

Patient Information and Health History

Please help us to provide you with the best treatment possible by taking the time to complete this questionnaire carefully. Your answers will be completely confidential. If there is anything that you would like to add, please write it either in the margin or in the Comments section at the end. If you have any questions, please don't hesitate to ask.

Personal Information

Name:	Age:	Sex/Gender:	Cell phone:
Full address:	Date of Birth:		Home phone:
	Marital Status:		Work phone:
Email (kept private):	Height:	Weight:	Occupation:
<hr/>			
Please list main concern(s). How long ago did each begin?	What treatments have you tried (chiropractic, massage, ice, heat, rest, movement)? Does anything help?	Have you had acupuncture before? How recently?	
	Have you seen a physician?	Whom may we thank for referring you?	
	Did you receive a diagnosis? What?		
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Past Medical History – please include *approximate dates*

<i>please circle</i> High Blood Pressure Cancer HIV/AIDS Diabetes Stroke Heart Attack Seizures Hepatitis Other:	Surgeries Hospitalizations	Significant Trauma <i>(auto accidents, falls, fractures, etc.)</i>
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Family Medical History— Significant illnesses in your family – ***please circle*** and include relation

Cancer (where?)	Hepatitis	Seizures
Diabetes	High Blood Pressure	Asthma/Allergies
Heart Attack	Stroke	Other

Current medications and supplements:

Please list any allergies (*medications, foods, chemicals, etc.*)

What do you do for exercise? How often?

Diet

Do you restrict your diet in any way? (*vegetarian, no red meat, organic, etc.*)

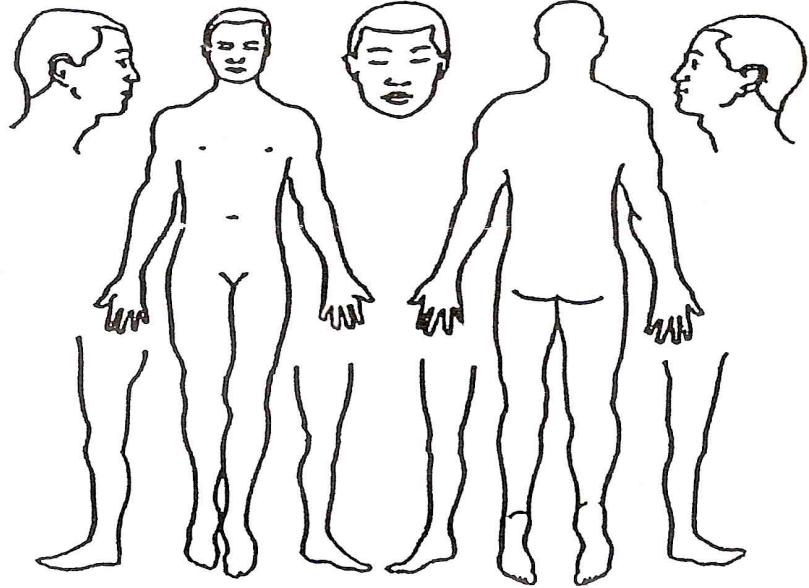
Approximately how much water do you drink a day?

How much caffeine do you drink?

Do you use tobacco? What kind (cigarettes, cigars, etc.) and how much?

Please list any recreational drug use and frequency (strictly confidential).

Please mark any areas of pain or discomfort



Rate each symptom you experience: 1 = occasionally, 2 = often, 3 = always (leave blank if never)

General

fevers/chills 1 2 3
 fatigue 1 2 3
 weight loss 1 2 3
 weight gain 1 2 3
 peculiar tastes or smells 1 2 3
 sudden energy drop 1 2 3
 what time of day? _____

Sleep

how much sleep do you get? _____
 difficulty falling asleep 1 2 3
 waking often 1 2 3
 difficulty falling back asleep (after
 waking) 1 2 3
 vivid/disturbing dreams 1 2 3
 night sweats 1 2 3

Head, Eyes, ENT

dizziness/vertigo 1 2 3
 red/itchy/dry/watery eyes 1 2 3
 eye strain/pain/"floaters" 1 2 3
 blurry/failing vision 1 2 3
 glasses (how strong?) 1 2 3
 night blindness 1 2 3
 cataracts/glaucoma 1 2 3
 earaches 1 2 3

Skin, Hair and Nails

sweating 1 2 3
 sensitive scars 1 2 3
 acne 1 2 3
 itching 1 2 3
 eczema/psoriasis 1 2 3
 dry skin 1 2 3
 damp/clammy skin 1 2 3
 bleed or bruise easily 1 2 3
 loss of hair 1 2 3
 brittle or weak nails 1 2 3
 other:

