient Signature_____

Date_____