

Patient Health Inquiry Form

Objective: *The following questions are designed to help me better understand how to approach the treatment of your condition and the thoughts and direction you have surrounding your current and future health.*

In your personal opinion, what do you consider "good health" to be?

Why did you choose Acupuncture Treatment for this condition?

Where have you sought treatment in the past for your current condition you are seeking treatment for?

How long did you allow yourself to receive treatment for your current condition?

What was the total cost of past treatment for this condition? (eg. MD's, Chiropractic, Physical Therapy, Surgery etc.)

_____ \$0-100
_____ \$100-500
_____ \$500-1000
_____ \$1000-1500
_____ \$1500 or greater

Considering the amount of time you have experienced this condition, how long do you expect treatment to take in order to yield results?

Essential Circles of Life
Acupuncture and Herbal Medicine

Do you expect changes to occur after each treatment?

What are your long-term goals with treatment? What are your short-term goals with treatment?

What responsibility are **You** willing to take in order to help your body heal itself? Are you willing to make lifestyle changes, i.e. diet, exercise, relaxation techniques? If so, what? –Please be realistic with what you are willing to change.

Release Form

Name: _____ Age: _____ Sex: _____ Date: _____
Address: _____ City: _____ State & Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Email: _____
How did you hear about us? _____

I understand that Chinese Medicine, like any other modality of healing, offers no guarantee or promise of immediate or long term changes in the patient's physiological or psychological condition.

I also understand the risks involved in Chinese Medicine could cause serious injury. These injuries include but are not limited to burns (scarring moxa or TDP lamp), numbness, bruising, possible infection, pneumothorax, miscarriage or premature labor.

I also understand and consent to the use of any viable form of medical technique used in the field of Chinese Medicine as allowed in the United States and the State of North Carolina. These techniques include acupuncture (insertion of needles in the body), moxibustion, cupping/gua sha, tui na (massage and body rotation), bleeding techniques and electrotherapy with needles.

I am aware that my practitioner may suggest the use of certain herbs and patent medicines to help me with my condition. These herbs and patent medicines may come in the form of powders, loose herbs, granules, pills and tablets. I also understand that research concerning the interaction between herbs and prescription drugs is limited and therefore release my practitioner from any liability thereof.

Having read through the information above I understand the risks and practices involved in Chinese Medicine and consent to treatment.

Patient's Signature

Legal Guardian (if under 18 yrs. Old)

Date

Please inform your practitioner if you have ever been HIV or Hepatitis Positive. Please be considerate of your practitioner and other patients. It is very important to inform your practitioner of pacemaker or any other electrical devices in the body. If you suspect that you may be pregnant, please let your practitioner aware of this immediately.

Who is your primary care physician? _____

Phone: _____

In an Emergency please notify? Phone: _____

What is your *Main Complaint* you want to address? _____

How long ago did the problem begin? _____

Have you been given a diagnosis for the problem? _____

What kind of treatments have you tried for this condition? Have any of the treatments alleviated the condition? _____

Past Medical History:

Childhood Health: _____

Illnesses: _____

Surgeries: _____

Significant Injuries or Trauma: _____

Do you have or ever have had any significant infectious disease? _____

Have you taken any prescription drugs, over-the-counter drugs, herbs or vitamins recently or in the past 3 months? **Please list on last page.**

Average/Typical Blood Pressure: _____/_____ Average Pulse Rate: _____

Weight: _____ Height: _____

Social/Personal History:

Place of Upbringing? _____

Current Occupation? _____

Unusual Stresses or High Stress Levels? _____

Current Emotional Health? _____

Any Predominate Emotions? _____

Current Quality of Life? _____

Do you exercise regularly? _____

Have you traveled abroad in the past year? If so, where? _____

Drug Use-Cigarettes, Alcohol, Marijuana etc. Quantity of Use? _____

Family Medical History:

Please list if Mother/Father/Siblings are currently living. Any significant illnesses or deaths as a result of? _____

Personal Medical History: Please circle all that apply

Significant Illnesses:

Cancer
Rheumatic Fever
Thyroid Disease: Hypo/Hyper
STD
Asthma
Stroke

Seizures
Hepatitis A, B, C,
Tuberculosis
Mental Illness
High Blood Pressure
Other: _____

Diabetes: Type I, Type II
HIV/AIDS
Heart Disease
Allergies
High Cholesterol

General Information:

Poor Appetite
Chills/Fever
Bleeding
Poor Balance

Peculiar Tastes/Smells
Insomnia
Night Sweats
Emotional Changes

Sweat Easily
Sudden Weight Loss/Gain
Tremors
Bruising Easily

Skin and Hair:

Rashes
Ulcers
Hair Loss/Early Graying

Itching
Eczema/Psoriasis
Dandruff

Change in Skin Texture/Condition
Acne

Ear, Nose and Throat, Disorders of the Head:

Dizziness
Eye Strain
Eye/Ear Discharge
Sores on Eyes/Ears/Mouth

Migraines
Glaucoma/Degeneration
Ringing in the Ears
Toothache

Eye Pain
Flowery Vision (Floaters, Blurry Vision etc.)
Sinus Problems/Nose Bleeds
TMJ

Respiratory/Cardiovascular:

Cough
Easily Winded
Irregular Heartbeat
Poor Circulation

Phlegm
Chest Pain
Palpitations
Cold Hands/Feet

Shortness of Breath/Asthma
Cold Sweats
Blood Clots
Swelling of Hands/Feet

Gastrointestinal:

Nausea/Vomiting
Constipation
Gastric Ulcers
Hemorrhoids

Bloating
Blood in Stools
Intestinal Gas

Belching
Diarrhea
Indigestion

Genito-Urinary:

Painful Urination
Night Urination
Kidney Stones

Urgent Urination
Frequent Urination
Discolored Urine

Scanty Urination
Incontinence of Urine (unable to hold)
Impotence/Premature Ejaculation

Gynecological and Pregnancy:

Irregular Periods
Continuous Heavy Flow
Clots
Vaginal Discharge
Number of Pregnancies _____
Number of Premature Births _____
Date of Last Menses _____

Spotting
Discoloration (Prolonged Dark Red, Pale, Purple, etc.)
PMS
Fertility Problems
Number of Miscarriages/Abortions _____

Painful Menstruation
Light Flow
Duration of Flow _____
Date of Last Pap _____

Neuro/Psychological: _____

Poor Memory
Irritable/Easily Angered
Depression

- Poor Concentration
- Disorientation
- Mood Swings

Hyperactivity
Anxiety
Lack of Coordination

Any other problems you would like your practitioner to be aware of?

Any other pain throughout the body (sprains, arthritis etc.?) Please list location.

Medication List:

[illegible]