Acupuncture & Chinese Medicine Patient Health History Form

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Successful health care and preventative medicine is best achieved when the practitioner has a comprehensive history of the patient. The nature of your response to the following questions will go a long way in assisting my understanding of your health &wellness goals. Please fill out this form as thoroughly as possible. Some of the questions may seem unrelated to your current condition; however, they are important in reaching the most accurate TCM diagnosis& treatment plan. ***All information is strictly confidential.***

Name_____Date:_____

Address:_____

City:_____State:_____Zip:_____

Phone(cell)_____(home)_____(work)_____

Which phone number is appropriate to leave a message for you? ☐cell ☐ home ☐ work

Email address:_____

Age:____Birthdate:_____Gender:_____Occupation:_____

Emergency contact & phone#:_____

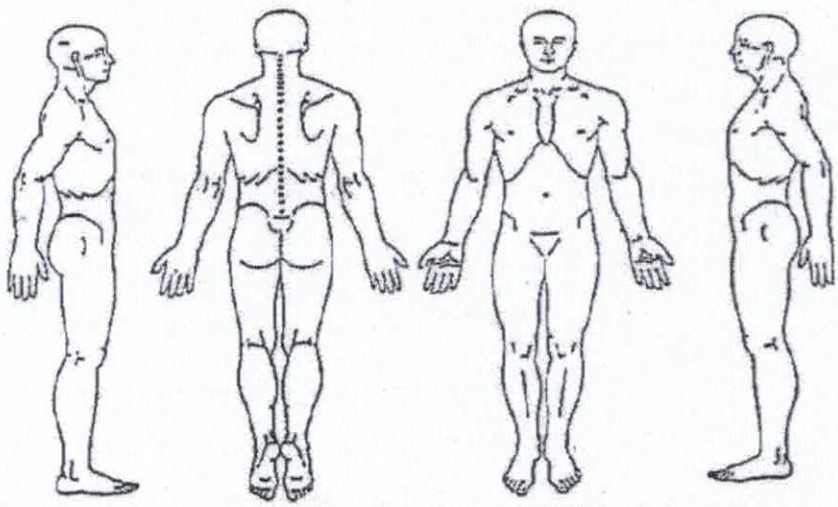
Emergency contact relation to you:_____How did you hear about me? _____

Have you ever been treated with Acupuncture/Chinese Medicine? _____

Are you currently under the care of a physician? ☐No ☐Yes...If yes, please explain_____

_____

Are you currently pain? Please indicate where & describe: _____



Please indicate in order of importance the health concerns that you would like to improve:

1. Condition:_____

When & how did it begin?_____

What makes it better?_____ worse?_____

How does it affect your daily activities & sleep? _____

What other treatment methods have you tried? ☐ Western Medicine ☐ Pharmaceuticals ☐ Chiropractor
☐Physical Therapy ☐ Massage Therapy ☐ Acupuncture ☐ Herbs ☐ Homeopathy
☐ Other:_____ Results: _____

2. Condition:_____

When & how did it begin? _____

What makes it better? _____ worse? _____

How does it affect your daily activities & sleep? _____

What other treatment methods have you tried? ☐ Western Medicine ☐ Pharmaceuticals ☐ Chiropractor
☐Physical Therapy ☐ Massage Therapy ☐ Acupuncture ☐ Herbs ☐ Homeopathy☐
Other:_____ Results: _____

3. Condition:_____

When & how did it begin? _____

What makes it better? _____ worse?_____

How does it affect your daily activities & sleep? _____

What other treatment methods have you tried? ☐ Western Medicine ☐ Pharmaceuticals ☐ Chiropractor
☐Physical Therapy ☐ Massage Therapy ☐ Acupuncture ☐ Herbs ☐ Homeopathy
☐ Other:_____ Results: _____

Additional comments_____

_____

What are your expectations for today's visit?_____

MEDICALHISTORY

Allergies (drugs, plants, food, metals, chemicals/environmental):

_____

_____

_____

Significant Trauma (auto accidents, falls, etc) Please include dates & be specific:

Hospitalizations/Surgeries; including added hardware/implants (include dates):

How would you describe your health before age 18?

How would you describe your health as an adult?

Have you ever been diagnosed with any of the following?

