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### Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please identify the health concerns that brought you to the Clinic in order of importance below:

<u>Condition</u>	<u>For how long?</u>	<u>Past treatment that helped this condition</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

List any foods, drugs, or medications you are hypersensitive or allergic to. Please detail reaction:

\_\_\_\_\_

List current medications (prescribed and over-the-counter), including herbs and supplements. Detail dosage:

\_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Highest weight: \_\_\_\_\_ Lowest weight: \_\_\_\_\_ Ideal weight: \_\_\_\_\_

Childhood & adulthood major illnesses, accidents, hospitalizations, surgeries:

<u>Event</u>	<u>Date</u>	<u>Event</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

#### Family Medical History (immediate blood relatives)

<input type="checkbox"/> Allergies _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autoimmune disease _____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Emotional/Psychological Disorder _____
		<input type="checkbox"/> Other _____

**Lifestyle:** Which of the following is/ are a part of your daily life?

<input type="checkbox"/> Exercise	<input type="checkbox"/> Coffee	<input type="checkbox"/> Dieting
<input type="checkbox"/> Relaxation/meditation	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Stress
<input type="checkbox"/> Tobacco smoking/chewing	<input type="checkbox"/> Recreational drugs	<input type="checkbox"/> Occupational hazards
		<input type="checkbox"/> Other _____

## SYMPTOM LIST

Please check symptoms you currently have (with a "C") or have experienced in the past (with a date).

<b>Emotional/Psychological</b>			
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stress	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Chronic sadness/grief
<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent irritability	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Overly fearful
<input type="checkbox"/> Manic	<input type="checkbox"/> Frequent anger	<input type="checkbox"/> Frequent Worry	<input type="checkbox"/> Addictions:
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Obsessive/Compulsive	(to what?): _____
<b>Immune &amp; Inflammation</b>			
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Raynaud's Syndrome
<input type="checkbox"/> Hashimoto's disease	<input type="checkbox"/> Frequent illness	<input type="checkbox"/> Herpes	<input type="checkbox"/> Connective tissue inflammation
<input type="checkbox"/> Grave's disease	<input type="checkbox"/> Frequent infection	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Food allergies
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Hay fever	<input type="checkbox"/> HIV	<input type="checkbox"/> Environmental allergies
<input type="checkbox"/> Lupus	<input type="checkbox"/> Frequent swollen glands	<input type="checkbox"/> Cold sores	<input type="checkbox"/> Seasonal allergies
<input type="checkbox"/> Colitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mononucleosis	
<input type="checkbox"/> Crohn's disease			
<b>Eyes, Ears, Nose, Throat &amp; Head</b>			
<input type="checkbox"/> Impaired vision	<input type="checkbox"/> Watery eyes	<input type="checkbox"/> Runny nose	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Impaired hearing	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Toothache
<input type="checkbox"/> Eye pain/strain	<input type="checkbox"/> Ear ringing	<input type="checkbox"/> Snoring	<input type="checkbox"/> TMJ/Jaw problems
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Earaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Dry eyes	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Teeth grinding	<input type="checkbox"/> Dry mouth
<input type="checkbox"/> Red & painful eyes	<input type="checkbox"/> Bleeding gums		<input type="checkbox"/> Dry throat
<b>Gastrointestinal &amp; Elimination</b>			
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Discomfort after eating	
<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Discomfort relieved by eating	
<input type="checkbox"/> Decreased appetite	<input type="checkbox"/> Constipation	<input type="checkbox"/> Gallstones/Gallbladder disease	
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Loose stools		
<input type="checkbox"/> Gas	<input type="checkbox"/> Diarrhea	___ # of Bowel movements per day	
<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Irritable bowel		
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Inflammatory bowel	<b>Please circle type of BM:</b>	
<input type="checkbox"/> Heartburn/Acid reflux	<input type="checkbox"/> Polyps	loose hard dry soft sticky (sticks to bowl) "normal"	
<input type="checkbox"/> Belching	<input type="checkbox"/> Leaky gut	<b>Please circle color of BM:</b>	
<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Greasy foods upset	brown pale color green black bloody	
<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Bloating after meals		
<b>Cardiovascular &amp; Blood</b>			
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> TIA/Stroke	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Palpitations/Fluttering	<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Cold hands/feet	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Hands & feet go to sleep easily	<input type="checkbox"/> Heart attack
<input type="checkbox"/> Anemia	<input type="checkbox"/> High LDL cholesterol	<input type="checkbox"/> Chest pressure or tightness	<input type="checkbox"/> Numbness
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Low HDL cholesterol	<input type="checkbox"/> Fast pulse (over 100 beats/min)	<input type="checkbox"/> Varicose veins
	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Slow pulse (under 60 beats/min)	
<b>Endocrine</b>	<b>Neurological</b>	<b>Respiratory</b>	
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Persistent cough
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Nerve pain/inflammation	<input type="checkbox"/> Frequent colds & flu	<input type="checkbox"/> Pleurisy
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Vertigo/Dizziness	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Asthma
<input type="checkbox"/> Feeling hot or cold	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Hypo adrenal	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Emphysema
	<input type="checkbox"/> Loss of Balance		

