Luna Sparks Acupuncture
Health History Questionnaire

Personal and Confidential Patient Information

Office Policies Concerning Confidentiality

The confidentiality of your personal information is very important to us. We attempt to meet or exceed HIPAA guidelines concerning your personal and healthcare information. Please read the HIPAA information that we provide to you for more detail on our policies. We respect your right to refuse to give us any personal information, but the more information that we have the easier it is for us to help you. Thank you for your assistance.

Please fill out this information completely and legibly: Circle Yes/No

Full Legal Name:____
Name or nickname that you would like to be called by us:____________________
Home Address: Street:______________________________________
City:____________________State:__________Zip:____________
Current Occupation:____
Age:_______ Date: of Birth:__________ Place of Birth:______________
Cell Phone:____________________ ok to leave a detailed message? Yes/No
Home Phone:____________________ ok to leave a detailed message? Yes/No
Work Phone:____________________ ok to leave a detailed message? Yes/No
Best phone to call you for appointment reminders or important information: Cell/ Home/ Work
Email:________________________________

Your Personal Medical Doctor:________________________________
Phone:______________Address:__________________________
Other Healthcare Provider:
Phone:______________Address:__________________________

In Emergency Notify:____
Relationship to you:______________________ Phone:____________

How did you find out about this practice? (Please circle all that apply)
Personal referral / Professional Referral (M.D., D.C. etc.) / Flyer / Seminar
Wellness Event / Tai Chi / Chi Kung
Internet: Yelp / Google / Other:________________________________
Who referred you?____
May I send this person a "Thank You" card for referring you? Yes / No

Have you tried Acupuncture before? Yes / No Provider's Name:__________________
Have you tried Chinese Herbal Remedies? Yes / No
Have your tried Acupressure? Yes / No

Patient Signature:____________________________ Date:_____________

Patient Printed Name:____

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Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

Patient Name:_________________________________ Date:___________________

Gender: Female_____ Male____ Trans____ Non-binary______Fill in the blank______________

Lifestyle and Medications

List Vitamins and Supplements that you take both regularly and occasionally

Name	Purpose	How long	Dosage	Frequency	Last dose

List all pharmaceutical drugs you take regularly and as needed (e.g. nasal spray)

Name	Purpose	How long	Dosage	Frequency	Last dose

List all other pharmaceutical drugs taken in the last six months

Name	Purpose	How long	Dosage	Frequency	Last dose

Do you currently follow a regular exercise program? Yes / No Describe:____________________

____

What did you eat in the last 24 hours?

Breakfast ____

Lunch ____

Dinner ____

Snacks____

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Patient Medical History

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

1.______________________________

2.______________________________

3.______________________________

4.______________________________

5.______________________________

Additional______________________________

How do these conditions impair your daily activities? ____________________

____

____

How was your childhood health? __________________________

Traumas/Accidents/Surgeries

Year	Description

Recent exams/tests

☐ Physical Exam *Date* *Result*	☐ Cholesterol *Date* *Result*	☐ Prostate *Date* *Result*	☐ Blood (Which one?) *Date* *Result*
☐ HIV/STD *Date* *Result*	☐ Pap Smear *Date* *Result*	☐ Mammography *Date* *Result*	☐ Other *Date* *Result*

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Patient Medical History continued

Check any you have had in the past:

___Diabetes	___Allergies	___Glaucoma	___Rheumatic fever
___Heart disease	___CVA (Stroke)	___Vein condition	___Thyroid disorder
___Asthma	___Pneumonia	___Tuberculosis	___Emphysema
___Jaundice	___Gonorrhea	___Mumps	___Bleeding deficiency
___Syphilis	___Measles	___Chicken Pox	___Nervous disorder
___Meningitis	___HIV	___Polio	___Mononucleosis
___Epilepsy	___High Fever	___Hepatitis	___Multiple sclerosis
___Paralysis	___Irregular Pap Smear	___Migraines	___High blood pressure
___other lung disease	___other liver disease	___other heart illness	___other kidney disease

___Other:

Patient Profile

Please check the following that currently pertain to you (if you have symptoms in the following categories, Traditional Chinese Medicine (TCM) indicates you have a problem with that organ's function):

Overall Temperature (TCM Kidney function)

___Cold hands	___Cold toes	___Difficulty keeping eyes open
___Cold fingers	___Cold toes	___Feel worse after exercise
___Sweaty hands	___Sweaty feet	___Afternoon flushes or night sweats
___Perspire easily	___Thirsty	___Hot flashes any time of days
___Lack of perspiration	___Take water to bed	___Heat in the hands, feet &/or chest

Overall Energy (TCM lung/kidney function)

___Shortness of breath	___General weakness	___Hot body temperature (sensation)
___Catch colds easily	___Low energy	___Cold body temperature (sensation)

Overall Blood (TCM liver, spleen heart function)

___Dizziness	___See floating black spots

Overall TCM heart function

___Palpitations	___Anxiety	___Sores on tip of tongue
___Restlessness	___Mental confusion	___Chest pain traveling to shoulder
___Frequent dreams	___Wake un-refreshed	___Drink coffee # cups/week________