☐ Bleeding disorder	☐ Diabetes	☐ Heart disease	☐ Lung disease	☐ Hepatitis/Liver disease
☐ Kidney disease	☐ Cancer	☐ Thyroid disorder	☐ HIV/Aids	☐ Migraines
☐ Rheumatoid arthritis	☐ Stroke	☐ Depression	☐ Tuberculosis	☐ Mental health disorders
☐ Other arthritis	☐ Anemia	☐ Alzheimer's	☐ Neuropathy	☐ Epilepsy/seizures

☐ Neurological disease (Multiple Sclerosis, Parkinson's, ALS, etc)
☐ Autoimmune disorder:
☐ Other:

Your Dental health:

☐ bleeding gums	☐ receding gums	☐ halitosis	☐ loose/missing teeth	☐ root canals
☐ teeth grinding	☐ jaw clenching	☐ bitter taste	☐ periodontal disease	☐ gingivitis

FAMILY MEDICAL HISTORY: (check all that apply)

☐ Arthritis	☐ Diabetes	☐ Bleeding disorders	☐ Heart disease	☐ High blood pressure
☐ Cancer	☐ Stroke	☐ Substance abuse	☐ Kidney disease	☐ Thyroid disorders
☐ Epilepsy/seizures	☐ Mental Health disorders			
☐ Alzheimer's disease	☐ Neurological disease (Multiple Sclerosis, Parkinson's, ALS, etc)			

☐ Other:

Please explain checked answers:

Pharmaceuticals taken within last 2 months & reason for taking:

Supplements taken with last 2 months (vitamins, herbs, homeopathy, etc):

LIFESTYLE:

What forms of activity/exercise do you engage in & how often? _____

Do you follow any special diet? (vegetarian, raw, medical related, etc): _____

_____

Typical daily food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Cravings: _____

Food sensitivities/allergies: _____

Daily consumption of: water_____ caffeinated tea_____ caffeinated coffee_____

soda _____ diet soda _____ alcohol _____

Recreational drug use: _____

Do you smoke? How much? _____

How would you describe your overall energy levels? _____

How would you describe your overall stress levels? _____

Do you set aside time for daily meditation/prayer? ☐Yes ☐No

Have you served in the military? If so, which branch, when & where? _____

Hours of sleep you get each night? _____ _____ Do you feel rested when you awake in the morning? ☐Yes ☐No

Please check all that apply: ☐insomnia ☐snoring ☐ apnea ☐ excessive sleeping

☐sleepwalking ☐ narcolepsy ☐ restless legs ☐Other: _____

Please check any of the following symptoms you've had in the past 6 months:

GENERAL

☐ Feel hot/feverish
☐ Feel thirsty
☐ Cold hands/feet
☐Change in appetite
☐ Feeling of heaviness
☐ Sweat easily
☐ Crave cold beverage
☐ Bruise easily
☐ Weight loss
☐ Peculiar tastes/smells
☐ Afternoon/night sweats
☐ Crave hot beverage
☐Tired after eating
☐ Weight gain
☐ Lack of perspiration
☐Feel cold/chills
☐Fatigue
☐ Sip or gulp your drinks?

SKIN & HAIR

☐ Rashes/hives
☐ Itching
☐ Skin ulcers
☐Contagious skin condition
☐ Other skin/hair concerns: _____
☐ Eczema
☐ Acne
☐Recent moles
☐Recent change in hair or skin texture
☐ Psoriasis
☐ Warts
☐ Recent hair loss
☐ Dry skin
☐ Slow wound healing
☐ Fungal infection
☐ Dandruff

HEAD, EYES, EARS, NOSE & THROAT

☐ Dizziness
☐ Facial pain
☐ Corrective vision surgery
☐ Night blindness
☐ Glaucoma
☐ Tinnitus High or Low pitch
☐ Sneezing
☐ Recurrent sore throat
☐ Other head/neck concerns: _____
☐ Vertigo
☐ Jaw clicks/lock
☐ Glasses/contacts
☐ Color blindness
☐ Eye strain/pain
☐ Sinus congestion
☐ Nose bleeds
☐ Swollen glands
☐ Headache/Migraine
☐ Dry eyes/Red eyes
☐ Diminished vision
☐ Spots/floaters
☐ Diminished hearing
☐Sinus infection
☐ Loss of smell/taste
☐ Sensation of lump in throat
☐ Concussion
☐Excess tearing
☐ Blurred vision
☐ Cataracts
☐ Earache/pain/discharge
☐ Nasal discharge
☐ Dry mouth
☐ Mouth sores

RESPIRATORY

☐ Cough ☐ Coughing blood ☐ Asthma/wheezing ☐Frequent sighing
☐ Chest tightness ☐ Bronchitis ☐ Pneumonia ☐ Shortness of breath
☐Difficulty inhaling/exhaling ☐ Difficulty breathing when lying down ☐ Pain with deep breath
☐ Phlegm production: ☐ loose ☐ thick/sticky ☐ easy to expectorate ☐ color _____
☐ Other lung/breathing concerns: _____

CARDIOVASCULAR

☐ Chest pain ☐ Palpitation ☐ Irregular heartbeat ☐Fainting
☐ High blood pressure ☐ Low blood pressure ☐ Blood clots ☐ Deep vein thrombosis
☐ Varicose/spider veins ☐Swelling of feet/legs ☐ Swelling of hands ☐ Phlebitis
☐ Other heart or blood vessel concerns: _____