Cardiovascular and Circulatory

cold hands and/or feet 1 2 3
 cold feeling in whole body 1 2 3
 rapid heart beat 1 2 3
 irregular heartbeat 1 2 3
 high blood pressure 1 2 3
 low blood pressure 1 2 3
 palpitations 1 2 3
 lightheadedness/fainting 1 2 3
 swelling/edema 1 2 3
 blood clots 1 2 3
 other:

ringing in the ears 1 2 3
 plugged feeling in ears 1 2 3
 hearing loss (temp/perm) 1 2 3
 runny nose 1 2 3
 sinus pressure/sinus infections 1 2 3
 nose bleeds 1 2 3
 gum trouble 1 2 3
 sores on lips/tongue 1 2 3
 teeth clenching/ grinding 1 2 3
 jaw clicking/pain 1 2 3
 swollen glands 1 2 3
 other:

Respiratory

dry/sore throat/hoarse voice 1 2 3
 recurrent sore throats 1 2 3
 frequent colds 1 2 3
 sneezing/coughing 1 2 3
 phlegm – color: _____ 1 2 3
 asthma/wheezing 1 2 3
 shortness of breath 1 2 3
 difficulty breathing 1 2 3
 seasonal/other allergies 1 2 3
 difficulty/pain with deep breath 1 2 3
 chest pain/tightness 1 2 3
 other:

Digestion

difficulty swallowing 1 2 3
 nausea/vomiting 1 2 3
 poor appetite 1 2 3
 excessive hunger 1 2 3
 fatigue after meals 1 2 3
 thirst (for hot or cold drinks?) 1 2 3
 cravings (for specific foods, other)
 _____ 1 2 3
 bad breath 1 2 3
 belching/burping 1 2 3
 gas/bloating 1 2 3
 abdominal pain/cramps 1 2 3
 indigestion/heartburn 1 2 3
 gall bladder trouble 1 2 3
 how often do you have a bowel
 movement? _____
 diarrhea, loose stool 1 2 3
 constipation 1 2 3
 dry stool 1 2 3
 laxative use 1 2 3
 blood/mucus in stool 1 2 3
 hemorrhoids 1 2 3
 rectal pain/itching 1 2 3
 other:

Male reproductive health

scrotum/testicle pain 1 2 3
 prostate trouble 1 2 3
 erection difficulties 1 2 3

Ob-Gyn

Could you be pregnant? Y N
 age of first period: _____
 duration of typical period: _____
 duration of cycle: _____
 date of last period: _____
 irregular periods 1 2 3
 painful periods 1 2 3
 bleeding between periods 1 2 3
 heavy menstrual flow 1 2 3
 light menstrual flow 1 2 3
 cramping 1 2 3
 clots in menstrual flow 1 2 3
 vaginal discharge 1 2 3
 breast issues: _____ 1 2 3
 # pregnancies: _____
 # abortions: _____
 # miscarriages: _____
 premature births: _____
 # live births (years?): _____

Have you ever taken birth control?
 When and for how long?

premenstrual & menstrual symptoms

(circle ones you have, write in others)

bloating breast tenderness
 irritability mood swings
 fatigue poor coordination
 loose stool acne
 other:

menopause symptoms

(circle ones you have, write in others)

hot flashes night sweats
 Irritability mood swings
 fatigue
 other:

menopause – age you started? _____

Genito-Urinary

waking to urinate 1 2 3
 frequent/urgent urination 1 2 3
 pain/burning upon urination 1 2 3
 inability to hold urine 1 2 3
 difficulty urinating 1 2 3
 weak urinary flow 1 2 3
 dark yellow urine 1 2 3
 cloudy urine 1 2 3
 clear urine 1 2 3
 blood in urine 1 2 3
 urinary tract infections 1 2 3
 kidney infections/stones 1 2 3
 low libido 1 2 3
 excessive libido 1 2 3
 sores on genitals 1 2 3
 other:

Psychological/Neurological

excessive worry 1 2 3
 excessive sadness 1 2 3
 excessive anger 1 2 3
 excessive fear 1 2 3
 racing thoughts 1 2 3
 crying spells 1 2 3
 easily startled 1 2 3
 nervousness 1 2 3
 anxious 1 2 3
 irritability 1 2 3
 quick temper 1 2 3
 overwhelmed 1 2 3
 easily susceptible to stress 1 2 3
 difficulty concentration 1 2 3
 depression 1 2 3
 poor memory 1 2 3
 seizures 1 2 3
 loss of balance 1 2 3
 other:

Have you ever taken psychiatric
 medication? Y N
 When and which?

Comments: Please list any other
 issues you would like to discuss.

Acupuncture Informed Consent to Treat

I, (printed name) _____ hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be consumed according to the instructions provided. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is common with cupping. Rare risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax (lung puncture). Infection is another possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (of plant, animal, and mineral origin) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although (as with pharmaceuticals) some are toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. **I will notify a clinical staff member who is caring for me if I am or become pregnant.**

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient chart, but all my records will be kept confidential and will not be released without written consent. The exception to this is that patients wishing to have their insurance pay for part of the treatment do hereby consent to have all relevant information shared with their insurance provider only insofar as needed for the office to receive reimbursement.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been informed of the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient Signature **X** _____
(or patient representative – indicate relationship if signing for patient)