HEALTH HISTORY QUESTIONNAIRE

Confidential Information for your Acupuncturist Date: ____/____/_____

Name: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Name, Phone Number and Relation to Patient: _____

To retain your health care privacy, may we contact you at these phone numbers? Yes No
If No, what is the best way to reach you to retain your privacy? _____

Age: _____ Date of Birth: _____/_____/_____ Occupation: _____

Guardian (if under 18 years of age): _____

How did you hear about our office? _____

Insurance Company: _____ **Policy #**: _____

Does your insurance pay for Acupuncture?_____ Are there any restrictions_____

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No

Do you have: *High Blood Pressure *Seizures *Hepatitis *Hiv *Diabetes *Pace Maker *Blood thinning meds

Please indicate the use and frequency of the following:

Coffee_____ **Soda**_____ **Water**_____ **Alcohol**_____ **Tobacco**_____

Medications	**Reason for Medication**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Circle any you have or have had in the past:

Diabetes	Allergies	Glaucoma	Rheumatic Fever	Heart Disease	CVA (Stroke)
Vein condition	Asthma	Pneumonia	Tuberculosis	Emphysema	Hepatitis
Jaundice	Sinus Problems	Bleeding Tendency	High Blood Pressure	Cancer (What kind):	
Meningitis	Epilepsy	Nervous Disorder	Paralysis	Kidney Disorder	Stomach Disorder
Mononucleosis	Migraines	HIV/AIDS	Thyroid Disorder	Liver Disorder	Lung Disorder

Other: _____

Family Medical History: Please circle all that apply in your immediate family

Cancer	Diabetes	High Blood Pressure	Stroke	Seizures	Allergies
Asthma	Heart Disease	Other Major Illnesses: _____			

III. PATIENT PROFILE

Do you have a regular exercise program? If yes, describe:

Are you on a restricted diet? If yes, describe:

Pain Conditions:
Indicate any areas of pain in the body and the location of any scars on the body:

Is the pain sensation:

Sharp	Burning	Aching	Cramping	Dull	Moving	Fixed

Do any of the following lessen the pain:

Pressure	Cold	Heat	Exercise	Other:

Do any of the following worsen the pain:

Pressure	Cold	Heat	Exercise	Other:

Please check the following that pertain to you:

Overall Body Temperature:

❑ Hot body temperature or sensation	❑ Cold hands	❑ Sweaty hands	❑ Afternoon flushes
❑ Cold body temperature of sensation	❑Cold feet	❑ Sweaty feet	❑ Night sweats
❑ Heat in the hands, feet and chest	❑ Hot flashes any time of the day		❑ Lack of perspiration
❑ Perspire easily	❑ Thirsty: for hot or cold drinks		

Overall Energy:

❑ Difficulty keeping eyes open in the daytime	❑ Shortness of breath	❑ General weakness
❑ Easily catch colds	❑ Low Energy	❑ Feel worse after exercise

Overall Blood Function:

❑ See floaters or floating black spots in the eyes ❑ Recent moles, unusual moles
❑ Freckles ❑ Dizziness ❑ Pimples

Heart Function:

❑ Cardiovascular disease ❑ High blood pressure ❑ Low blood pressure
❑ Chest pain ❑ Fainting ❑ Palpitations ❑ Sores on tip of tongue
❑ Restlessness ❑ Anxiety ❑ Hard to fall asleep ❑ Wake unrefreshed
❑ Nightmares ❑ Restless sleep ❑ Mental Confusion ❑ Restless dreaming
❑ Waking during the night ❑ Chest pain traveling to shoulders or down arms

Lung Function:

❑ Profuse nasal discharge: thin/clear/runny thick/white thick/yellow
❑ Cough: Wet or Dry ❑ Nose Bleeds ❑ Sinus Congestion ❑ Dry mouth
❑ Dry, itchy throat ❑ Sore throat ❑ Dry skin ❑ Allergies: to what?
❑ Sneezing ❑ Hives ❑ Stiff neck ❑ Stiff shoulders
❑ Bronchitis ❑ Rashes ❑ Itching ❑ Eczema
❑ Dandruff ❑ Sadness ❑ Melancholy ❑ Difficulty inhale or exhale
❑ Alternating fever and chills ❑ Achy feeling in the body ❑ Smoke cigarettes

Spleen Function:

❑ Low appetite ❑ Changes in appetite ❑ Cravings, for what?
❑ Abrupt weight gain ❑ Abrupt weight loss ❑ Abdominal bloating
❑ Abdominal gas ❑ Stomach Gurgling ❑ Fatigue after eating
❑ Easily bruised ❑ Hemorrhoids ❑ Pensive/Over-thinking
❑ Worry ❑ Prolapsed organs: which organ?

