Kairos Counseling and Wellness
Patient Health History Form

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Welcome! It is an honor to partner with you in your healing process. Please fill out the following information as accurately and completely as possible in order that I might better support you in your health goals. I am committed to working with you to develop treatment plans and lifestyle recommendations that are understandable and manageable. Your compliance with these will ensure the best possible outcomes in your healing journey. All information you provide is confidential.

Today's date _____/_____/_____

General Information

Name_____Birthdate_____/_____/_____Age_____Gender____
Address_____City_____State_____Zip_____
Phone numbers (please mark * next to best number):
Home_____Cell_____Work_____
E-mail address_____
Would you like to receive our e-newsletter with supportive health information? □ Y □ N
Marital Status_____# of children & their ages _____
Occupation_____Hours per week_____
Employer & location _____
Health Insurance Co._____
How did you hear about Kairos Counseling and Wellness? _____

Emergency Contact

Name_____Phone_____Relationship_____
Under 18 ---Responsible Party Information
Name_____
Relationship to Patient_____

Healthcare Providers

Physicians: GP/Primary Care: _____
OB-GYN: _____
Chiropractor: _____
Physical Therapist: _____
Psychotherapist: _____
Other: _____
May I contact these providers to ensure coordination of your care? □ Y □ N

Health Concerns

Please list your major health concerns in order of importance to you:
_____
_____
_____
_____
_____
_____

HEALTH HISTORY

Please indicate approximate dates and briefly describe the nature of any major medical and/or traumatic experiences you have had (e.g. Major injuries or accidents, surgeries, diagnosis of a disorder/disease, death of a loved one, etc.).

Date____/_____Event_____
_____
Date____/_____Event_____
_____
Date____/_____Event_____
_____
Date____/_____Event_____
_____
Date____/_____Event_____
_____
Date____/_____Event_____
_____
Date____/_____Event_____
_____

Family History (List any family physical or mental illnesses and age of death):

Mother_____
Father_____
Maternal Grandparents_____
Paternal Grandparents_____
Siblings_____
Children_____

Antibiotic and Steroid Usage

In the past 3 years please list antibiotics and steroids used (list name if known), reason for prescription (i.e.: infection, acne, inflammation), and duration of treatment (how long used)

Name_____ Reason _____
Duration of treatment _____
Name_____ Reason _____
Duration of treatment _____
Name_____ Reason _____
Duration of treatment _____
Name_____ Reason _____
Duration of treatment _____
Do you have a childhood history of extensive antibiotic or steroid use? If so please explain _____
_____
_____

Medications, Herbs, Supplements (List those you are currently taking INCLUDING BIRTH CONTROL & INHALERS):

Name_____Reason _____
How long and Dosage_____
Name_____Reason _____
How long and Dosage_____
Name_____Reason _____
How long and Dosage_____
Name_____Reason _____
How long and Dosage_____
Name_____Reason _____
How long and Dosage_____

Diagnostic Tests

Please list the date of your most recent tests and **provide copies of labs within the last 6 months**

Complete Physical _____ CBC _____CMP_____ HbA1c_____ Vit D _____
Thyroid panel _____ Iron panel _____ CRP _____ ANA _____
Colonoscopy_____ Mammogram _____ Pap Smear _____
Other Diagnostics _____

Immunizations

Please indicate those received in the last 5 years with dates if possible

Shingles _____ Flu Shot _____ Hep A_____ Hep B_____ TDAP_____ HPV _____
Other _____

Medical Devices/Implants

Please indicate the date you received the device
Pacemaker_____ IUD_____ TENS unit _____Insulin pump_____
Glucose Monitor_____ Port _____Stent _____ Joint replacement_____
Other device/implant _____

LIFESTYLE HABITS AND SYMPTOMS SURVEY

Diet

Describe your typical daily diet:
Breakfast_____
Lunch_____
Dinner_____
Food sensitivities? _____

