

HEALTH HISTORY QUESTIONNAIRE FOR PATIENTS

Welcome to our clinic! Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the **comments** section. Thank you!

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Age: _____ Height: _____ Weight: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____

Occupation: _____ Marital Status: _____

In Emergency Notify: _____

Referred by: _____

Family Physician: _____

Insurance Carrier: _____

Have you tried acupuncture or Chinese herbal medicine before? _____

WHAT IS YOUR MAIN PROBLEM? (please explain)

To what extent does this problem affect your daily activities (work, sleep, eating, etc)?

How long has it been since you first noticed symptoms?

Have you been given a diagnosis for the problem by your family physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Other significant illness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Surgeries | (describe) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Venereal disease | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid disease | _____ |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Birth trauma (prolonged | <input type="checkbox"/> Accidents or significant |
| <input type="checkbox"/> Heart disease | labor, forceps delivery, etc) | trauma (describe) |
| <input type="checkbox"/> Seizures | | _____ |

OTHER RELEVANT MEDICAL HISTORY

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- | | | |
|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other |

OCCUPATION

Occupational stress factors (physical, psychological, chemical):

LIFESTYLE

Do you follow a regular exercise program? If so, please describe:

Please describe your average daily diet:

Please check any of the following habits that apply. How much and how often do you use them?

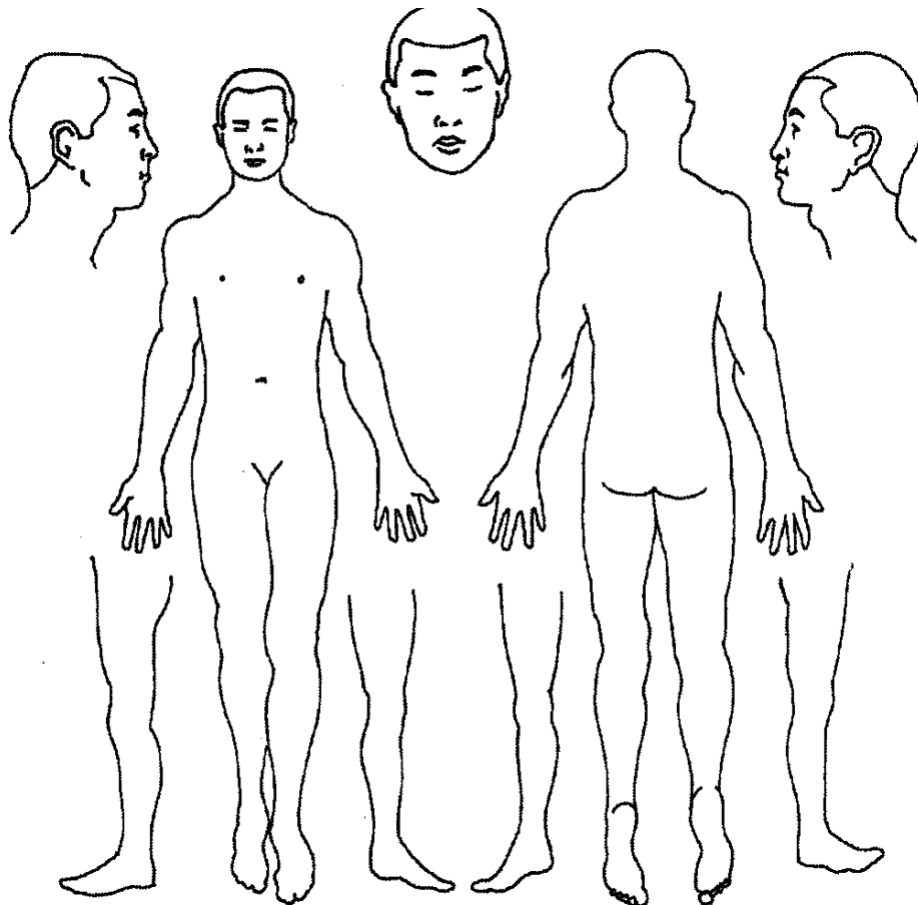
- | | | |
|--|--|--|
| <input type="checkbox"/> Cigarette smoking | <input type="checkbox"/> Coffee, tea or cola | <input type="checkbox"/> Alcoholic beverages |
|--|--|--|

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

Please describe any use of drugs for non-medical purposes:

Symbol	Reaction
--------	----------

Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
~	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
--	colder
+	hotter
Physical	
∅	sores
*	rashes
<< >>	spasms



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INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- | | | |
|---|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweating easily | <input type="checkbox"/> Sudden energy drop
(time of day?) |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleeding or bruising easily | |

Other unusual or abnormal conditions you have noticed in your general sense of health

SKIN AND HAIR

- | | | |
|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Pimples | <input type="checkbox"/> Changes in texture of hair
or skin |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Dandruff | |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | |

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

- | | | |
|---|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Color blindness | <input type="checkbox"/> Recurrent sore throat |
| <input type="checkbox"/> Concussions | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Earaches | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Teeth problems |
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Headaches (where? when?) |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Jaw clicks |

Any other head or neck problems

CARDIOVASCULAR

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling of feet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Fainting | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Difficulty in breathing |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Phlebitis |

Any other heart or blood vessel problems

RESPIRATORY

- | | | |
|--|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing when
lying down |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Excessive phlegm (color?) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | |

Any other lung problems

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- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Belching | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Black stools | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Abdominal pain or cramps |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Chronic laxative use |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bad breath | |

Any other problems with stomach or intestines

GENITOURINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Decrease in flow |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Sores on genitals |

Do you wake up at night to urinate? If so, how often?

Any particular color to your urine?

Any other genital or urinary problems:

REPRODUCTIVE AND GYNECOLOGIC

- | | | |
|---|---|---|
| <input type="checkbox"/> Premenstrual changes | <input type="checkbox"/> Heavy menstrual flow | <input type="checkbox"/> Premature births |
| <input type="checkbox"/> Menstrual clots | <input type="checkbox"/> Light menstrual flow | <input type="checkbox"/> Miscarriages |
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Abortions |
| <input type="checkbox"/> Unusual menses | <input type="checkbox"/> Other problems | |

Age at first menses

Age at menopause

Number of pregnancies

Time between cycles

Duration of bleeding

First day of last menses

Do you practice birth control?

If so, what type?

For how long?

Any other gynecologic problems

MUSCULOSKELETAL

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Hand/wrist pains |
| <input type="checkbox"/> Muscle pains | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pains | <input type="checkbox"/> Hip pain |

Any other joint or bone problems

NEUROPSYCHOLOGICAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Bad temper |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Concussion | <input type="checkbox"/> Easily susceptible to stress |
| <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Depression | |

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological problems

COMMENTS

Please list any other problems you would like to discuss:

INFORMED CONSENT TO ACUPUNCTURE 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 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, Tiu-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be 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 a generally 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 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 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 effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral 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 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 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, the above 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 SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE