Acupuncture Health History Form

Patient Information

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____

Height _____ Weight _____ lb/kg

Sex: ☐ Male ☐ Female ☐ Other Marital Status _____

Date of Birth (month/day/year)_____ Age _____

Occupation _____ Email Address _____

Have you had acupuncture before?

☐ No ☐ Yes. Name of Acupuncturist _____

Emergency Contact: _____
Phone Number(s):_____
Relationship: _____

Major Complaint

Primary reason for your visit today? _____

_____

Has this condition been diagnosed by a physician, or other provider?

☐ No ☐ Yes, Diagnoses _____

Are you being treated for this condition by anyone else? ☐ Yes ☐ No

If Yes, what is the treatment? _____

Have these treatments helped? ☐ Yes ☐ Somewhat ☐ Not Much ☐ Not at all

How does this condition affect you? _____

How long have you had this condition? _____

Personal Health History

Your general health as a child was? ___ Excellent ___ Good ___ Average ___ Poor

Did you feel safe and nurtured as a child? ___ Always ___Usually ___ Sometimes ___Never

Check all the illnesses or conditions which you currently have or have had in the past:

☐ AIDs / HIV	☐ Eating Disorders	☐ Kidney Disease	☐ Rheumatic Fever
☐ Alcoholism	☐ Epilepsy	☐ Measles	☐ Scarlet Fever
☐ Allergies	☐ Glaucoma	☐ Meningitis	☐ Sexually
☐ Antibiotics Use	☐ Heart Disease	☐ Mental Illness	Transmitted Disease
☐ Asthma	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Bleed Easily	☐ High Blood	☐ Mumps	☐ Tuberculosis
☐ Cancer	Pressure	☐ Obesity	☐ Typhoid Fever
☐ Chicken Pox	☐ High Fevers	☐ Pneumonia	☐ Ulcers
☐ Diabetes	☐ Hyperthyroid	☐ Polio	☐ Vascular Disease
☐ Drug Abuse	☐ Hypothyroid	☐ Other _____	
	☐ Jaundice	_____	

Are you taking Coumadin or Warfarin? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Do you have seizures? ☐ Yes ☐ No

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly

If yes, please identify: ☐ HIV / AIDs ☐ Hepatitis B ☐ Hepatis C ☐ Flu/ Cold ☐Streptococcus ☐ Mononucleosis ☐ Tuberculosis ☐ Other _____

Known or suspected allergies: _____

Personal Health Inventory

Please put a check mark (✓) by the symptoms that you have now.

Place an (✗) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang	
☐ Dry Skin	☐ Palpitations
☐ Fatigue	☐ Restlessness
☐ Feverish in the afternoon or flushes	☐ Sores on tip of tongue
☐ General weakness	☐ Speech problems
☐ Heat sensations in hands, feet, chest	☐ Sweats easily
☐ Insomnia	☐ Thirst at night
☐ Mental confusion	☐ You feel worse after exercise
☐ Night sweats	☐ You see floating black spots

Gastrointestinal Conditions	
☐ Nausea	☐ Gas
☐ Diarrhea	☐ Black stools
☐ Undigested food in stools	☐ Itchy anus
☐ Hemorrhoids	☐ Hard stools
☐ Vomiting	☐ Hiccup
☐ Constipation	☐ Blood in stools
☐ IBS	☐ Burning anus
☐ Gastritis	☐ Bad breath
☐ Acid regurgitation	☐ Bloating after meals
☐ Laxative use	☐ Mucus in stools
☐ Stomach cramps	☐ Rectal pain
☐ Enteritis	☐ Gurgling sounds
☐ Ulcerative colitis	☐ Intestinal cramping
	☐ Loose stools
Head, Eyes, Nose and Throat	
☐ Glasses	☐ Recurrent sore throat
☐ Blurred vision	☐ Spots in eyes
☐ TMJ	☐ Grinding teeth
☐ Excessive saliva	☐ Sores on lips
☐ Eye strain	☐ Swollen glands
☐ Night blindness	☐ "Floaters" in vision
☐ Gum disease	☐ Soft teeth
☐ Sinus problems	☐ Sores on tongue
☐ Red eyes	☐ Lumps in throat
☐ Glaucoma	☐ Poor vision
☐ Sore gums	☐ Multiple cavities
☐ Clear throat often	☐ Dry mouth
☐ Itchy eyes	☐ Enlarged thyroid
☐ Cataracts	☐ Nose bleeds
☐ Bleeding gums	☐ Ringing in ears
☐ Migraines	☐ Poor hearing
☐ Concussions	☐ Earaches
	☐ Headaches
Respiratory Conditions	
☐ Feeling short of breath	☐ Chest Pain
☐ Lightheaded	☐ Palpitations
☐ Fast heartbeat	☐ Phlebitis
☐ Orthostatic hypotension	☐ Productive cough with (circle all that apply)
☐ Difficulty breathing lying down	A lot of sputum/ Sticky sputum/
	Clear sputum/ Very little sputum/
	Green sputum/ Blood in sputum

