HEALTH HISTORY FORM

NAME: (CELL):

ADDRESS: CITY/ZIP:

EMAIL:

DATE OF BIRTH: MO / DAY / YR: / / AGE: SEX: (CIRCLE) MALE FEMALE

HEIGHT: ‘ “ WEIGHT: LBS. SINGLE MARRIED OTHER

Referred by:

Occupation: Employer:

Employer Address: Employer Tel:

State your present problem (Major Symptoms/Complaints):

How long has this been a problem?

Have you been examined or treated by a physician, dentist, podiatrist, chiropractor, or physical therapist for this condition?

If so, what is the diagnosis?

Physician’s Name: Specialty:

Address: Tel:

MEDICAL HISTORY: CHECK ALL THE BOXES THAT APPLY

	NOW	PAST		NOW	PAST		NOW	PAST
ARTHRITIS			CHRONIC FATIGUE			HYPOGLYCEMIA		
ABORTION			DIGESTIVE DISORDER			INSOMNIA		
ANEMIA			EMPHYSEMA			MENSTRUAL-HEAVY		
ASTHMA			EPILEPSY			MENSTRUAL-LOW		
BLEEDING TENDENCY			GALL BLADDER DISEASE			MENSTRUAL IRREGULARITY		
BLOOD PRESSURE-HIGH			HEADACHES			PREGNANCY		
BLOOD PRESSURE- LOW			HEART DISEASE			VAGINAL INFECTIONS		
BRONCHITIS			HIV+			THYROID PROBLEMS		

PLEASE SPECIFY:

Allergies:

Cancer:

Diabetes:

Hepatitis (A,B,C):

Psychological Disorder:

Trauma/Accidents/Surgeries:

Current Medications (Drugs, Vitamins, Herbs, Supplements):

Other:

I, the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures with the scope of practice of Traditional Chinese medicine.

Patient’s signature **Date**

Acupuncture Patient Information Form

First Name:		Last Name:	
Chief Complaint:	**Duration:**	**Pain Scale: (10=severe)**	**Frequency:**
1.		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
2.		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
3.		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
4.		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
5.		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
History of Chief Complaint:			
☐ Developed over time ☐ Injury ☐ Auto Accident ☐ Other:			
Stress Level:		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
Energy Level:		**0 1 2 3 4 5 6 7 8 9 10**	☐<25% ☐<50% ☐<75% ☐ <100%
Dominant Hand (Please Circle): Left Right Both			

Sleep Quality: (Please Circle):
Difficult falling asleep Wake up at the night Wake up too early Non-Refreshing sleep
No problems Other:

How many hours of sleep nightly:

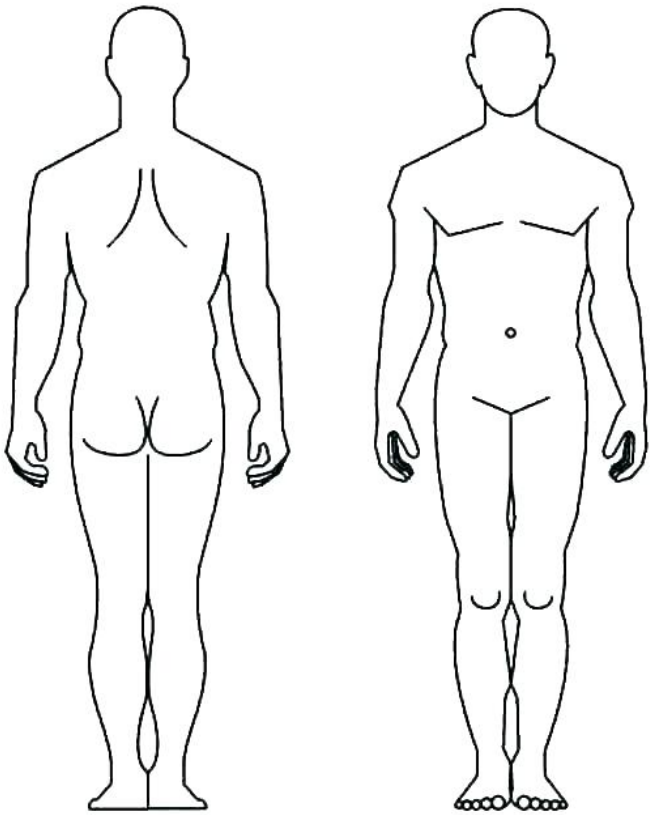
Daily Bowel movements (Please circle): Yes No Other:

Urination (Please circle): Normal Frequent Painful

Color: Light or Dark

Do the following conditions help for the pain?
(please circle):
1. Heat: Yes/No
2. Ice: Yes/No
3. Rest: Yes/No
4. Activity: Yes/No
5. Other:

Please mark the areas of pain/discomfort below:



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Mandatory Disclosure of Information

You are the most important person on your health-care team and, as such, are entitled to receive clear and comprehensive information about the modalities, techniques, and duration of your therapy. Becoming informed and understanding what to expect from your treatment from the beginning will help make your experience more comfortable and, I believe, more effective overall. If you have questions about your health, your treatment, or any aspect of traditional Chinese medicine (TCM), please feel free to contact me.

Purpose and Benefit of Treatment

Acupuncture and herbal medicine have been used to treat disease for thousands of years. The World Health Organization cites dozens of conditions that can be effectively treated by Chinese medical methods. These include musculoskeletal injuries, digestive disorders, respiratory diseases, women's health issues, and many more.

About the Clinic

In my practice, I comply with all rules and regulations with respect to the practice of acupuncture, including those related to the proper sterilization and maintenance of equipment and the sanitization of acupuncture clinics. To prevent cross-contamination and infection, I use only sterile, single-use, disposable needles in my practice.

Before Your Treatment

To facilitate your treatment, please wear loose, comfortable clothing that can be pulled high enough to expose your elbows and knees. It's a good idea to have a light meal before acupuncture, but don't arrive uncomfortably full. Avoid consuming alcohol before and immediately after your visit; likewise with strenuous exercise.

Please do not brush or scrape your tongue before coming in for treatment—the tongue's natural coating is one of our primary diagnostic tools and, once brushed off, is lost to us for the day. Coffee, cigarettes, and artificially colored foods, while not advisable under most circumstances, can also stain your tongue coat and are best avoided in the hours before a treatment.

Please try to arrive a few minutes before your treatment is scheduled to begin so as to be relaxed and receptive at the appropriate time.

After Your Treatment

Though most people feel extremely relaxed after acupuncture, some report feeling a bit lightheaded. If this happens to you, please rest awhile in the waiting room. It will pass in short order.

Some patients occasionally experience a worsening of their symptoms after an acupuncture treatment. This can be a part of the healing process and is usually soon followed by a marked improvement in overall wellbeing. Please contact our office if you have any concerns or feel any unpleasant effects after your visit.

Herbal prescriptions and herbal patent medicines are intended solely for the person for whom they are dispensed. Please do not share your prescriptions with others, as even identical symptoms may stem from very different root causes. As with pharmaceuticals, Chinese herbs constitute a powerful medicine, and as such it's unwise to self-diagnose, especially without proper background training.

Cancellation & Late Arrival

If you need to cancel or reschedule your appointment, please give me at least twenty-four hours' notice. Without such notice, and except in emergency situations, I reserve the right to charge for missed appointments. Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

Your Privacy

I believe absolutely in the right to privacy of my patients and will never disclose any of your personal information without your express consent, unless required to do so by law.

Informed Consent to Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of traditional Chinese medicine, including but not limited to herbology, moxibustion, cupping, electro-acupuncture, acupressure, dermal friction (gua sha), infra-red (heat lamps), and massage (tui na), on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist who may treat me now or in the future while working with or associated with this acupuncture clinic.

I understand that there are some minor risks attendant to acupuncture treatment, including but not limited to slight bruising of the skin(hematoma) and/or bleeding, dizziness, nausea, and occasional aggravation of symptoms existing prior to the treatment. Bruising is a common side effect of cupping. Burns and scarring are potential risks of moxibustion. I understand that the risk of infection in acupuncture is negligible as all needles are sterile and disposed of after a single use.

I understand that the herbs and nutritional supplements (which may come from plant, animal, or mineral sources) recommended in this clinic are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, indigestion, vomiting, diarrhea, headache, hives, and tingling of the tongue.

I understand that some herbs and acupuncture points may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist. Additionally, I will inform the acupuncturist if I have a severe bleeding disorder or if I am wearing a pacemaker or other electronic medical device.

I have had an opportunity to discuss with the acupuncturist and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on my treating acupuncturist to exercise judgment during the course of my treatment, based upon the facts then known, and to proceed in a manner that he determines is in my best interests.
I hereby release my treating acupuncturist from all liability that may occur in connection with the abovementioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Please sign and date below to indicate that you have read and understood this form.

_____ _____

Signature of patient Date

(or patient's representative, if the patient is a minor or is physically or legally incapacitated)