Elm City Wellness

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Acupuncture Health History Form

Patient Information

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Height _____ Weight _____ Sex: ☐ Male ☐ Female Marital Status _____

Date of Birth _____ Age _____

Occupation _____ Email _____

Have you had acupuncture before? ☐ No ☐ Yes, Name of Acupuncturist _____

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 Transmitted Disease
☐ Antibiotic Use	☐ Heart Disease	☐ Mental Illness	
☐ Asthma	☐ Hepatitis	☐ Multiple Sclerosis	☐ Stroke
☐ Bleed Easily	☐ High Blood Pressure	☐ Mumps	☐ Tuberculosis
☐ Cancer	☐ High Fevers	☐ Obesity	☐ Typhoid Fever
☐ Chicken Pox	☐ Hyperthyroid	☐ Pneumonia	☐ Ulcers
☐ Diabetes	☐ Hypothyroid	☐ Polio	☐ Vascular Disease
☐ Drug Abuse	☐ Jaundice	☐ Other _____	

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 ☐ Hepatitis 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 a star (✱) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang

- ☐ anxiety
- ☐ catches colds easily or frequently
- ☐ chest pain traveling to shoulder
- ☐ cold feet
- ☐ cold hands
- ☐ difficult to concentrate
- ☐ dizziness
- ☐ dream disturbed sleep
- ☐ dry skin
- ☐ fatigue
- ☐ feverish in the afternoon or flushes
- ☐ general weakness
- ☐ heat sensations in hands, feet, chest
- ☐ insomnia
- ☐ mental confusion
- ☐ night sweats
- ☐ palpitations
- ☐ restlessness
- ☐ sores on tip of tongue
- ☐ speech problems
- ☐ sweats easily
- ☐ thirst, at night
- ☐ you feel worse after exercise
- ☐ you see floating black spots

LU

- ☐ allergies
- ☐ chills alternating with fever
- ☐ cough
- ☐ difficulty breathing
- ☐ dry mouth, throat, nose
- ☐ feeling achy
- ☐ headaches
- ☐ nasal discharge
- ☐ nose bleeds
- ☐ shortness of breath
- ☐ sinus congestion
- ☐ sneezing
- ☐ sore throat
- ☐ stiff neck/ shoulders

SP

- ☐ abdominal bloating and / or gas after eating
- ☐ belching
- ☐ chest congestion
- ☐ constipation
- ☐ diarrhea
- ☐ eating disorders
- ☐ fatigue after eating
- ☐ gas
- ☐ general feeling of heaviness in your body
- ☐ hemorrhoids
- ☐ loose stools
- ☐ low appetite
- ☐ mental heaviness, sluggishness or fogginess
- ☐ nausea
- ☐ prolapsed organs (previously diagnosed)
- ☐ swollen feet
- ☐ swollen hands
- ☐ you bruise easily

ST

- ☐ bad breath
- ☐ belching
- ☐ bleeding, swollen or painful gums
- ☐ burning sensation after eating
- ☐ constipation
- ☐ heartburn
- ☐ large appetite
- ☐ mouth sores (canker or cold sores)
- ☐ stomach pain
- ☐ vomiting

HT / PC

- ☐ chest pain
- ☐ edema
- ☐ high blood pressure
- ☐ insomnia
- ☐ low blood pressure
- ☐ palpitations
- ☐ stroke
- ☐ varicose veins

LR / GB

- ☐ bitter taste in mouth
- ☐ blood shot eyes
- ☐ blurred vision
- ☐ chest pain
- ☐ convulsions
- ☐ diarrhea alternating with constipation
- ☐ difficulty swallowing
- ☐ dry eyes
- ☐ feeling of a lump in your throat
- ☐ headache at the top of your head
- ☐ hot flashes
- ☐ muscle spasms, twitching, cramping
- ☐ numbness of hands and feet
- ☐ pain in rib cage
- ☐ red, sore or irritated eyes
- ☐ seizures
- ☐ skin rashes
- ☐ tight feeling in chest
- ☐ TMJ or locked jaw
- ☐ you anger easily
- ☐ you feel better after exercise

KI / BL

- ☐ frequent urination
- ☐ hair loss
- ☐ joint pain
- ☐ lack of bladder control
- ☐ loose teeth
- ☐ low back pain
- ☐ memory problems
- ☐ night blindness or low vision
- ☐ ringing in your ears
- ☐ sore, cold or weak knees
- ☐ you get up more than one time at night to urinate

Other _____

_____

_____

_____

_____

_____

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 _____

Women 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 One Cycle to 1st Day of the Next) _____

Number of: Pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Hysterectomy ☐ Yes ☐ Partial ☐ Complete Date _____ ☐ No

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

☐ Other _____

Men 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

☐ Other _____

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

Drug / Supplement / Vitamin	Reason For Taking	For How Long	Dosage	Frequency

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? _____
Is your urination painful? ☐ Yes ☐ No

Appetite ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____

Diet ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____
Are you vegetarian or vegan? ☐ Yes ☐ No For how long? _____

Food / Drink:

Foods You Crave _____ When? _____

Daily Water Intake _____ Daily Soda Intake ____ Caffeine? ☐ Yes ☐ No

Daily Coffee Intake _____ Caffeine? ☐ Yes ☐ No Daily Tea Intake _____ Caffeine? ☐ Yes ☐ No

Do you drink alcohol? How Much? _____ How Often? _____ What kinds? _____
Past Use? ☐ Yes ☐ No Date Stopped _____

Do you use tobacco? ☐ Yes ☐ No Past Use? ☐ Yes ☐ No Date Stopped _____

Do you use recreational drugs? ☐ Yes ☐ No Past Use? ☐ Yes ☐ No Date Stopped _____

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 _____

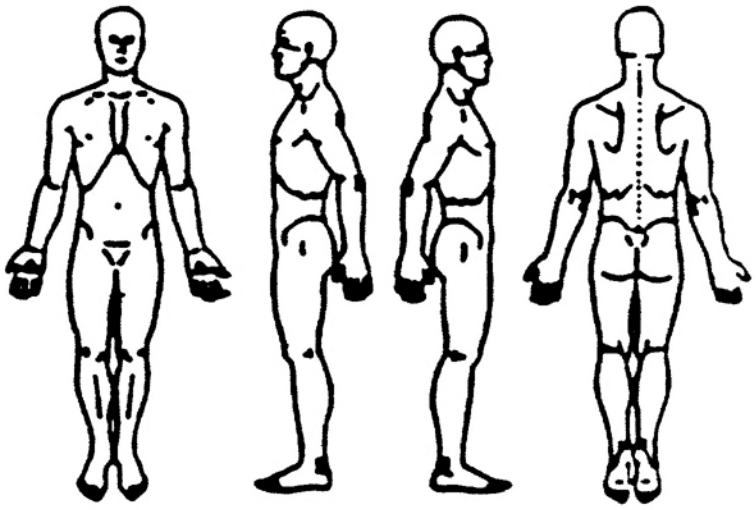
Exercise ☐ Great ☐ Good ☐ Fair ☐ Poor Comments _____
How often? _____ What kind? _____

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 (10 being worst) how strong is your pain?_____

What does your pain feel like? (check all that apply)

☐ Dull ☐ Sharp ☐ Stabbing ☐ Sore ☐ Achy ☐ Cramping ☐ Burning ☐ Constant
☐ Comes and Goes ☐ Fixed ☐ Moves About

Does the pain radiate? ☐ No ☐ Yes Where? _____

What helps the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture
☐ Massage ☐ Nothing ☐ Other _____

What aggravates the pain? ☐ Ice ☐ Heat ☐ Rest ☐ Movement ☐ Pressure ☐ Moisture
☐ Massage ☐ Nothing ☐ Other _____

Does anything relieve this pain? (i.e.; medications, over the counter drugs, liniments)

_____

Other treatments you have had for this pain? _____

_____

Anything you wish to add? _____

_____

_____

The above information is true to the best of my knowledge.

X Patient's Signature_____ Date _____

Elm City Wellness
Acupuncture – Consent to Treatment

I, _____, hereby authorize Edward Haberli of Elm City Wellness, to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including by not limited to the following:

(Please check any boxes you DO NOT GIVE your consent for)

- □ Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
- □ Heat treatments using *Artemesia vulgaris* (moxibustion, "moxa") or a conventional heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle or on top of a barrier such as salt or a slice of ginger. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.
- □ A massage technique called "gua sha". This treatment leaves redness on the skin that can last for 1-5 days. Slight bruising and tenderness may persist after the treatment.
- □ Cupping may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting for 1-5 days.
- □ Electrical stimulation of the needles may be used which produces a vibration or tapping sensation or ion pumping cords may be attached to the needles.
- □ Bloodletting, along or in conjunction with cupping, may be used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is pressed from the puncture.
- □ Chinese Herbal Medicine, to be administered orally and/or topically. Some patients may experience side effects from their particular prescription. Please inform ELM CITY WELLNESS of any adverse side-effects you may be experiencing.

Please read and initial the following:

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. _____

I understand that 24-hour notice is required for cancellations, otherwise I will be charged the cost of the session by whatever payment method is on file. If I decline to have payment on file, I am required to pre-pay each time I book an appointment. _____

Signature of Patient:_____

Printed name of Patient:_____

Date:_____

Practitioner Signature:_____