(Please print)

Name:_____ _____Today's Date:_____
(First) (Middle) (Last)

Date of Birth:____/____/____ Age:_____ Gender: M/F Marital status: S M D W Sep.

Address:_____ Occupation:_____

City:_____ State:_____ Zip:_____ Email:_____

Cell:_____ Emergency Contact:_____ Ph:_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive care and for what reason?

_____

2. Name of primary health clinic/doctor:_____Ph:_____

3. Primary complaint/reason for visit today Past treatment

a._____ _____

How does this condition affect you?_____

b. _____ _____

How does this condition affect you?_____

c._____ _____

4. If Applicable, please list any food, drug, or medications you are **hypersensitive or allergic to (include reaction)**

_____

_____

a. List any medications/ frequency **(prescription and over-the-counter),** vitamins, and supplements you are currently taking:

_____

_____

6. Do you have any infectious disease? Y N If yes, please identify:_____

7. Circle any that apply to you: Pacemaker Cochlear Implant Diabetes HIV/AIDS Seizures

TB CHEMO/RAD Hemophilia Hepatitis A B C Hypertension Cancer Blood thinning Meds

8. Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (**E**xcellent, **F**air, **P**oor)	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____

254 E. Hwy 246 Ste C Buellton, CA. 93463 Ph: 805-895-1164 Fax: 805-693-4677
www.acudawn.com
email: acudawn@gmail.com
Dawn Wafer L.Ac.11733

Name_____ Date of Birth_____Today's Date_____
(9-23 please circle any that you are experiencing now)

9. **Emotional**

Mood Swings Irritable Mental Tension Anxiety Depression Bipolar Excess Grief

10. **Energy and Immunity**

Fatigue Slow Wound Healing Chronic Infections Fatigue after eating Chronic Fatigue Syndrome

11. **Head, Eye, Ear, Nose, Throat**

Impaired Vision Eye pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Excess Thirst Lack of Thirst

Impaired Hearing Ear Ringing Earaches Headache Tongue/Mouth sores Flushed Face

Nose Bleeds Bleeding Gums Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Sinus Problems

12. **Respiratory/Chest**

Pneumonia Frequent Colds Difficulty Breathing Emphysema Asthma/Wheezing

Persistent Cough Pleurisy Tuberculosis Sensation of object in Throat Sore Throat

Shortness of Breath Fullness in Chest Palpitations Sighing Allergies Bronchitis

13. **Circulatory/Cardiovascular**

Heart Disease Chest pain Swelling of Ankles High Blood pressure Palpitations/Fluttering Stroke

Heart Murmurs Rheumatic Fever Varicose Veins Always Cold Cold Limbs Cold Hands/Feet

14. **Digestive System**

Ulcer Acid Reflux Change in Appetite Nausea Vomiting Epigastric Pain Heartburn

Always Hungry Belching Gall Bladder Disease Liver Disease Bloody Stool Hemorrhoids Abdominal Pain

Diarrhea Constipation Alternating Constipation/Diarrhea Undigested Food in Stool Poor Appetite No Appetite

15. **Genito-Urinary Tract**

Kidney Disease Painful Urination Cloudy Urine Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night Dark Urine

16. **Female Reproductive/Breast**

Irregular Cycle Breast Lumps/Tenderness Nipple Discharge Heavy Flow Low Libido

Vaginal Discharge Premenstrual Problems Clotting Bleeding In-between Cycles

Menopausal Symptoms Difficulty Conceiving Painful Periods STD's (herpes, warts, etc.)

Do you have any reason to believe you may be pregnant? Y N If Yes, what is your expected due date_____

17. **Menstrual/Birthing History**

1.Age of first menses:_____2. Birth Control Type:_____3. Last Pap:_____4.Results:_____

4.# of Days of Menses:_____6.# Pregnancies:_____7. Length of Cycle:_____8. # Live Births:_____

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18. **Male Reproductive**

Sexual Difficulties Prostrate Problems Testicular Pain/Swelling Penile Discharge Impotence

STD's (herpes, warts, etc.) Low sex drive Other_____

19. **Musculoskeletal**

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Weak/Sore Knees Joint Pain (if so, where?):_____

20. **Neurologic**

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy Poor Memory

21. **Endocrine**

Hypoglycemia Hypothyroid Diabetes Mellitus Night Sweats Spontaneous Sweats Feeling Hot or Cold

22. **Sleep Patterns**

Difficulty Falling Asleep Difficulty Staying Asleep Insomnia Wakes Un-rested Nightmares

Dream Disturbed Sleep

23. **Dermatology**

Brittle Nails Dry Skin Itchy Skin Psoriasis Rashes Eczema Loss of Hair Acne

24. **Lifestyle:**

a. How often do you eat? Every_____hours. Experience any of these after: Lethargy_____Energized_____

Acid reflux_____

b. How much of the following substances do you consume **daily**?

Dairy Products (milk, cheese, butter, ice cream, etc.):_____

Meats/Fish/Poultry:_____

Breads & Grains:_____

Cooked Vegetables:_____

Raw Fruits/Vegetables:_____

Do you have any specific food or flavor cravings (i.e. salt, sugar, etc.):_____

c. Exercise Routine:_____

d. How many hours per night do you sleep?_____ Do you wake rested? Y N

e. Forms and how often of following: Nicotine_____Alcohol_____Caffeine_____Marijuana_____

f. How much water do you drink per day?_____

g. Occupation, Interests, and Hobbies:_____

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Name _____Date of Birth_____Today's date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTICE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment – To give you medical treatment or other types of health services.
b) Payment – To bill you or a third party for payment for services provided to you.
c) Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object.

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risk (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials to respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we do not have to give you a chance to agree or object.

a) Patient directories – You can decide what health data, if any, you want to be listed in patient directories
b) Persons involved in your care or payment for your care – We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights related to the health data we keep about you:

a. Right to inspect your health records and to receive a copy of your health records upon request
b. Right to amend information in your health record you believe is inaccurate or incomplete
c. Right to know whom we have disclosed your information
d. Right to ask for limits on the health information data we give out about you
e. Right to receive communication from us about your health information in alternate ways
f. Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTIVES of this practice.

Signature of patient or representative Date

Print patient name Patient Birth Date

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