Health History Questionnaire

Please help us provide you with the best possible evaluation by taking the time to fill out this questionnaire carefully. *All of your answers will be held absolutely confidential*. If you have questions, please ask. Thank you.

Name: _____ Age: _____ DOB: _____ Sex: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Occupation: _____

Marital Status: _____ Height: _____ Weight: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Family Physician: _____

How did you hear about us? _____

Have you ever been treated by acupuncture before? □Yes □No

Please indicate if any of the following pertain to you: (Marking "yes" does not make you ineligible for treatment. However, it may restrict some of our treatment modalities):

□ Hepatitis □ HIV □ High Blood Pressure □ Seizures □ Pacemaker □ Blood-Thinning Meds □ Pregnancy

What is the main problem (s) you would like help with today? (List in order of importance)

1. _____
2. _____
3. _____

When did this problem begin? (please be specific)

1. _____ 2. _____ 3. _____

What was the cause of this problem: _____

_____

What makes it better: (hot, cold, massage, etc.): _____

_____

What makes it worse: (activity, weather, AM, PM): _____

_____

What kind of treatment have you tried? Were any of them helpful? _____

_____

What medical diagnosis have you been given, if any?: _____

_____

Is your current condition getting: _____ Better _____ Worse _____ Comes & Goes _____ Same

What is the level of pain or intensity on a scale of 1-10 (10 worst, 0 none): _____

What % of day do you experience relief if any? _____

What would you like to achieve with acupuncture treatments? _____

_____

Current Medications & Supplements: _____

_____

_____

Significant Trauma Incidents or Surgery (auto accidents, falls, hitting head, broken bones, etc.) *Please include dates*:

_____

_____

Illness (Asthma, Diabetes, Thyroid Disease, etc.): _____

_____

_____

Do you have a regular exercise program? If so, please describe: _____

_____

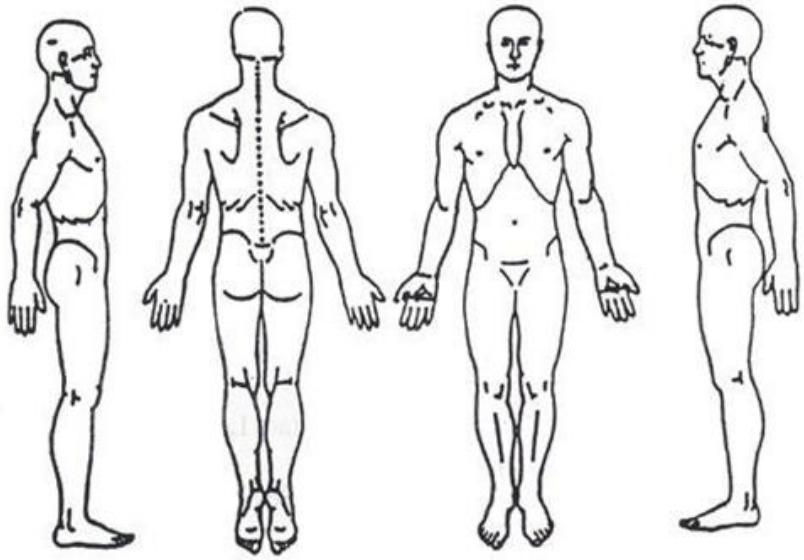
Allergies/Sensitivities (Foods, drugs, medications, environmental factors, etc.): _____

_____

How many cigarettes do you smoke a day? _____ How much alcohol do you drink per week? _____

How much coffee/tea or cola do you drink per day? _____ Any special diet? _____

Please indicate any painful or distressed body part by circling the particular area on the diagram below:



Please check if you have had any of the following: (particularly in the past 3 months)

GENERAL:
- □ Chills
- □ Fevers
- □ Night Sweats
- □ Localized weakness
- □ Bleed or bruise easily
- □ Peculiar tastes or smells
- □ Strong thirst (cold or hot)
- □ No thirst
- □ Puffiness/Swelling
- □ Weight loss/gain
- □ Poor balance
- □ Edema
- □ Tremors
- □ Fatigue
- □ Sudden energy drop
- □ Poor sleep
- □ Bad dreams
- □ Cravings
- □ Change in appetite

SKIN & HAIR:
- □ Rashes
- □ Pimples
- □ Itching
- □ Eczema
- □ Psoriasis
- □ Skin Ulcers
- □ Hives
- □ Recent moles
- □ Loss of hair
- □ Itching
- □ Dandruff

