

Confidential Patient Case History

Please print clearly.



THE WELLNESS SPA AT THE
WILFRED R. CAMERON WELLNESS CENTER
OF THE WASHINGTON HOSPITAL

240 Wellness Way
Washington, PA 15301-9697
724.250.5238
www.spaharmony.org

First Name _____ Last Name _____ (Circle One: Mr / Mrs / Ms)

Address _____

City _____ State _____ Zip _____

Day Telephone _____ Evening Telephone _____

Email _____ Cell Phone _____

Date of Birth _____ Age _____ Marital Status _____ Number of children _____ Name of Spouse _____

Occupation _____ Who is responsible for this account? _____

In case of emergency, contact: Name _____ Phone _____

How did you hear about acupuncture at Spa Harmony? (Circle all that apply.)

Observer/Reporter _____ Member of the Wellness Center _____ Direct Mail _____ Friend _____ Redeeming a Gift Card _____ Web Site _____ Other _____

Are you a member of the Wilfred R. Cameron Wellness Center? Yes No *We may use mailing information for internal business or marketing purposes.*

Please check the appropriate box for any symptoms you now have or had. O = Occasional, F = Frequent, C = Constant

<table border="0"> <tr> <td>O</td><td>F</td><td>C</td><td>General</td> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chills</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Convulsions</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dizziness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fainting</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fatigue</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Fever</td></tr> <tr><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td>Spinal curvature</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Swollen joints</td></tr> <tr> <td>O</td><td>F</td><td>C</td><td>Gastro-intestinal</td> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Belching or gas</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Colitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Colon trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Constipation</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diarrhea</td></tr> <tr><td><input type="checkbox"/></td><td><input 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type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Deafness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dental decay</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Earache</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ear discharge</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ear noises</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Enlarged glands</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Enlarged thyroid</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Eye pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Failing vision</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Far/Near sightedness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Gum trouble</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hay fever</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hoarseness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nasal obstruction</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Nosebleeds</td></tr> <tr><td><input 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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulder																																																																																																																																																																																																																																																																																																																																																																							
O	F	C	Pain or numbness in																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tailbone																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints																																																																																																																																																																																																																																																																																																																																																																							
O	F	C	Gastro-intestinal																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distension of abdomen																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood																																																																																																																																																																																																																																																																																																																																																																							
O	F	C	Eyes, Ears, Nose, Throat																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far/Near sightedness																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis																																																																																																																																																																																																																																																																																																																																																																							
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat																																																																																																																																																																																																																																																																																																																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles																																																																																																																																																																																																																																																																																																																																																																							

continued next page

Please check the appropriate box for any symptoms you now have or had. O = Occasional, F = Frequent, C = Constant

O F C Respiratory

- Chest pain
- Chronic cough
- Difficult breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

O F C Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin eruptions (rash)
- Varicose veins

O F C Genito/Urinary

- Bed wetting
- Blood in urine
- Frequent urination
- Cannot control kidney
- Kidney infection/stone
- Painful urination
- Prostrate trouble
- Pus in urine

O F C For women only

- Congested breasts
- Cramps or backache
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation
- Vaginal discharge

Are you pregnant? yes no

Please check the following conditions you have had:

- | | | |
|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Influenza | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Malaria | <input type="checkbox"/> Typhoid fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mumps | |

1. What hurts the most, or is your major complaint today? _____

2. When did this start? _____ How? _____

3. What makes the condition worse? _____

4. What makes the condition better? _____

5. Is the pain: dull sharp constant

6. Does the pain travel? yes no Where? _____

Confidential Patient Case History (cont.)

7. List previous doctors you've seen, their findings, treatments and results. _____

8. List all prescriptions and "over the counter" medications you now use and the amount: _____

9. List all operations you have had, and the dates: _____

10. List all vehicular collisions, or other situations involving injury, the date and treatment given: _____

11. List previous acupuncturists you've seen, the dates and results: _____

12. Do you consume alcohol? yes no How much? _____

Do you consume coffee? yes no How much? _____

Do you smoke? yes no How much? _____

Do you exercise? yes no How much? _____

13. List all conditions you have been treated for in the last ten years. _____

14. Have you ever tested positive for HIV? yes no

Consent for Treatment

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the Wellness Center will share patient health information according to federal and state law for treatment and operations. I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges.