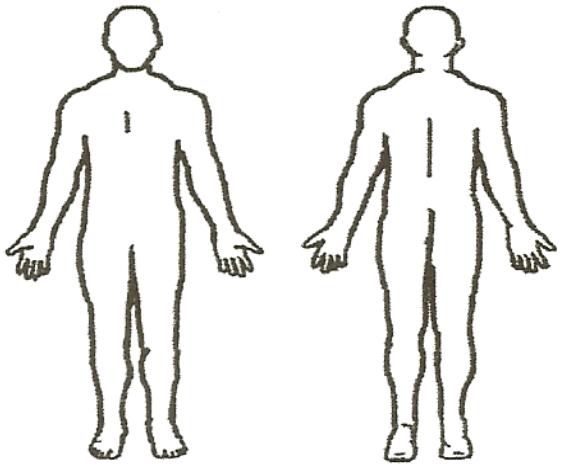
Do you?..... (please the answer the following questions with a yes or no and/or describe as requested)

Average 8 hours of RESTFUL sleep/night? _____
Exercise? What type/how often? _____
Drink filtered water? How many ounces/day? _____
Drink caffeinated beverages? Cups/day? _____
Drink soft drinks? #/day? _____
Eat sugar? In what form? Amount/day? _____
Drink alcohol? Drinks/week? _____
Use over the counter pain meds? Type? Frequency/week? _____
Use antacids or Acid Reducing Meds? Type? How often? _____
Use mouthwash? How often? _____
Have amalgam dental fillings (mercury or metal)? ? _____
Regularly use plastic water bottles/food containers? _____
Use manufactured cosmetics/personal care products daily? _____
Watch TV? Hours/week? _____
Use a Computer? Hours/week? _____
Smoke cigarettes? Packs/day? _____
Smoke cigarettes in the past? Year you quit? _____
Use marijuana? Form? How often? _____
Desire support in reducing/eliminating addictive habits? _____
Been outside the U.S. in past 12 months? Where? _____
Have a Spiritual/religious practice? _____
Have a social support system? _____
What are the major sources of joy in your life? _____
What are the major sources of stress in your life? _____

Muscles/Joints/Bones

□ Swollen Joints (SJ)
□ Pain (P)
□ Weakness (W)
□Numbness (N)
□ Tingling (T)

Using the abbreviations listed with each symptom mark the affected area(s) on the diagrams at right for anything you are currently experiencing



Please CHECK any of the symptoms or disorders below that you HAVE HAD IN THE LAST YEAR AND *CIRCLE THOSE THAT YOU ARE CURRENTLY EXPERIENCING*

Ear/Eyes/Nose/Throat/Respiratory

□Asthma/Wheezing □ Persistent cough □ Difficulty Breathing □Frequent colds/flu □Enlarged glands □Hoarseness/Sore throat □ Ear aches □Ringing in Ears □Eye Pain □Dry eyes □Blurred or poor vision □ Acute Nasal Congestion □ Chronic Nasal Congestion □ Nose Bleeds □ Sinus infections (chronic)
□ Allergies to: _____

Skin

□Acne □Easy Bruising □Rashes □Itching □ Eczema □ Psoriasis □ Shingles □ Dry Skin □ Excessive sweating □ Non healing sores □ Changes in Skin color (lightening or darkening) □ Thickening of skin □ Scarring

Genito-Urinary

□Blood/Pus in Urine □Frequent urination □Burning Urination □Urgent urination □ Incontinence □ Kidney Infection □Bladder Infection □ Kidney Stones □ Kidney disorder

Cardiovascular

□ Chest pain □ Hardening of Arteries □Blood Clots □ High Blood Pressure □Low Blood Pressure □Previous Heart Attack □Stroke □ Irregular Heart beat □ Heart Surgery □ Poor circulation (cold hands/feet) □ Swollen ankles/hands

Gastrointestinal/Hepatic

□ Belching □ Gas □ Bloating □Abdominal Distention □ Constipation □ Diarrhea □Excessive hunger □ Poor appetite □Hemorrhoids □Indigestion □ Nausea □ Vomiting □ Bitter Taste in Mouth □ Bad Breath □ Mouth Sores □ Bleeding Gums □ Hepatitis □ Liver disease □ Gallstones or sluggish bile □ Abdominal pain, location _____