Spleen, Stomach, Large Intestine, Small Intestine Function:

❑ Loose Stools ❑ Incomplete Bowel Movements ❑ Constipation
❑ Diarrhea ❑ Blood in Stools ❑ Undigested food in stools
❑ Mucous in stools ❑ Black or tarry stools ❑ Chronic use of laxatives: what type of laxative?

Dampness trapped in body:

❑ General sensation of heaviness in body ❑ Phlegm production ❑ Mental sluggishness
❑ Mental fogginess ❑ Swollen hands ❑ Swollen feet ❑ Swollen joints
❑ Chest congestion ❑ Nausea ❑ Snoring ❑ Dizziness

Stomach Function:

❑ Burning sensation after eating ❑ Large appetite ❑ Bad breath ❑ Vomiting
❑ Sores on lips, tongue or mouth ❑ Ulcer (if diagnosed) ❑ Belching ❑ Acid regurgitation
❑ Cold sensation in stomach ❑ Hiccoughs ❑ Stomach Pain ❑ Heartburn
❑ Bleeding, swollen or painful gums

Liver and Gallbladder Function:

❑Chest pains	❑Tight sensation in chest	❑Bitter taste in mouth
❑Anger easily	❑Frustration	❑Depression
❑Irritability	❑Skin rashes	❑Tingling sensations
❑Numbness	❑Muscle Spasms	❑Muscle Twitching
❑Muscle Cramping	❑Seizures	❑Convulsions

❑Lump in throat	❑Teeth Grinding	❑Alternating diarrhea and constipation
❑Neck tension	❑Shoulder tension	❑Hip pain/Sciatica
❑High pitch ringing in the ears		❑Gallstones, history of or currently

❑Frequently unable to adapt to stress (what causes this stress?)

❑ **Headaches:**
❑**Migraines**
❑How Often? ❑ Describe location:

Eyes:

❑ Itchy	❑ Red or Bloodshot	❑ Hot	❑ Dry
❑ Watery	❑ Gritty or sandy feeling	❑ Blurry vision	❑ Decreased night vision
❑ Near-sighted	❑ Far-sighted	❑ Cataracts	❑ Visual Disturbances

Kidney, Urinary Bladder Function:

❑ Frequent cavities	❑ Easily Broken Bones	❑ Poor hearing	❑ Earaches
❑ Painful knees	❑ Weak knees	❑ Cold in knees	❑ Low back pain
❑ Memory problems	❑ Excessive hair loss	❑ Pre-mature grey hair	❑ Low-pitch ringing in the ears
❑ Kidney stones	❑ Bladder infections	❑ Fear	❑ Easily startled
❑ Foot or ankle weakness or pain		❑ Lack bladder control	❑ Sneeze or jump incontinence

Urination:
How many times per day do you urinate?
Do you wake during the night to urinate? How many times per night?

❑ Normal color urine	❑ Dark yellow	❑ Clear	❑ Reddish
❑ Cloudy	❑ Scanty	❑ Profuse	❑ Strong Odor
❑ Burning	❑ Painful	❑ Difficult	❑ Urgent

Libido:
❑ Normal ❑ High ❑ Low

Women only:

Do you practice birth control? ❑Y ❑N If so, what type and for how long?
Pregnant? ❑Y ❑N Is there a chance you may be pregnant now? ❑Y ❑N
Vaginal discharge: ❑Y ❑N
Regular menstrual cycle? ❑Y ❑N
Number of children: _____ Number of pregnancies: _____
Age of first menstruation: _____ Age of menopause (if applicable):_____
Average number of days of flow: _____ Average number of days of entire cycle: _____
Uterine bleeding/spotting between periods? ❑Y ❑N How much and how often?

Women Only:

Do you experience any of the following pre-menstrual syndromes?

- ❑ Nausea
- ❑ Vomiting
- ❑ Water retention
- ❑ Breast swelling
- ❑ Food cravings
- ❑ Headaches
- ❑ Migraines
- ❑ Breast tenderness
- ❑ Depression
- ❑ Irritability
- ❑ Anxiety
- ❑ Other emotions: _____
- ❑ Dull pain, where? _____
- ❑ Sharp pain, where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (describe size: large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Both Men and Women:

Please tell us of any other problems you would like to discuss: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date_____

Acupuncturist Signature: _____ Date_____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I 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 this office or any other office or clinic, whether signatories to this form or not. I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist 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 office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about 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 for any future condition(s) for which I seek treatment.

Patient's Name _____ Are you pregnant? _____

Patient's Signature_____ Date Signed _____

Parent's Signature (if patient is under 18) _____

Complaint

Hx/Dx

Date

Subjective: Heat/cold, sweat, head/body, chest/abd, hunger/thirst, urination/stool, vision/hearing, Sleep, reproductive, co