Sleep & Energy	Skin	Kidneys & Urinary Tract	Blood Sugar Regulation
<input type="checkbox"/> Insomnia <input type="checkbox"/> Light sleeper/wake easily <input type="checkbox"/> Can't fall back to sleep <input type="checkbox"/> Fatigue <input type="checkbox"/> Tired during day but awake at night <input type="checkbox"/> Can't relax <input type="checkbox"/> Poor memory <input type="checkbox"/> Fuzzy thinking	<input type="checkbox"/> Rashes <input type="checkbox"/> Eczema <input type="checkbox"/> Hives <input type="checkbox"/> Dandruff <input type="checkbox"/> Fungal infections <input type="checkbox"/> Warts <input type="checkbox"/> Psoriasis <input type="checkbox"/> Sweat easily during day <input type="checkbox"/> Sweat easily at night <input type="checkbox"/> Never sweat <input type="checkbox"/> Itchy skin <input type="checkbox"/> Dry skin <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Kidney disease <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urinary tract infection <input type="checkbox"/> Frequent urination in general <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Kidney stones <input type="checkbox"/> Impaired urination <input type="checkbox"/> Blood in urine	<input type="checkbox"/> Emotional eating <input type="checkbox"/> Excessive appetite <input type="checkbox"/> Hungry between meals <input type="checkbox"/> Irritable before meals <input type="checkbox"/> Get shaky if hungry <input type="checkbox"/> Afternoon headaches <input type="checkbox"/> Crave sweets in afternoon <input type="checkbox"/> Compulsive eating <input type="checkbox"/> Frequent dieting <input type="checkbox"/> Frequent overeating
<b>Women</b>			
<input type="checkbox"/> PMS symptoms <input type="checkbox"/> Irregular/missed periods <input type="checkbox"/> Painful periods <input type="checkbox"/> Short cycles (<26 days) <input type="checkbox"/> Long cycles (>35 days) <input type="checkbox"/> Clots in menstrual blood <input type="checkbox"/> Fatigue after menses <input type="checkbox"/> Spotting between periods <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Pregnant now  _____ <b>Date of last period</b>  ____# <b>Days of bleeding</b>  <b>Color of blood:</b> bright dark pale  <b>Type of blood:</b> light medium heavy	<input type="checkbox"/> Current or past sexual or physical abuse <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Pain with intercourse  <b>Current method of birth control:</b> _____  <b>Past methods of birth control:</b> _____  ____# of Pregnancies ____# of Births ____# of Miscarriages ____# of Abortions  Note any complications during pregnancies, births, postpartum: _____	<input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Breast fibroids <input type="checkbox"/> Breast lumps <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Ovarian Cyst <input type="checkbox"/> Hysterectomy, when: _____  Monthly breast exam? Y N Last Pap Smear: _____ Last mammogram: _____  <input type="checkbox"/> Cancer: ovarian uterine breast cervical <input type="checkbox"/> Menopause symptoms <input type="checkbox"/> Hormone Replacement Therapy <input type="checkbox"/> Decreased sexual energy <input type="checkbox"/> Increased sexual energy	
<b>Men</b>	<b>Musculoskeletal</b>		
<input type="checkbox"/> Prostate hypertrophy (BPH) /cancer <input type="checkbox"/> Testicular pain/swelling <input type="checkbox"/> Difficulty conceiving <input type="checkbox"/> Penile discharge <input type="checkbox"/> Increased sexual energy <input type="checkbox"/> Decreased sexual energy <input type="checkbox"/> Sexual difficulties <input type="checkbox"/> Current past sexual or physical abuse <input type="checkbox"/> Sexually transmitted diseases	Note any current joint, muscle, tendon, or ligament problems. Include 1) Cause, 2) Diagnosis, 3) When problem started, 4) Treatment that's helped: _____ _____ _____ _____ _____  Note any past major musculoskeletal problems or injuries: _____ _____		

