Patient Information and Health History Questionnaire

Name: _____ Date of birth: _____ Birth time:_____

Phone: (Home): _____ (Cell): _____

May we communicate with you via text message? _____ E-Mail: _____

Employer: _____ Occupation: _____

Address: _____ City/State/Zip: _____

If you are under the care of a physician, indicate name, specialty, and phone #:

_____

In case of emergency, who can we contact? Name: _____

Relationship: _____ Phone: _____

Referred by: _____ Have you received acupuncture or Chinese herbs before? _____

What is your primary reason for seeking treatment? _____

_____

When and how did this condition begin? _____

_____

To what extent does this problem interfere with your daily activities? _____

_____

What makes it better? _____

What makes it worse? _____

What other treatment have you received for this condition? _____

_____

Write down any diagnoses you have received from a physician: _____

_____

List any medicines, herbs, or supplements you are currently taking: _____

_____

_____

Check conditions you have now or have had in the past:

- ❑ Anemia
- ❑ Arrhythmia
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disorder: _____
- ❑ Bipolar disorder
- ❑ Bleeding disorder
- ❑ Cancer: what kind? _____
- ❑ Concussion
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ Drug or Alcohol Addiction
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV
- ❑ Kidney Disease
- ❑ Pacemaker
- ❑ Seizures
- ❑ Stroke
- ❑ Thyroid Disorders

Family History: check the conditions found in your close relatives:

- ❑ Asthma
- ❑ Cancer: what kind? _____
- ❑ Depression
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Seizures
- ❑ Stroke
- ❑ Other: _____

Please list major illnesses, injuries, or surgeries and the year they occurred:

_____

_____

_____

_____

Please list any medications, foods, or other substances you are allergic to:

_____

_____

_____

Habits/Lifestyle:

Do you get regular exercise? Yes No

Type(s):_____

How Often?_____

Do you get sufficient sleep? Yes no

How many hours sleep per night? _____

If you partake of any of the following things, check the box and write how often:

- ❑ Alcohol: _____drinks per_____
- ❑ Coffee: _____ cups per _____
- ❑ Soda: _____ sodas per _____
- ❑ Tobacco: ____cigarettes per____
- ❑ Vaping: _____ times per _____
- ❑ Marijuana: _____times per_____

Diet: Describe your average daily diet

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Please list any dietary restrictions:

_____

_____

Please list any food sensitivities:

_____

_____

Female health history questions:

Are you possibly pregnant? _____

Date of last period: _____

Number of pregnancies: _____

Number of live births: _____

If you use birth control, what type and for how long?

_____

CONSENT TO RECEIVE TREATMENT

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 patients 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 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, Tui-Na (Oriental massage), Oriental 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 the 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 Oriental 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 know 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:

_____ Date:_____

(Or Patient Representative--Indicate relationship if signing for patient: _____)

Office Signature:

_____ Date:_____

Name: _____

Main Complaint(s): _____

_____

_____

Physical Pain /Musculoskeletal:

where in your body do you have pain?_____

_____

_____

- ❑ Sharp/Pricking/stabbing
- ❑ Fixed pain
- ❑ Pain moves around
- ❑ Tightness
- ❑ Stiffness
- ❑ Paralysis
- ❑ Radiating or electric
- ❑ Heavy sensation
- ❑ Swelling/edema
- ❑ Burning sensation
- ❑ Dull Pain
- ❑ Soreness
- ❑ Muscle weakness
- ❑ Pain is better with activity
- ❑ Pain is worse with activity
- ❑ Muscle cramps or spasm
- ❑ Tremors
- ❑ Tics
- ❑ Muscle twitches

Headaches: **#_____ per _____**

- ❑ eyes
- ❑ forehead
- ❑ sinuses
- ❑ temples
- ❑ top of head
- ❑ back of head
- ❑ vomiting
- ❑ sides of head
- ❑ one-sided
- ❑ dull pain
- ❑ stabbing pain
- ❑ tension
- ❑ pressure
- ❑ aura

Sweating:

- ❑ Spontaneous
- ❑ Excessive
- ❑ Easy to sweat
- ❑ Difficult to sweat
- ❑ No sweat
- ❑ Night sweat
- ❑ Sweat after eating

Weather/Environment:

I do not like:	I prefer:
❑ Wind	❑ Wind
❑ Cold	❑ Cold
❑ A/C	❑ A/C
❑ Damp	❑ Damp
❑ Rainy	❑ Rainy
❑ Heat	❑ Heat
❑ Humidity	❑ Humidity

Body Temperature:

- ❑ I run cold/I get cold easily
- ❑ I run hot/I get hot easily
- ❑ Cold body
- ❑ Cold hands and/or feet
- ❑ Very warm or hot body
- ❑ Hot hands and/or feet

Cough/Wheeze/Breathing:

- ❑ Dry cough
- ❑ Cough worse at night
- ❑ Profuse phlegm
- ❑ Scant phlegm
- ❑ Easy to expectorate
- ❑ Difficult to expectorate
- ❑ Difficult to breathe when lying down
- ❑ Yellow phlegm
- ❑ White phlegm
- ❑ Foamy phlegm
- ❑ Blood streaked sputum
- ❑ Excessive salivation
- ❑ Asthma
- ❑ Shortness of breath
- ❑ Chest congestion
- ❑ Chest oppression
- ❑ Chest distention
- ❑ Chest pain
- ❑ Burning sensation in chest
- ❑ Pain or distension in ribsides

I feel dryness in my…

- ❑ Mouth
- ❑ Eyes
- ❑ Ears
- ❑ Throat
- ❑ Nose
- ❑ Skin

Eyes:

- ❑ Blurry vision
- ❑ Poor vision
- ❑ Floaters
- ❑ Itchy
- ❑ sensitive to light
- ❑ Watery
- ❑ Red

Skin Disorders:

- ❑ Numbness
- ❑ Electric sensation
- ❑ Itching
- ❑ Rashes
- ❑ Oily skin
- ❑ Oozing fluid
- ❑ Nonhealing sores
- ❑ Dryness
- ❑ Scaling
- ❑ Cracking
- ❑ Redness
- ❑ Swelling
- ❑ Pain
- ❑ Acne
- ❑ Boils
- ❑ Dark spots

Ear/Nose/Throat/Mouth:

- ❑ Allergies
- ❑ Nasal congestion
- ❑ Runny nose
- ❑ Sneezing
- ❑ Post nasal drip
- ❑ Sinus congestion
- ❑ Tinnitus
- ❑ Deafness
- ❑ Poor hearing
- ❑ Ear pain
- ❑ Blocked ear
- ❑ Sore throat
- ❑ Mouth Ulcers
- ❑ Painful gums
- ❑ Gum Ulcers
- ❑ Tongue pain
- ❑ Burning tongue
- ❑ Bitter, metallic, or unclean taste in mouth
- ❑ Sticky or sweet taste in mouth

Thirst:

- ❑ Not thirsty
- ❑ Thirsty but doesn't drink
- ❑ I like cold drinks
- ❑ I like room temperature
- ❑ I like warm/hot drinks
- ❑ Thirsty at night
- ❑ Unquenchable thirst
- ❑ Drinking causes bloating
- ❑ Drinking causes nausea

How many cups of water do you drink per day? _____

Do you drink any of the following once a week or more?

- ❑ Smoothie
- ❑ Coffee
- ❑ Green tea
- ❑ Alcohol
- ❑ Soda
- ❑ Energy drink

Appetite:

- ❑ No or low appetite
- ❑ Big appetite
- ❑ Get full easily
- ❑ I eat more than 3 meals
- ❑ I need to snack a lot
- ❑ I feel bad if I don't eat when I first get hungry

Typical diet:

Breakfast:_____
Lunch:_____
Dinner:_____

Dietary Restrictions/Sensitivities:

_____
_____

Digestion:

- ❑ Upper abdomen pain or discomfort
- ❑ Middle abdomen pain or discomfort (belly button area)
- ❑ Lower abdomen pain or discomfort
- ❑ Tensed pain
- ❑ Cramping pain
- ❑ Stabbing pain
- ❑ Dull pain
- ❑ Burning
- ❑ Distension
- ❑ Bloating
- ❑ Gas
- ❑ Nausea
- ❑ Acid reflux
- ❑ Discomfort before eating
- ❑ Discomfort after eating
- ❑ Discomfort with stress or anxiety