HEENT:
- □ Migraines
- □ Headaches
- □ Dizziness
- □ Glasses
- □ Blurry vision
- □ Dry eyes
- □ Spots in front of eyes
- □ Eye pain
- □ Poor hearing
- □ Ringing in ears
- □ Earaches
- □ Grinding teeth
- □ Jaw clicks/TMJ
- □ Concussions
- □ Sores on lips of tongue
- □ Nose bleeds
- □ Sinus problems
- □ Facial pain

CARDIOVASCULAR:
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Irregular heartbeat
- □ Chest pain/discomfort
- □ Cold hands or feet
- □ Swelling in hands or feet
- □ Blood clots
- □ Phlebitis
- □ Fainting/Lightheadedness
- □ Palpitations
- □ Varicose or Spider Veins

RESPIRATORY:
- □ Cough
- □ Asthma/Wheezing
- □ Pain with deep breath
- □ Difficulty breathing when lying down
- □ Production of phlegm
- □ Coughing blood
- □ Pneumonia
- □ Bronchitis
- □ Chest Tightness

GASTRO-INTESTINAL:
- □ Nausea
- □ Vomiting
- □ Heartburn
- □ Belching
- □ Ulcers
- □ Abdominal Pain
- □ Indigestion
- □ Bad breath
- □ Diarrhea/Constipation
- □ IBS/Crohn's disease
- □ Acid Reflux/GERD
- □ Blood in stool
- □ Intestinal Gas
- □ Hemorrhoids

GENITO-URINARY:
- □ Pain on urination
- □ Urgency to urinate
- □ Frequent urination
- □ Unable to hold urine
- □ Blood in urine
- □ Incomplete urination
- □ Decrease in flow
- □ Kidney stones
- □ Impotency
- □ Pain with intercourse
- □ Change in sexual drive
- □ Night urination, if so…how often? _____

PREGNANCY & GYNECOLOGY:

Number of Pregnancies: _____
Number of Live births: _____
Age of first menses: _____
Date of last menses: _____
Duration of menses: _____
Date of last menses: _____
- □ Heavy periods
- □ Light periods
- □ Painful periods
- □ Irregular periods
- □ PMS
- □ Clots
- □ Menopausal
- □ PCOS
- □ Endometriosis
- □ Breast lumps
- □ Uterine Fibroids
- □ Last PAP? _____
- □ Birth control?
  Type/How Long?: _____

MUSCULOSKELETAL:
- □ Neck pain
- □ Shoulder pain
- □ Back pain
- □ Elbow pain
- □ Hand/wrist pain
- □ Knee pain
- □ Foot/ankle pain
- □ Hip pain
- □ Muscle pain
- □ Muscle weakness
- □ Muscle Cramping/Spasm
- □ Joint pain/weakness
- □ Carpal Tunnel
- □ Osteoporosis/Osteopenia
- □ Arthritis
- □ Sciatica
- □ Tendonitis

NEURO-PSYCHOLOGICAL:
- □ Seizures
- □ Numbness
- □ Bad temper
- □ Mood swings
- □ Vertigo
- □ Loss of balance/coordination
- □ Depression
- □ Easily susceptible to stress
- □ Poor memory
- □ Anxiety
- □ Substance abuse
- □ Treated for emotional problems?
- □ Attempted or considered suicide?

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 Kate Frame L.Ac. (Licensed Acupuncturist) 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 above, 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 the acupuncturist cannot treat me for a given condition beyond 60 calendar days from the date of first treatment, unless I obtain an examination and diagnosis from a physician, dentist, or podiatrist for that condition. I understand methods of treatment include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electric stimulation, Tui-Na (Chinese massage), and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain and to treat certain diseases of dysfunction of the body. I have been informed that acupuncture is a generally safe method of treatment, but occasionally there may be some side effects, including bruising, dizziness, fainting, or numbness or tingling near the needle sites that may last a few days. Bruising is a common side effect of cupping. There have been rare and unusual risks of acupuncture including nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this office uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion, cupping, and the use of the heat lamp and can be refused at any time. I understand while this document describes the major risks of treatment, other side effects and risks may occur.

I do not expect the staff to explain and anticipate all possible risks and complications of treatments. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 and that I can stop treatments at any time. 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. I will notify the practitioner immediately of unpleasant or unanticipated side effects associated with treatment.

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 for any future condition for which I seek treatment.

Patient Signature: **X** Date:

Or Patient Representative (Include relationship if signing for patient)