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

Please list the 5 major health concern in your order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PART II Please check mark the appropriate number “0 - 3” on all questions below. 0 as the least/never to 3 as the most/always.

Category I	0	1	2	3
Feeling that bowels do not empty completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdominal pain relief by passing stool or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternating constipation and diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard dry or small stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coated tongue of “fuzzy” debris on tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pass large amount of foul smelling gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 3 bowel movements daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you use laxatives frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category II</b>				
Excessive belching burping or bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas immediately following a meal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offensive breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sense of fullness during and after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty digesting fruits and vegetables; undigested foods found in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category III</b>				
Stomach pain, burning or aching 1- 4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you frequently use antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling hungry an hour or two after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn when lying down or bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Temporary relief from antacids, food, milk, carbonated beverages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems subside with rest and relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category IV</b>				
Roughage and fiber cause constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion and fullness lasts 2-4 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain, tenderness, soreness on left side under rib cage bloated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive passage of gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst and appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category V	0	1	2	3
Greasy or high fat foods cause distress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower bowel gas and or bloating several hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bitter metallic taste in mouth, especially in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yellowish cast to eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stool color alternates for clay colored to normal brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reddened skin, especially palms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry or flaky skin and/or hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of gallbladder attacks or stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had your gallbladder removed	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category VI</b>				
Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depend on coffee to keep yourself going or started	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get lightheaded and if meals are missed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating relieves fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel shaky, jittery, tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitated, easily upset, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory, forgetful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category VII</b>				
Fatigue after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave sweets during the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating sweets does not relieve cravings for sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Must have sweets after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waist girth is equal or larger than hip girth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased thirst & appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category VIII</b>				
Cannot stay asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crave salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow starter in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness when standing up quickly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches with exertion or stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weak nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Category IX</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Cannot fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perspire easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Under high amounts of stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain when under stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake up tired even after 6 or more hours of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive perspiration or perspiration with little or no activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category X</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Tired, sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold – hands, feet, all over .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Require excessive amounts of sleep to function properly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in weight gain even with low-calorie diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gain weight easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult, infrequent bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression, lack of motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches that wear off as the day progresses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outer third of eyebrow thins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinning of hair on scalp, face or genitals or excessive falling hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness of skin and/or scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental sluggishness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XI</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inward trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased pulse even at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous and emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XII</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Diminished sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual disorders or lack of menstruation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased ability to eat sugars without symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XIII</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Increased sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tolerance to sugars reduced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
“Splitting” type headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Category XIV (Male Only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Urination difficulty or dribbling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination frequent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain inside of legs or heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling of incomplete bowel evacuation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg nervousness at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XV (Males Only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Decrease in libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in spontaneous morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in fullness of erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in maintain morning erections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spells of mental fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Episodes of depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decrease in physical stamina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in fat distribution around chest and hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More emotional then in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XVI (Menstruating Females Only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Are you perimenopausal	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Alternating menstrual cycle lengths	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Extended menstrual cycle, greater than 32 days	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Shortened menses, less than every 24 days	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Pain and cramping during periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty blood flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy blood flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain and swelling during menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic pain during menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable and depressed during menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne break outs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial hair growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss/thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Category XVII (Menopausal Females only)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental fogginess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disinterest in sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shrinking breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial hair growth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased vaginal, pain, dryness or itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### PART III

How many alcohol beverages they consume per week? \_\_\_\_\_

How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times a week do you eat raw nuts or seeds? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_

How many times a week do you workout? \_\_\_\_\_

List the three worst foods you eat during the average week? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

List the three healthiest foods you eat during the average week? \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Do you smoke? \_\_\_\_\_ If yes, how many times a day \_\_\_\_\_, a week \_\_\_\_\_.