For Men Only

□ Erectile Dysfunction □ Penile Discharge, Pain or Itching □ Testicular Lumps □Prostate Problems □Low libido

For Women Only

□ Irregular Menstrual Cycle □ Bleeding Between Periods □ Painful Periods □ Excessive Menstrual Flow □ Scanty Menstrual Flow □ Scanty Menstrual Flow □ Large Clots in Menstrual Flow □ Pre-Menstrual Syndrome □ Previous Miscarriage □ Menopause Symptoms □ Breast Lumps □Low libido □ Fatigue □ Night Sweats □ Hot Flashes □ Insomnia □ Poor Memory □ Vaginal pain □ Vaginal dryness □ Pain during intercourse □ Chronic yeast infections □ Changes in vaginal tissue

Age of First Menses _____Average length of Cycle in Days_____
Average number of days of flow_____ Flow amount & color (i.e.: light, dark red)_____
First day of most recent menses (begins with first day of bleeding)_____
Are you actively trying to conceive at the present time? _____
Is there a possibility you are pregnant? _____
# of full term pregnancies_____ # of Miscarriages_____ Date of Onset of Menopause_____

CLINIC POLICIES, INFORMED CONSENT AND HIPPA PRIVACY PRACTICES

Cancellation and Late Policies
In the event that you must cancel an appointment, please give the courtesy of as much notice as you can, but at least 24 hours notice. You will be charged the full fee for your session if you do not show up for your appointment or cancel your appointment with less than 24 hours notice. If you are going to be late, please call and I will hold your appointment time as scheduled. If you do not give notice, I will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the full payment of the session.

Fees
It is my policy that you pay the entire session fee and any herbal supplements needed at the time of each session. I will provide a minimum of one month's notice of any changes to my fees.

Phone Calls and Emails
You may phone or email me and I will respond within one business day. I am however generally unavailable on weekends and will respond on Monday when back in the clinic. Phone and email contacts that require beyond 5 minutes of my time are considered session work and will be billed according to the normal fee schedule with a minimum amount of $55/call.

Confidentiality and Notice of HIPPA Privacy Practices
As a health care provider, I am required by law to maintain and protect the confidentiality of your health information. You must give me written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations according to the "Notice of Privacy Practices" (available at HHS.gov) and include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information: You may request restrictions on your disclosures. You may inspect and receive copies of your records within 30 days with a request. You may request to view changes to your records or correct information you believe is wrong in your records. You may be informed about who has read your record and you may request a copy of the full "Notice of Privacy Practices."

Informed consent
I have read and understood the clinic's policies. I agree to the all of the above treatment terms and conditions and I certify that the information I have provided above is correct to the best of my knowledge. I assume all responsibility for any errors or omissions that I have made to this form. I hereby request and consent to receive acupuncture and other treatments within the scope of Chinese Medicine from Dr. Bianca Schmidt. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, massage, herbal medicine, and nutritional counseling. I understand that the herbs are considered safe and need to be consumed according to the instructions provided orally and in writing as some herbs are toxic in larger doses. I will notify Dr. Schmidt if I am or become pregnant and I understand that some herbs and acupuncture points are contraindicated in pregnancy. I understand that some rare but possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue and will immediately notify Dr. Schmidt of any unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is a generally safe method of treatment, but that some side effects may occur, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a rare but potential risk of moxibustion, cupping, and heat lamps. Temporary bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). While Dr. Schmidt uses sterile, disposable needles and maintains a clean and safe environment I understand that infection is another possible risk. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect Dr. Schmidt to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise her best judgment during the course of treatment, based upon the facts then known, that is in my best interest. I understand that results are not guaranteed. I acknowledge receipt of the "Notice of Privacy Practices" and "Patient Rights" and I understand that my signature does not authorize disclosure but only acknowledges that I have received a copy of the full Notice. My signature below also certifies that I have read and been told the risks of acupuncture and other treatments and have had the opportunity to ask questions. I intend this consent form to cover treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature _____**Date** _____
(0r Patient Representative- indicate relationship if signing for patient)

Clinic Signature _____**Date**_____
(Dr. Bianca Schmidt, DACM, L.Ac.)