

PERSONAL INFORMATION (CONFIDENTIAL)

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Tel:(Cell) _____ Tel:(Work) _____ Tel: (Home) _____

Email _____ Occupation _____

Date of Birth _____ Age _____ Height _____ Weight _____

Marital (Relationship) Status _____ Number of Children _____

Physician's Name _____ Physician's Telephone _____

Referred by _____ Relationship to you _____

Main Complaint: _____

What other forms of treatment have you sought? _____

What makes the condition better or worse? _____

Chronic health problems: _____

Serious illnesses (age): _____

Significant trauma (age): _____

Please list any medications you are currently taking:

Medication	Dosage	Reason

Please list your history of surgeries and hospitalizations:

Surgery / Hospitalization	Age	Outcome

WOMEN'S HEALTH HISTORY (CONFIDENTIAL)

TEMPERATURE

How is your body temperature (as you experience it, NOT on a thermometer). Please check all that apply:

- Often cold Cold hands and feet Often thirsty Prefer cold drinks
 Often warm or feverish Hot palms and soles Prefer hot drinks Hot or sweaty at night

Do you tend to wear more clothing than other people in the same room? More Same Less

Do you tend to sweat easily? Yes No. If yes, with exertion without exertion

ENERGY & EXERCISE

How is your energy level? Low Medium High What time of day is it highest? _____ Lowest? _____

What improves your energy? _____

What drains your energy? _____

What type of exercise do you do? _____ How often? _____

SLEEP

How many hours a night do you sleep? _____ Do you feel rested when you wake up? Yes No

Do you experience any of the following? Please check all that apply:

- Difficulty falling asleep Vivid dreams Snoring Waking easily
 Difficulty waking up Restless sleep Waking to urinate Other

EMOTIONS

What two emotions seem most predominant in your life? _____

How do you hold stress? _____

How do you relax? _____

What do you do for recreation? _____

Do you experience any of the following? Please check all that apply:

- Panic attacks Nervousness Bad temper Poor memory
 Anxiety Depression Fear attacks Poor concentration

GYNECOLOGY

Are you currently pregnant? Yes No

At what age did you start menstruating? _____ Date of last menstrual period? _____

Number of pregnancies? _____ Number of miscarriages? _____ Number of abortions? _____

Number days of menstrual cycle (e.g 28) _____ Number days of menstrual flow _____

Color of blood _____

Have you had or do you currently have (check all that apply):

- Fibroids Skipped periods Bleeding between periods Hot flashes
 Ovarian cysts Light flow Diarrhea w/ period Night Sweats
 Endometriosis Heavy flow Constipation w/ period Painful intercourse
 Fibrocystic breasts Clots in flow Yeast infections Fatigue after sex
 Breast lump Mid-cycle pain Vaginal discharge Strong libido
 Breast tenderness Nipple discharge Other infections Weak libido
 Irregular cycles Pain before period Itching or burning Low lubrication
 No periods Pain during period Abnormal Pap test Other

URINARY

How many times a day you urinate? _____ How many times at night? _____

What color is your urine usually? _____

Do you, or have you ever experienced the following? Please check all that apply:

- Trouble starting flow Frequent urination Incontinence Painful urination
 Burning Dribbling Blood in urine Kidney stones
 Urinary tract infections Bladder infection PID Other

GASTROINTESTINAL

How would you describe your appetite? Strong Moderate Poor

Do you experience strong food cravings? Yes No

For what flavors? Sweet Salty Sour Bitter Spicy Fried

Other _____

Number of bowel movements per day /per week? _____ Color? _____

Do you have a tendency to experience (check all that apply):

- | | | | |
|-----------------------------------------|-----------------------------------------|----------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Belching | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Undigested food in stool |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Loose stool |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Hard stool |
| <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Rectal burn or itch | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Painful defecation | <input type="checkbox"/> Black or tarry stools |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Grey or white stools |

MUSCLES, JOINTS & BONES

Do you have pain, weakness, or discomfort? Yes No. Where? _____

Describe the pain, please check all that apply:

- | | | | |
|-------------------------------------------|-------------------------------------------|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Superficial | <input type="checkbox"/> Aching | <input type="checkbox"/> Numbness / Tingling |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Deep | <input type="checkbox"/> Burning | <input type="checkbox"/> Worse with humidity |
| <input type="checkbox"/> Better with heat | <input type="checkbox"/> Worse in evening | <input type="checkbox"/> Better with cold | <input type="checkbox"/> Better with exercise |
| <input type="checkbox"/> Worse with heat | <input type="checkbox"/> Worse in morning | <input type="checkbox"/> Worse with cold | <input type="checkbox"/> Worse with exercise |

Have you experienced any of the following? Please check all that apply:

- | | | | |
|---------------------------------------------------|-----------------------------------------------|-----------------------------------------|---------------------------------------|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Meniscus tears | <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Bone pain |
| <input type="checkbox"/> Repetitive strain injury | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Other |

HEAD, EYES, EARS, NOSE, & THROAT

Do you smoke? Yes No. If yes, number of packs per day _____ for _____ years.

Please check all that apply: I have

- | | | | |
|----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Cold sores | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Mouth / tongue sores | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Chronic congestion | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Ear pain / infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Popping / clogged ears |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough blood or mucus | <input type="checkbox"/> Painful/red eyes | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> See spots/floaters | <input type="checkbox"/> Other |

CARDIOVASCULAR

Have you experienced any of the following conditions? Please check all that apply:

- | | | | |
|--------------------------------------|-----------------------------------------------|-------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Palpitation | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Low blood pressure |

SKIN & HAIR

Do you frequently experience any of the following conditions? Please check all that apply:

- | | | | |
|-----------------------------------|--------------------------------------|------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Premature gray hair |

PAST MEDICAL HISTORY

Have you had any of these conditions? Please check all that apply:

- | | | | |
|---------------------------------------------|----------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |

INFORMED CONSENT TO ACUPUNCTURE AND HERBAL TREATMENT

I consent to acupuncture and herbal treatments and other procedures associated with Chinese medicine by the acupuncturist named below. I have discussed the nature and purpose of my treatment with the acupuncturist. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, Tui Na (Chinese massage) and nutritional counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases and imbalances of the body. Most people experience a sense of well-being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days. Dizziness or fainting may also occur, especially if the patient is late for a meal. Bruising is a common side effect of cupping. Unusual risks of acupuncture include miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist named below uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are another potential risk of moxibustion. 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, or mineral sources), which may be recommended, are traditionally considered safe, although some may be toxic in large doses. I understand that certain herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided. The herbs may have an unpleasant smell or taste. I will immediately notify the acupuncturist named below of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the acupuncturist if I am or become pregnant, since this will affect the treatment.

I do not expect the acupuncturist to be able to anticipate and explain all the possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based on the facts known to them, is in my best interests.

I understand that all my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this 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 conditions(s) for which I seek treatment.

Print name

Patient signature

Date

Acupuncturist's signature

Date