Stool: BM #____ per _____

- ❑ Formed
- ❑ Sticky
- ❑ Incomplete
- ❑ Loose
- ❑ Undigested food
- ❑ Liquid
- ❑ No strength to pass
- ❑ Difficult to pass
- ❑ Dry and hard
- ❑ need laxatives
- ❑ Very smelly
- ❑ Painful
- ❑ Burning
- ❑ Blood
- ❑ Mucus
- ❑ Urgency
- ❑ Cramping
- ❑ Hemorrhoids
- ❑ Pain before BM
- ❑ Pain after BM

Urination:

How many times per day? _____
How many times at night? _____

- ❑ Painful
- ❑ Urgent
- ❑ Profuse
- ❑ Scant
- ❑ Interrupted
- ❑ Hesitant
- ❑ Thin Stream
- ❑ Dark yellow
- ❑ Light yellow
- ❑ Clear
- ❑ Red/Pink
- ❑ Incontinence

Palpitations (feeling your heart pounding)

- ❑ Daytime
- ❑ Nighttime
- ❑ With pain
- ❑ With anxiety
- ❑ With shortness of breath

Vertigo/Dizziness:

- ❑ Daytime
- ❑ Nighttime
- ❑ Upon standing
- ❑ Need to sit or lay down
- ❑ With nausea

Sleep: Hours per night: _____

- ❑ Good ☺
- ❑ Difficulty falling asleep
- ❑ Superficial/Light
- ❑ Restless
- ❑ Wake frequently
- ❑ Wake up easily/too early
- ❑ Disturbed by vivid dreams
- ❑ Nightmares
- ❑ Sleep paralysis
- ❑ Sleep walking
- ❑ Wake up tired
- ❑ Low energy in general
- ❑ Interrupted by:
  - ❑ Pain
  - ❑ Urination
  - ❑ Other:
  - ❑ heat
  - ❑ thoughts

Emotional state:

- ❑ Content
- ❑ Numb
- ❑ Disconnected
- ❑ Sensitive
- ❑ Cry easily
- ❑ Sad
- ❑ Depressed
- ❑ Irritable
- ❑ Anxious
- ❑ Worry a lot
- ❑ Aggressive
- ❑ Easy to anger
- ❑ Strong dramatic emotions

Menstruation:

Length of Cycle: _____
# of days bleeding: _____

- ❑ Amenorrhea
- ❑ Irregular cycle
- ❑ scanty period
- ❑ heavy period
- ❑ spotting between menses
- ❑ bleeding non stop
- ❑ clots in menstrual blood
- ❑ menstrual cramps
- ❑ Sore low back
- ❑ Radiating pain in legs
- ❑ Abdominal bloating
- ❑ Breast tenderness
- ❑ Acne
- ❑ Cold low back/abdomen
- ❑ Mood fluctuation
- ❑ Spontaneous sweating
- ❑ Night sweating
- ❑ Low appetite
- ❑ Nausea
- ❑ Loose stools
- ❑ Constipation

Female Disorders:

- ❑ Profuse vaginal discharge
- ❑ Strong smelling discharge
- ❑ Vaginal dryness
- ❑ Vaginal itching
- ❑ Vaginal pain
- ❑ Genital sores
- ❑ Low libido
- ❑ Excessive libido
- ❑ Breast pain
- ❑ Breast lumps
- ❑ Uterine Fibroids
- ❑ Ovarian Cyst
- ❑ Pelvic Pain

Male Disorders:

- ❑ Scrotal itching
- ❑ Scrotal dampness
- ❑ Scrotal pain
- ❑ Perineum pain
- ❑ Genital sores
- ❑ Prostatic fluid in urine
- ❑ Premature ejaculation
- ❑ Spermatorrhea
- ❑ Excessive libido
- ❑ Low Libido
- ❑ Soft erections
- ❑ Impotence
- ❑ Infertility
- ❑ Low sperm quality