Signature of Patient: _____ Date: _____

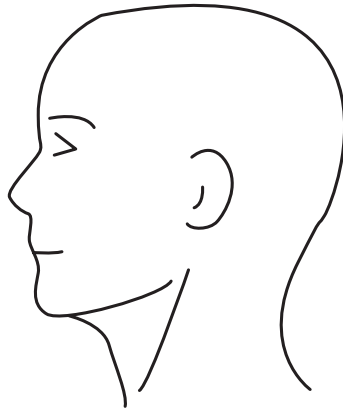
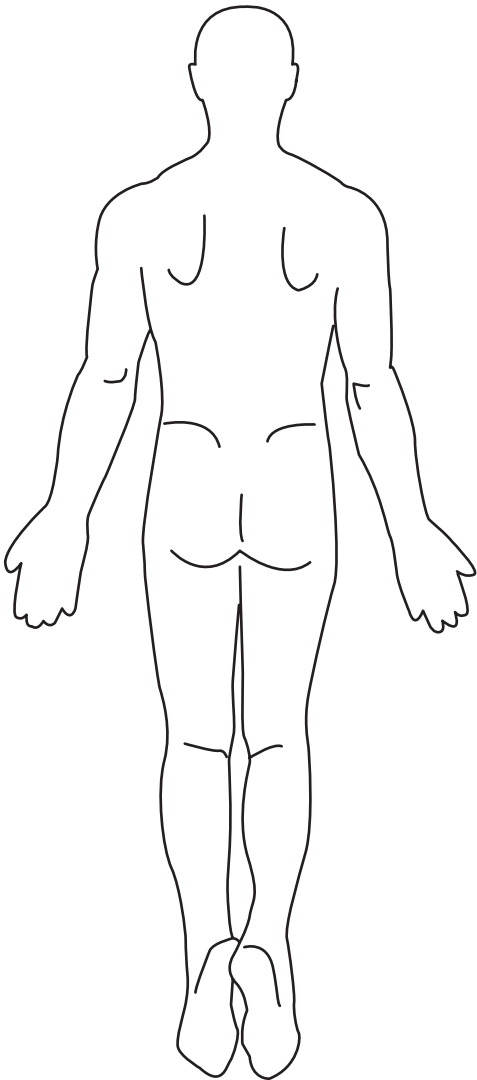
Signature of Legally Authorized Representative: _____

Relationship of Legally Authorized Representative to Patient: _____

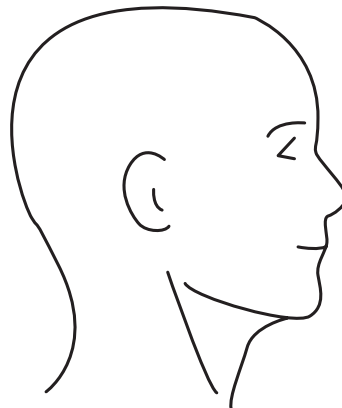
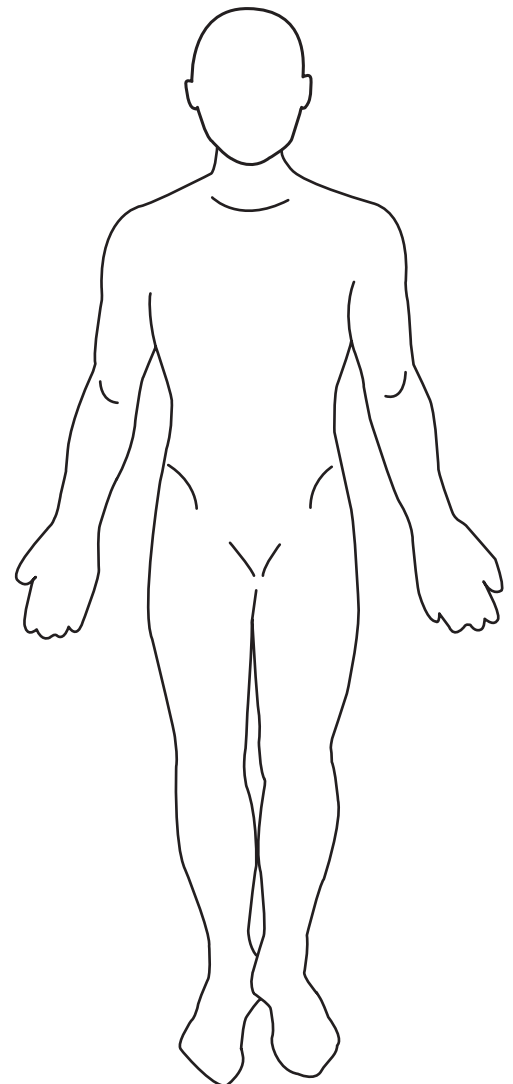
I understand that the health information that I have provided will be used in a manner consistent with the Notice of Privacy Practices at The Washington Hospital (Privacy Notice). I have been offered the opportunity to read the Privacy Notice.

Signature: _____ Date: _____

Please draw in areas of pain.



LT VIEW



RT VIEW

Circle level of pain below.

Least 1 2 3 4 5 6 7 8 9 10 Most