Health History Questionnaire

All information is confidential.

Wellness Workshop SF

Date	First Name		Last Name			Middle Initial	
Date of Birth	Sex	Gender ID	Age	Eye Color	Height	Weight	
Street Address			City			State	Zip
Daytime Phone ( )			Evening Phone ( )				
E-Mail					Social Security Number		
Emergency Contact Name			Emergency Contact Number				
Occupation			Place of Employment				
How did you hear about us?							
Have you had Acupuncture before?			Did you have a positive experience?				

Insurance Company	Policy Holder Name	Relationship to Patient
Policy # / ID #	Group #	

	Severe	Moderate	Slight	Major Complaint(s) in order of importance to you
1				
2				
3				
4				
5				

When/How did this condition occur? Give dates if possible.

1)

2)

3)

How do these conditions impair your daily activities?

1)

2)

3)

Treatment(s) you have received for this condition
(*in order of which helped most*):

1)

2)

3)

3938 20th St., San Francisco, CA 94114 - P (415) 779-2913 F (415) 520-5941 - WellnessWorkshopSF@gmail.com

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MEDICAL HISTORY Please list surgeries, hospitalizations, accidents, and physical or emotional trauma that you have experiened.

Year	Procedure or Condition

PRESCRIPTION DRUGS Please list all prescripion medications you use. Include those which you may only use occasionally.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SUPPLEMENTS - Please list all herbs and supplements you take. Include those which you may only use occasionally.

Name	Purpose	How Long	Dose	How Often	Last Dose

OTHER SUBSTANCES Please list any other substances that you take. Include those which you may only use occasionally.

Coffee		Cups per week:		Age Started:		Age Quit:	
Tobacco		Sticks per day:		Age Started:		Age Quit:	
Alcohol		Drinks per week:		Age Started:		Age Quit:	
Marijuana		User per week:		Age Started:		Age Quit:	
Other		User per week:		Age Started:		Age Quit:	
Other		User per week:		Age Started:		Age Quit:	

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PATIENT INFORMED CONSENT AGREEEMENT

I, the undersigned "Patient", agree to receive acupuncture treatments and related therapies by Andrew Perzigian, L.Ac. Treatment methods may include, but are not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. However, I understand that Andrew Perzigian, L.Ac., uses only sterile disposable single-use needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify Andrew Perzigian, L.Ac., immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Andrew Perzigian, L.Ac., to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I will notify Andrew Perzigian, L.Ac., if I am or become pregnant.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

If I am unable to attend a pre-scheduled appointment, I agree to cancel at least 24 hours in advance. I understand that failure to do so will result in my being charged the full amount of the treatment price. I also understand that if I am more than 15 minutes late to an appointment, the remainder of my time-slot may be given to another client.

I understand that Andrew Perzigian, L.Ac., has the right to refuse treatment to any patient at any time. Reasons for refusal of treatment include crude behavior or inappropriate conduct.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Printed Name of Patient (and Representative):

_____

Patient / Representative Signature:

X_____

Date: _____

Printed Name of Practitioner:

Andrew Perzigian, L.Ac

Practitioner Signature:

X_____

Date: _____

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