

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week Length of workout Type of Activity

Diet

Meals per day Snacks Caffeinated Drinks Alcohol per week

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Personal History Please check any conditions or symptoms you have now.

- | | | | |
|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility | <input type="checkbox"/> Emphysema |

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- | | | | |
|---------------------------------------------------|-----------------------------------------|---------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diabetes ____ | <input type="checkbox"/> Seizures ____ | <input type="checkbox"/> Heart Disease ____ | <input type="checkbox"/> Stroke ____ |
| <input type="checkbox"/> High Blood Pressure ____ | <input type="checkbox"/> Allergies ____ | <input type="checkbox"/> Cancer ____ | <input type="checkbox"/> Asthma ____ |
| <input type="checkbox"/> Other _____ | | | |
-
-

Please **check** if you have had any of these items listed below in the last **year**
Put a **star** on the box if you had this in the past but do not any longer.

General

- | | | | |
|----------------------------------------------|---------------------------------------------|-------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Dental/gum problems |

Muscle weakness/fatigue

Sudden energy drop

Strong thirst (hot or cold drinks)

Skin and Hair

Rashes

Eczema/Psoriasis

Skin discoloration

Dermatitis

Ulcerations

Dandruff

Acne

Warts

Hives/Allergic Dermatitis

Loss of hair

Change in skin/hair texture

Fungal Infection

Itching

Recent moles

Face flushing

Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

Dizziness

Eye Strain

Color Blindness

Ringing in ears

Nose bleeds

Sores on lips/tongue

Difficulty swallowing

Eye pain

Cataracts

Poor hearing

Recurrent sore throats/colds

Dental problems

Migraines

Poor vision

Blurred vision

Spots in front of eyes

Grinding teeth

Jaw clicks/locks

Glasses

Night Blindness

Earaches

Sinus problems

Facial pain

Headaches

Cardiovascular

Chest pain or pressure

Cold hands/feet

Shortness of breath

Low blood pressure

Irregular heart beat

Swelling of hands/feet

Varicose/spider veins

Spontaneous sweating

Palpitations at rest

Blood clots

Pressure in chest

Dizziness

Fainting

Phlebitis

High blood pressure

Respiratory

Cough/Wheezing

Pneumonia

Difficulty breathing when lying down

Coughing blood

Pain with deep inhalation

Asthma

Tight sensation in chest

Production of phlegm... what color? _____

Bronchitis

Difficult inhale/exhale

Gastrointestinal

Nausea

Gas

Indigestion

Bloating/Edema

Changes in appetite

Excessive appetite

Vomiting

Belching

Bad breath

Chronic laxative use

Acid reflux/GERD

Significant thirst

Diarrhea

Black stools

Rectal pain

Loose stools (>2 per day)

Hernia

IBS/Crohn's Disease

Constipation

Blood in stool

Hemorrhoids

Abdominal pain/cramps

Poor appetite

Genito-Urinary

Pain on urination

Unable to hold urine

Impotence

Premature ejaculation

Nocturnal emission

Night urination... What time? _____ How often? _____

Frequent urination

Kidney stones

Sores on genitals

Decreased libido

Pain in testicles

Blood in urine

Scanty flow

Urinary tract infection

Prostatitis

Herpes

Urgent urination

Copious flow

Burning urination

Dribbling after urination

Infections

Excessive libido

Gynecological/Reproductive

Difficult/Painful intercourse

Vaginal dryness

Vaginal sores

Vaginal discharge

Ovarian cysts

Endometriosis

Uterine Fibroids

Fibrocystic breast tissue

Age of first menses _____

Date of last menses _____

Date of last PAP/Pelvic _____

Number of pregnancies _____

- | | | |
|-------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of live births _____ |
| | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of miscarriages _____ |
| Do you practice birth control? _____ | | <input type="checkbox"/> Number of abortions _____ |
| What type? _____ | How long? _____ | |

Musculoskeletal

- | | | | |
|-----------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain Low___ Middle___ Upper___ | <input type="checkbox"/> Bursitis | | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) | | | |

Neuropsychological

- | | | | |
|------------------------------------------------|-----------------------------------------------|-------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Seasonal Affective Disorder |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | |

Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the below name licensed acupuncturist.

I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

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. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately*.

I have been informed that I have a right to refuse any form of treatment. 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 also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. 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. _____
initials

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. _____
initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____
initials

To be completed by the patient's representative, if the patient is a minor, or physically/legally incapacitated.

Name of Patient _____

Patient's Representative _____

Relationship or Authority of Patient _____

Witness _____

Patient's Name

Patient's Signature

Date Signed