Skin and Hair Conditions	
☐ Rashes	☐ Alopecia/hair loss
☐ Eczema	☐ Ulcerations
☐ Dandruff	☐ Shingles
☐ Premature grey hair	☐ Fungal infections
☐ Hives	☐ Brittle hair
☐ Psoriasis	☐ Dry skin
☐ Itchy skin	☐ Oily skin Acne
	☐ Recurrent sore throat
Cardiovascular Conditions	
☐ Chest pain	☐ Low blood pressure
☐ Edema	☐ Palpitations
☐ High blood pressure	☐ Stroke
☐ Insomnia	☐ Varicose veins
☐ Fainting	☐ Lightheaded
☐ Fast heartbeat	☐ Slow heartbeat
☐ Orthostatic hypotension	☐ Irregular heartbeat
☐ Heart attack	☐ Phlebitis
Genito-urinary Conditions	
☐ Painful urination	☐ Clear urine
☐ Cloudy urination	☐ Frequent bladder infections
☐ Dark yellow urine	☐ Frequent kidney infections
☐ Burning urination	☐Urinary incontinence
☐ Frequent urination	☐ Retention of urine
☐ Scanty urination	☐ Copious urination
☐ Light yellow urine	☐ Urination at night

Neuropsychological Conditions		
☐ Seizures	☐ ADHD	☐ Poor memory
☐ Tics	☐ Tingling	☐ Irritability
☐ Anxiety	☐ Depression	☐ Trigeminal neuralgia
☐ Abuse survivor	☐ Easily stressed	☐ Bell's palsy
☐ Numbness	☐ Parkinson's	☐Fainting

Medications: *Please list medications, herbal supplements and vitamins you are currently taking.*

Family History

How do you feel about the following areas of your life in the past month?

Significant Other ☐Great ☐Good ☐Fair ☐Poor ☐N/A Comments _____

Family ☐Great ☐Good ☐Fair ☐Poor ☐N/A Comments _____

Self ☐Great ☐Good ☐Fair ☐Poor Comments _____

Check illnesses which have occurred in any of your <u>blood relatives:</u>

☐ Alcoholism	☐ Cancer	☐ Heart Disease	☐ Mental Illness
☐ Allergies	☐ Diabetes	☐ High Blood Pressure	☐ Obesity
☐ Bleed easily	☐ Epilepsy	☐ Kidney Disease	☐ Stroke

☐ Other _____

Females Only

Are you pregnant? ☐ Yes. How many months? _____ ☐ No ☐ Trying ☐ Maybe

Method of birth control? _____

Age of First Menses _____ Date of Last Menses _____ Age of Menopause _____

Typical Length of Menses (Days You Bleed) _____

Typical Length of Cycle (From the 1st Day of Cycle to 1st Day to the Next) _____

Number of: Pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Hysterectomy ☐ Yes ☐ Partial ☐ Complete Date _____

Check all that apply to you:

☐ Scanty Flow	☐ Painful periods	☐ Low Libido
☐ Heavy Flow	☐ Breast Tenderness	☐ Excessive Libido
☐ Clotting	☐ Breast Lumps	☐ Painful Intercourse
☐ Vaginal Discharge	☐ Nipple Discharge	☐ Infertility
☐ Abnormal Pap Smear	☐ Fibrocystic Breasts	☐ Fibroids
☐ Menopausal Symptoms	☐ Bleeding Between Cycles	☐ Endometriosis
☐ Premenstrual Problems	☐ Irregular Cycles	☐ Ovarian Cysts

☐ Sexually Transmitted Disease: _____

☐ Other _____

Males Only

Check all that apply to you:

☐ Low Libido ☐ Seminal Emissions ☐ Prostate Problems

☐ Excessive Libido ☐ Premature Ejaculation ☐ Testicular Pain

☐ Impotence ☐ Painful Intercourse ☐ Testicular Redness

☐ Vasectomy, Date _____ ☐ Testicular Swelling

☐ Sexually Transmitted Disease: _____

☐ Other _____

Lifestyle

How would you rate the following areas of your health in the past month?

Digestion ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Stools ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How many times per day? _____Do they feel complete? ☐ Yes ☐ No

Stool consistency? ☐ Loose ☐ Formed ☐ Hard to Pass ☐ Other _____

What is the color of your stools? _____

Is there blood in your stools? ☐ Yes ☐ No How often? _____

Urination ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

How many times per day? _____ What color is your urine? _____

After you've gone to sleep do you get up to urinate? ☐ Yes ☐ No How often? _____

Appetite ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Diet ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Are you vegetarian or vegan? ☐ No ☐ Yes: for how long? _____

Do you have any of the following habits?