GASTROINTESTINAL

☐Belching ☐ Gas ☐ Bloating ☐ Indigestion
☐ Nausea/vomiting ☐ No appetite ☐ Acid reflux ☐Abdominal pain/cramps
☐ Excessive appetite ☐Sluggish digestion ☐ Tired after meals ☐ Diarrhea/loose stools
☐ Blood in stools/Black stools ☐ Mucus in stools ☐Undigested food in stools ☐Constipation/dry stools
☐ Incomplete bowel movements ☐ Hemorrhoids ☐ IBS/Crohn's ☐ Colitis
☐ Gall stones ☐How often do you have bowel movements? _____
Other Stomach or intestinal concerns: _____

URINARY

☐Frequent urination ☐ Urgent urination ☐ Burning/Pain with urination ☐ Blood in urine
☐ Unable to hold urine ☐ Difficulty urinating ☐ Lack of urine or decreased flow ☐Abundant urine flow
☐ Frequent UTI's ☐ Prolapsed bladder ☐ Kidney stones
Do you wake at night to urinate? ☐ No ☐Yes How often? _____
What color is your urine? ☐clear ☐ light yellow ☐ dark yellow ☐ cloudy ☐ reddish ☐ other _____
Does your fluid intake equal your urine output? ☐ Yes ☐ No
Other urinary concerns: _____

FEMALE REPRODUCTIVE

Are you pregnant? ☐ Yes ☐ No Age of first menses: _____
Is it possible that you are pregnant? ☐ Yes ☐ No Menopause Age: _____
Pregnancies: _____ # Live births: _____ # Miscarriages: _____ # Terminations: _____ # Premature births: _____
Pregnancies: ☐ Easy ☐Difficult Deliveries: ☐ Easy ☐ Difficult ☐Vaginal ☐Cesarean

☐ Irregular periods ☐ Painful periods ☐Endometriosis ☐ Bleeding between cycles
☐Breast tenderness ☐Fibrocystic breast tissue ☐ Breast lumps ☐ Nipple discharge
☐ Vaginal dryness ☐Vaginal discharge ☐ bleeding after sex ☐Polycystic Ovarian syndrome
☐ Uterine fibroids ☐ increased/decreased libido ☐ yeast infection ☐ genital itching/rash/sores
Cramps: ☐ dull ☐ sharp
PMS:
☐nausea/vomiting ☐ breast tenderness/swelling ☐ headache ☐ water retention
☐loose stools ☐ constipation ☐ depression ☐ irritability ☐ cry easily
Cravings: _____

Menstrual flow: ☐ light ☐ moderate ☐ heavy Clots? ☐ No ☐ Yes ☐ small ☐ large
Menstrual color? ☐ Pale red ☐Bright red ☐Purple ☐ Black ☐ Brown/rust
How many days does your period last? _____ How many days in your cycle? _____

Are you currently on birth control? What type? _____
What are your previous methods? _____
History of sexually transmitted infections: _____
Any other female concerns: _____

MALE REPRODUCTIVE

☐Enlarged/inflamed Prostate ☐ Cancer ☐Testicular pain/swelling ☐ decreased libido
☐genital itching/rash/sores ☐feeling of cold or numbness in the external genitalia ☐ Impotence
☐fungal infection ☐ history of sexually transmitted infections: _____
Any other concerns: _____

NEURO-PSYCHOLOGICAL

☐seizures	☐ tremors	☐ stroke	☐ poor memory	☐ concussion
☐loss of balance	☐ loss of coordination	☐ vertigo	☐ dizziness	☐ neuropathy
☐anxiety	☐ panic attacks	☐ depression	☐ ADD/ADHD	☐ Bipolar
☐excessive worry	☐ overthinking	☐ easily stressed	☐ easily angered	☐ fearful
☐poor concentration	☐ overwhelmed	☐ mood swings	☐ nervousness	

Have you ever considered/attempted suicide? ☐ No ☐ Yes
Any other neuro-psychological concerns: _____

MUSCULOSKELETAL

☐ Muscle tension ☐ Muscle weakness ☐Muscle spasms ☐ Joint pain/swelling
☐ Numbness ☐ Tingling ☐ Repetitive stress injury ☐ cold extremities
Muscle Pain: ☐ Neck ☐ Shoulder ☐ Elbow ☐ Hand/wrist ☐ Hip ☐ Knee ☐ Ankle/foot
Back ☐ upper ☐ mid ☐ lower ☐ sacrum ☐ sciatica ☐ Leg cramps ☐Plantar fasciitis
☐ Osteoporosis ☐ Degenerative disc disease ☐ Degenerative joint disease
Hardware implants? _____
Any other muscle, joint, bone concerns: _____
_____

Is there anything not covered in this questionnaire that you would like to discuss? _____

_____

Thank you for taking the time to answer these questions thoughtfully. Please sign & date:

_____

Patient signature Today's date

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated 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, Tui-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 have 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE