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: _____

_____

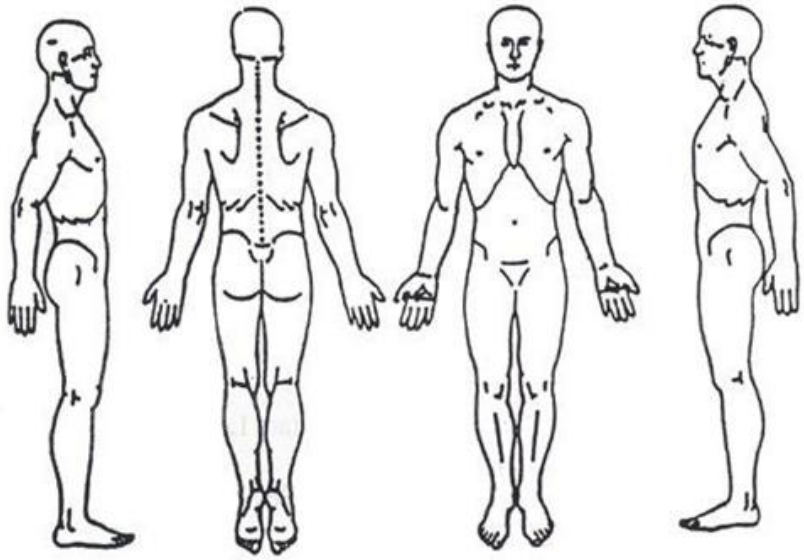
Allergies/Sensitivities (Foods, drugs, medications, environmental factors, etc.): _____

_____

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?

Cupping Therapy Consent Form

- I understand that all treatments at this facility are therapeutic in nature. I agree to communicate to the therapist any physical discomfort or draping issues during the session.

- Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommendations.

- It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.

- It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.

- I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be clear away by my circulatory system.

- I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.

- I understand that the first time I experience Cupping my body's immune system can temporarily react to this release as it might with the flu, producing flu-like effects like nausea, headache, aches, that will subside in time with rest and water. Water helps to dilute the intensity of the release so I understand it is important to stay thoroughly hydrated following the cupping treatment.

- I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after sunburn or when I'm hungry or thirsty.

- I understand that I should avoid exposure to cold, wet, and/or windy weather conditions, hot showers, baths, saunas, hot tubes, and aggressive exercise for 24 hours after cupping. I understand that exposure to such extreme can produce undesirable effects and I should avoid such situations. I understand that I should not apply ice, heat, or analgesic balms or lotions for 24 hours after your treatment.

- I understand that I should avoid caffeine, alcohol, sugary foods and drinks, dairy and processed meats and I should consume an abundance of clean water.

I _____ agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all the information stated above and will not hold the practitioner responsible.

Signature of Client _____ Date_____

Print Name _____