Rate your stress levels on a scale of 1-10 during the average week. \_\_\_\_\_

**Please list any medications you currently take and for what conditions:**

**Please list any natural supplements you currently take and for what conditions:**



Rachel Schneyer M.S. L.Ac  
 201 San Antonio Circle, Suite 154  
 Mountain View CA 94040  
 831-295-0555 phone  
 650-949-2778 fax

**PATIENT CONFIDENTIAL INFORMATION**

<b>Name:</b>	
<b>Mailing Address:</b>	<b>Social Security #:</b>
	<b>Sex:</b>
<b>Home Phone:</b> ( )	<b>Business Phone:</b> ( )
<b>Fax:</b> ( )	<b>Email:</b>
<b>Age:</b>	<b>Date of Birth:</b>
	<b>Marital Status:</b>
<b>Occupation:</b>	<b>Driver's License #:</b>
<b>Employer:</b>	<b>Phone:</b> ( )
<b>Emergency Contact:</b>	<b>Phone:</b> ( )
<b>Relationship:</b>	
<b>Have you previously been treated with Chinese medicine?</b> If so, for what complaint?	
<b>Health Care Practitioners/Doctors you see on a regular basis:</b> If so, for what complaint?	
<b>Personal Physician's name:</b>	<b>Phone:</b> ( )
<b>Date of last physical:</b>	
<b>For Minors: List both parents' or guardians' names and address (if different from above).</b>	
<b>Referred by:</b>	

**OFFICE POLICY**

**All fees for medical services and herbal supplements are due at the time of visit. If you need to cancel an appointment, please give me a minimum of 48 hours notice. I will be happy to reschedule your appointment. You will be expected to pay for your appointment in the event that the appointment is cancelled less than 24 hours in advance.**

**Initials: \_\_\_\_\_**

**I understand that I am ultimately responsible to pay for all services rendered to me. I agree to the above terms and cancellation policy.**

**I authorize the release of any medical or other information necessary for insurance claim processing and I understand that my individually identifiable medical information will be used only as necessary for purposes of treatment, payment, and other healthcare operations.**

**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 have received Rachel Schneyer's notice of Privacy Policies.**

**Signature:**  
**(parent/guardian signature if patient is minor)**

**Date:**



# Rachel Schneyer L.Ac

License# AC 11281  
 201 San Antonio Circle, Suite 154  
 Mountain View CA 94040  
 831-295-0555 phone  
 650-949-2778 fax

[ThriveHealth@gmail.com](mailto:ThriveHealth@gmail.com)

Patient \_\_\_\_\_

Next Appointment \_\_\_\_\_

Date \_\_\_\_\_

### CPT Procedure Codes

### Fee

- 97810 Acupuncture w/out e-stim \_\_\_\_\_
- 97811 Additional 15 minutes \_\_\_\_\_
- 97813 Acupuncture with e-stim \_\_\_\_\_
- 97814 Additional 15 minutes \_\_\_\_\_
- 97124 Massage \_\_\_\_\_
- 97140 Manual pressure therapy \_\_\_\_\_
- 97010 Moxa / Heat therapy \_\_\_\_\_
- 97026 Heat lamp \_\_\_\_\_
- 99071 Educational supplies \_\_\_\_\_
- 99070 Supplements \_\_\_\_\_

### New patient office visit

- 99205 Comprehensive \_\_\_\_\_
- 99202 Minimal \_\_\_\_\_

### Established patient office visit

- 99215 Moderate to high \_\_\_\_\_
- 99241 Consultation services \_\_\_\_\_
- 99245 \_\_\_\_\_
- 99350 Home visits \_\_\_\_\_
- 99010 Telephone consultation \_\_\_\_\_
- Other \_\_\_\_\_