Overall TCM lung function

___Cough	___Nose bleeds	___Nasal discharge, color___________
___Sinus congestion	___Sneezing	___Allergies, to what_______________
___Dry mouth	___Sore throat	___Headache, location______________
___Dry nose	___Stiff neck	___Alternating chills & fever

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Overall TCM lung function continued

___Dry throat
___Stiff shoulders
___Overall achy feeling in body
___Dry skin
___Difficulty breathing
___Smoke cigarettes, #/day_________
___Dry throat
___Sadness
___Melancholy

Overall TCM spleen function

___Low appetite
___Abdominal gas
___Gurgling noises in the stomach
___Abrupt weight gain
___Abdominal bloating
___Fatigue after eating
___Abrupt weight loss
___Easily bruised
___Prolapsed organs, which_________
___Pensive
___Over thinking
___Hemorrhoids
___Worry

Overall TCM spleen, stomach, large intestine, small intestine

___Loose stools
___Constipated
___Incomplete defecation
___Diarrhea
___Blood in stools
___Mucous in stools
___Undigested food in stools

Overall TCM dampness trapped in body

___Snoring
___Nausea
___General sensation of heaviness in body
___Mental heaviness
___Mental sluggishness
___Mental fogginess
___Swollen hands
___Swollen feet
___Swollen joints
___Chest congestion
___Excess fat
___Heavy limbs

Overall TCM stomach function

___Large appetite
___Bad breath
___Burning sensation after eating
___Mouth sores (Canker)
___Heartburn
___Bleeding, swollen, painful gums
___Acid regurgitation
___Ulcer (diagnosed)
___Belching
___Hiccoughs/hiccups
___Stomach pain
___Vomiting

Overall TCM Liver and gall bladder function

___Chest pain
___Flank pain
___Alternating diarrhea & constipation
___Easily angered
___Easily frustrated
___Tight sensation in chest, constraint
___Easily irritated
___Easily depressed
___Headaches, one-sided temporal
___Skin rashes
___Bitter taste in mouth
___Headaches, top of head
___Muscle Spasms
___Numbness
___Frequently unable to adapt to stress
___Muscle twitching
___Tingling sensation
___Sensation of lump in throat
___Muscle cramping
___Neck tension
___Limited range of motion, neck
___Seizures
___Shoulder tension
___Limited range of motion, shoulder
___Convulsions
___Drink alcohol #/week__
___Gallstones (history or current)
___High pitched ringing in ears

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Overall TCM Liver and gall bladder function continued		
___Recreational drugs	Which:	Frequency:

Overall Eyes (TCM liver function)

___Itchy ___Bloodshot ___Hot
___Dry ___Watery ___Gritty
___Blurry vision ___Near-sighted ___Far-sighted
___Decreased night vision

Overall TCM kidney, urinary bladder function

___Frequent cavities ___Sore knees ___Cold sensation in knees
___Low back pain ___Weak knees ___Memory problems
___Excessive hair loss ___Kidney stones ___Lack of bladder control
___Bladder infections ___Easily broken bones ___Low-pitched ringing in ears
___Fear ___Easily startled ___Wake during the night to urinate

Overall Urination

___Color: normal ___Color: dark yellow ___Color: clear
___Color: reddish ___Color: cloudy ___Discharge
___Volume: profuse ___Odor: strong ___Burning
___Volume: scanty ___Odor: none ___Urgent
___Frequent ___Painful ___Incontinence or urine leakage

Overall Libido

___Normal ___Low ___High

MEN ONLY

___Swollen testes ___Testicular pain ___Impotence
___Feeling of coldness or numbness in external genitalia ___Premature ejaculation
___Other symptom:____
___Anxiety
___Other emotion:____

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WOMEN ONLY

Important note: If you are post-menopausal please complete the following section to reflect your prior menstrual experience

Regular menstrual cycle? Yes / No
Pregnant? Yes / No
Number of children:______________________ Number of pregnancies:___________________

Age of first menstruation:_________________ Age of menopause:______________________

Average number of days of flow:___________ Average number of days of cycle:___________

Vaginal discharge? Yes / No
Bleeding/spotting between periods? Yes / No

Do you (or did you) experience any of the following pre-menstrual syndromes:

___Nausea ___Vomiting ___Water retention
___Breast swelling ___Food cravings ___Migraines
___Breast tenderness ___Depression ___Irritability
___Anxiety
___Other emotions:____

___Sharp pain, where?____

___Dull pain, where?____

Menstrual Chart:	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (**N**ormal, **H**eavy, **L**ight)							
Pain/Cramps (location, dull, sharp, other)							
Clots (large, small, black, purple red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

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ALL PATIENTS

Other comments:____

____

____

____

____

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____

____

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to treatment with acupuncture and other Oriental Medicine procedure modalities on me by John Luna-Sparks 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 John-Luna Sparks, including those working at this office or any other office or clinic.

I understand that treatments may include, but not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), CranioSacral, herbal treatments, supplements guasha, far infared heat lamps, nutritional counseling and life style modifications.