Caffeinated Drinks ☐ No ☐ Yes. How much? (e.g. 2/day)_____

Smoking ☐ No ☐ Yes: How much? (e.g. 2/day)_____

Alcohol ☐ No ☐ Yes: How much? (e.g. 2/day)_____

Recreational Drugs ☐ No ☐ Yes: Specify TYPE and How much: _____

Other (Describe) ☐ No ☐ Yes _____

How do you feel about the following areas of your life in the past month?

Energy ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

On a scale of 1 to 10? (10 is high energy) _____

Sleep ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

Hours per night? _____ Do you wake feeling rested? ☐ Yes ☐ No

Sex Life ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

School ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

Exercise ☐ Great ☐ Good ☐ Fair ☐ Poor Comments_____

How often? _____ What kind? _____

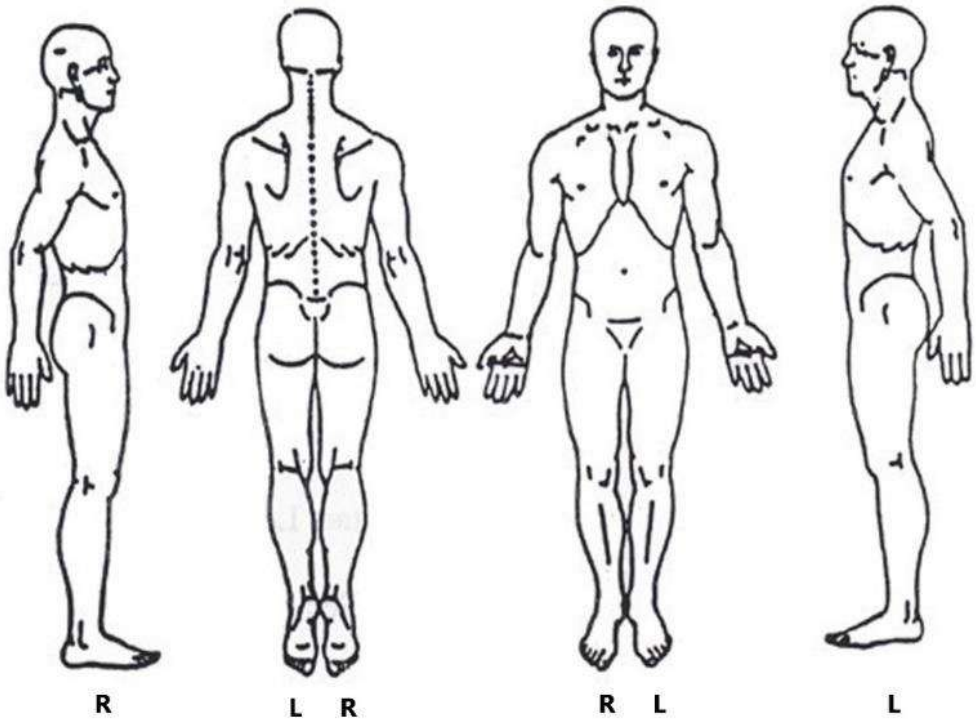
How would you rate your stress level on a scale of 1 to 10? (10 is high stress)_____

How well do you feel you handle your stress? ☐ Great ☐ Good ☐ Fair ☐ Poor

Pain

Please answer the following questions if you have pain.

Indicate on the diagram your areas of pain



How long have you had this pain? _____

Describe the onset of your pain.

_____

_____

_____

_____

On a scale of 1-10, how intense is your pain? (10 = intense)_____

What does your pain feel like? **Check all that apply.**

☐ Dull ☐ Cramping ☐ Fixed

☐ Sharp ☐ Burning ☐ Moves About

☐ Stabbing ☐ Constant

☐ Achy ☐ Comes-and-goes

Does the pain radiate? ☐ No ☐ Yes: where? _____

What relieves the pain? **Check all that apply.**

☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing

☐ Other _____

What aggravates the pain? **Check all that apply.**

☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture ☐ Massage ☐ Nothing

☐ Other _____

Have you had any other treatments for this pain? **Please identify and describe**.

_____

_____

Describe any concerns you have regarding your comfort and safety during an acupuncture treatment such as: needle phobia, bleeding disorders (e.g. haemophilia), pace maker, medication pump, blood pressure, infections, compromised skin (e.g. lesions, cuts, burns).

_____

_____

_____

_____

Informed Consent for Acupuncture Treatment

I hereby agree and consent to the performance of acupuncture and other traditional Chinese Medicine procedures. I understand that such procedures may include, but are not limited to acupuncture, acupressure, moxibustion, cupping & gua-sha (dermal friction technique), infrared heat lamp, laser therapy, breathing techniques, exercise therapy, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling based on traditional Chinese medical theory.

Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment. I have been informed that in all acupuncture treatments only sterile, disposable needles are used according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants.

By voluntarily signing below I, _____, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Name (Please Print) Signature of Patient (or legal guardian)

Date: _____

_____ Date: _____

Signature of Acupuncturist