Total Charges \_\_\_\_\_

Amount Paid \_\_\_\_\_

Balance Due \_\_\_\_\_

### ICD-CM Codes if not listed below \_\_\_\_\_

### Diagnosis: \_\_\_\_\_

- |   |        |  |        |
|---|--------|--|--------|
| <input type="checkbox"/> Abdominal pain       | 789.0  | <input type="checkbox"/> Joint pain            | 719.4  |
| <input type="checkbox"/> Back pain (postural) | 724.5  | <input type="checkbox"/> Ankle/foot pain       | 719.47 |
| <input type="checkbox"/> Thoracic spine pain  | 724.1  | <input type="checkbox"/> Elbow/arm pain        | 719.42 |
| <input type="checkbox"/> Lumbar/low back pain | 724.2  | <input type="checkbox"/> Hip/pelvis pain       | 719.45 |
| <input type="checkbox"/> Coccyx pain          | 724.70 | <input type="checkbox"/> Jaw pain              | 526.9  |
| <input type="checkbox"/> Bladder pain         | 788.9  | <input type="checkbox"/> Knee pain             | 719.46 |
| <input type="checkbox"/> Breast pain          | 611.71 | <input type="checkbox"/> Shoulder pain         | 719.41 |
| <input type="checkbox"/> Chest pain           | 786.50 | <input type="checkbox"/> Wrist pain            | 719.43 |
| <input type="checkbox"/> Ear pain             | 388.7  | <input type="checkbox"/> Limb / extremity pain | 729.5  |
| <input type="checkbox"/> Nausea               | 787.02 | <input type="checkbox"/> Muscle pain           | 729.1  |
| <input type="checkbox"/> Eye pain             | 379.91 | <input type="checkbox"/> Face pain             | 784.0  |
| <input type="checkbox"/> Fatigue / Malaise    | 780.79 | <input type="checkbox"/> Neck pain             | 723.1  |
| <input type="checkbox"/> Rectal pain          | 569.42 | <input type="checkbox"/> Neuralgia             | 729.2  |
| <input type="checkbox"/> Foot pain            | 729.5  | <input type="checkbox"/> Gastric pain          | 536.8  |
| <input type="checkbox"/> Hand pain            | 729.5  | <input type="checkbox"/> Sciatica              | 724.3  |
| <input type="checkbox"/> Headache and pain    | 784.0  | <input type="checkbox"/> Sinus pain            | 478.1  |
| <input type="checkbox"/> Migraine             | 346.90 | <input type="checkbox"/> Skin pain             | 782.0  |
| <input type="checkbox"/> Tension              | 307.81 | <input type="checkbox"/> Throat pain           | 784.1  |
| <input type="checkbox"/> Insomnia             | 780.52 | <input type="checkbox"/> Tooth pain            | 525.9  |
|   | 780.52 | <input type="checkbox"/> Uterus pain           | 625.9  |

Practitioner's Signature \_\_\_\_\_

## Herbal Formulas and Nutritional Supplements

Formula \_\_\_\_\_

Dosage \_\_\_\_\_

Formula \_\_\_\_\_

Dosage \_\_\_\_\_

Formula \_\_\_\_\_

Dosage \_\_\_\_\_

Notes/Procedures:



## Notice of Privacy Policy

Dear Patients:

HIPPA (Health Insurance Portability and Accountability Act) was established by congress to develop national safeguards to protect the confidentiality of patient medical information. The Privacy Section of this law was put into effect on April 14, 2003.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from the Clinic Front Desk.

Please sign the acknowledgement of receipt under “office policies” on the Patient Confidential information form, to indicate that you have received the notices for you and other minor family members and or dependents who receive care from Rachel Schneyer LAc.

Respectfully,

Rachel Schneyer M.S. LAc.

**This notice describes how medical information about you may be used and disclosed by Rachel Schneyer LAc. It also details how you can access this information. Please review it carefully.**

### **What is this notice and why is it important?**

This notice is required by law to inform you of how your health information will be protected, how Rachel Schneyer LAc. may use or disclose your health information, and about your rights regarding your health information. If you have any questions about this notice, please contact Rachel Schneyer LAc.