I understand that I have the opportunity and am encouraged to discuss with the treating acupuncturist or clinic personnel the nature and purpose of acupuncture treatments and other procedures at any time.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain disease or dysfunction of the body. I have been informed that acupuncture is generally a safe method of treatment but there may be bruising or tingling near the sites that may last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. If you choose to have a cupping treatment, there will be bruising, which is normal for that modality.

The herbs and nutritional supplements are from plant, animal and mineral sources. I understand tht some herbs may be inappropriate during pregnancy, while others do not combine well with the drug treatments. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will infrm the acupuncturist. It is important to inform the acupuncturist of all pharmaceuticals, supplements, or other, or other medications so that appropriate herbs can be selected. I agree to inform my acupuncturist of all changes in pharmaceutical usage.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgement during the course of the procedure which the acupuncturist feels at the time, based on facts then known, is in my best interest.

I understand the clinical, administrative staff, and medical consultants may review my medical records and lab reports, but not all my records are confidential and are handled according to HIPAA regulations.

I understand lab reports to help assess my condition may be ordered. These are not a substitute for lab reports that my medical doctor may order. These test are for different diagnosis criteria and may not be evaluated in the same manner as a medical doctor and do not replace diagnosis or treatment by my Medical Doctor.

I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above named procedures. 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. I understand that this is a general consent and it is always, at every treatment, my choice to accept, deny, or ask about any treatment offered to me.

To be completed by the patient

Patient's Name______________________________

Patient's Signature____________________________

Date Signed________________________________

Are You Pregnant? Yes / No

Do you have a pacemaker? Yes / No

To be completed by the patients representative

Name of Patient______________________________

Patients Representative_________________________

Relationship of Authority of Patient________________

Witness____________________________________

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Policies and Office Procedures

Office Policies:
The purpose of these office policies is to create an environment that supports the balance and health of our patients. Please read the following information and sign and date the bottom of the form if you fully understand and agree to these policies. If you feel that you need more information, please speak to john Luna-Sparks for clarification.

Professional Fees:
All fees are subject to change without notice. A full listing of current fees can be found on the Attending Practitioner's Statement:. At the present time, my discounted fees for payment at the time of service are as follows:

New Patient Consultation and Treatment…………………………………..…………….... $250
Established Patient Follow-up Acupuncture Treatment………………………..……….. $115
Established Patient Follow-up Sports Acupuncture may include Electostimulation ……... $140
Telemedicine Special Package…………………………………………………………...$350
Telemedicine Follow-up for Established Patients…………………….……………..….. $75

There is a full charge for missed appointments not cancelled with 48 hours' notice
Missed appointments severely impact this practice. Maintaining this missed appointment policy allows me to serve my patients and keep patient fees as low as possible.

Payment for Services:
Payment is due at the time of service. I accept cash, check, MasterCard, Visa, American Express, Flexible Spending Account debit cards and Health Service Account debit cards.

Patient Comfort and Safety:
Some of my patients are allergic to fragrances. To make their office visit a pleasant a healthy experience I ask that you not wear scented items into the office (perfume, colognes, lotions, etc.).

COVID-19 Precautions:
Due to COVID-19 we have instituted thorough infection control procedures. If you would like to review our infection control protocols related to COVID-19 please let us know.

Please turn off your cell phones in the office for the safety and harmony of yourselves and others.
If you expect to receive an urgent call, give my office number and I will alert you if called.

Confidentiality:
Clinic procedures and conduct are designed to meet or exceed HIPAA requirements for confidentiality. Please read the HIPAA policies. Clinic walls are not completely soundproof, so in the interest of your confidentiality, the comfort of other patients, and to maintain a harmonious and healthy atmosphere, I ask that all conversations be kept at a low volume. Thank you!

Urgent Care and Telephone Policy:
I do NOT have 24-hour availability or phone access. For MEDICAL EMERGENCIES CALL 911 OR YOUR MEDICAL DOCTOR. For general inquiries, I will return calls, received Monday through Friday during business hours, within 24 hours. Any questions about your specific health care needs or problems can be addressed at your next appointment with John Luna-Sparks.

If you suspect that herbs or supplements are causing inpleasant or unexpected results, discontinue them immediately and then call our office.

Prior to signing please read this form in its entirety

Signature:___________________________ Print Name:________________________________ Date:_________

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Acknowledgement of Receipt of Luna Sparks Acupuncture Practice's Notice of Privacy Practices

Practice: Luna Sparks Acupuncture
1700 Shattuck Ave,. 2nd Floor
Berkeley, CA 94709

Privacy Officer
John Luna-Sparks, L.Ac., Dipl. OM
Privacy Officer
(510) 334-6545

It is Luna Sparks Acupuncture practice's policy that treatment NEVER be conditioned on the signing of this acknowledgement of receipt of Notice of Privacy Practices. In addition, no retaliatory action will be tolerated from health care providers of staff in response to a patient's decision not to sign this acknowledgement.

By signing this document, I acknowledge that I have received a copy of Luna Sparks Acupuncture practice's Notice of Privacy Practices.

Signed:______________________________Date:____________________

Print Name:___________________________

If not signed by the patient, please indicate:

Relationship:
______Parent or guardian of minor patient
______Personal representative of an incompetent patient