### **Understanding Your Health Information**

Each time you visit Rachel Schneyer a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnosis, treatments, and a plan for future care. This information, referred to as your medical record, serves as a:

<ul style="list-style-type: none"><li>• Basis for planning your care and treatment</li><li>• Means of communication among health care providers</li><li>• Legal documents of the care you receive</li><li>• Means by which you or a third-party payer can verify that services you received were appropriately billed</li></ul>	<ul style="list-style-type: none"><li>• A data source for medical research and public health</li><li>• A source of data for planning facilities, marketing healthcare services and fundraising</li><li>• A tool for educating health professionals</li><li>• A tool with which we can assess and work to improve the care we provide</li></ul>
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Understanding what is in your record and how your health information is used helps you to ensure its accuracy; better understand how others may access and use your health information; and make more informed decisions when authorizing disclosures to others.

### **Your Health Information Rights**

- **To Obtain a copy of this notice**
- **Authorization to use your health information.** Before I use or disclose your health information, other than as described below, I will obtain your written authorization, which you may revoke at any time to stop future use or disclosure.

- **Access to your health information.** You may request a copy of your health information that Rachel Schneyer keeps in your medical or billing record. Your request must be submitted in writing and you may request a form for this purpose by calling 831-295-0555.
- **Amend your health information.** If you believe that the information we have about you is incorrect or incomplete, you may request that we correct or add information. Your request must be in writing and you may request a form for this purpose by calling 831-295-0555.
- **Request confidential communications.** You may request that when we communicate with you about your health information, we do so in a specific way (e.g. At a certain mailing address or phone number.) We will make every reasonable effort to agree to your request.
- **Limit our use or disclosure of your health information.** You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, health care operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with your ability to treat you or collect payment for our services.
- **Accounting disclosures.** You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment or health care operations. Disclosures that we make with your authorization will not be listed. We will provide on e list per year free of charge, but will charge for subsequent lists in the same year.

### **Our Responsibilities**

- We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and business associated, and provide this notice about our privacy practices, and abide by the terms of this notice.
- We reserve the right to change our policies and procedures for protecting health information. When we make a significant change in how we use or disclose your health information, we will also change this notice. The new notice will be posted in the clinic and will be available at the front desk.
- Except for the purpose related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization. You have the right to revoke

your authorization at any time. We are unable to take back any disclosure we have already made with your permission.

### **Examples of Uses and Disclosures for Treatment, Payment and Healthcare Operations**

- Facilitate your medical treatment
- Collect payment for health care services we provide
- Facilitate routine healthcare operations
- Notify family and friends in order to facilitate your care
- Inform persons about your death

### **Examples of Uses and Disclosures for other Purposes**

- Appointment reminders
- Marketing
- Research
- Workers Compensation
- Public Health
- To avert serious threat to health or safety of you or another person
- Correctional Institutions
- Law enforcement
- Food and Drug Administration
- Business Associates

### **Special Situations**

- Specialized Government Functions
- Regulatory oversight

*If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact Rachel Schneyer LAc. If you believe we have not properly protected your privacy, have violated your privacy rights, or disagree with a decision we have made about your rights please contact Rachel Schneyer 831-295-0555.*



**HIPPA**  
**OFFICE STAFF, STUDENT, BUSINESS**  
**ASSOCIATES & VISITORS**  
**PATIENT CONFIDENTIALITY FORM**

Under the Health Information Portability and Accountability Act (HIPPA), "individually identifiable health information" may be disclosed only with written permission to anyone other than the patient. All discussions about patients medical conditions must be kept in a private setting. All medical records are to be accessed on an as needed basis.

Office staff, students, business associates, and visitors to Rachel Schneyer LAc where patients are being treated must sign this confidentiality agreement in compliance with HIPPA Privacy Law. All office staff, students, business associates, and visitors must follow our protocol to protect the rights of our patients.

Please sign below to indicate that you have read and agree to the above policies.

Name: \_\_\_\_\_ Date \_\_\_\_\_

Signature: \_\_\_\_\_