Natural Acupuncture & Wellness, P.C.

Patient Health History Questionnaire

Welcome to our clinic! Please fill out this questionnaire completely. All of your answers will be held confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the "Comments" section. Thank You!

Today's date:_____

Name: _____
Last First M

Street address:_____ Apt #:_____

City:_____ State:_____ Zip code:_____

Birthdate:_____. Age:_____ Height:_____ Weight:_____

SS#:_____. M/F:_____. Marital Status:_____

Home phone:_____. Cell phone:_____

Employer:_____. Work phone:_____

Emergency contact: (with phone #):_____

Type of insurance:_____

Referred by:_____

E-mail: _____

Please describe your main complaints:_____

_____

_____

_____

Are you pregnant?_____ Allergies?_____

Are you taking any western medicines, herbs, vitamins?_____. Please list:_____

_____

_____

Any surgeries or major illnesses?_____

_____

Family health history (parents, siblings, children):_____

_____

Additional comments?_____

_____

In Traditional Chinese Medicine, diagnosis and treatment are based upon a particular complaint within the context of the patient's constitution. Thus, no single part (or complaint) may be understood outside its relation to the whole. An accounting of all signs and symptoms helps to shape the nature of the patient's imbalance, and facilitates appropriate treatment. Please mark all current symptoms:

_____Fatigue
_____Mental exhaustion
_____Physical exhaustion
_____Frequent colds
_____Allergies
_____Chills
_____Congestion
_____Cough
_____Shortness
_____Excessive sweating
_____Dry skin or dry hair
_____Chest oppression
_____Sore throat
_____Loss of voice
_____Constipation
_____Toothache
_____Feelings of grief
_____Sadness

_____Poor appetite
_____Muscle Weakness
_____Tendency to bruise
_____Abdominal distention
_____Heartburn
_____Nausea
_____Abdominal pain
_____Diarrhea
_____Vomiting
_____Belching
_____Bad breath
_____Jaw pain
_____Anemia
_____Varicosities
_____Hernia
_____Leg heaviness
_____Preference for sweets
_____Unclear thinking
_____Sinus headaches
_____Tendency to worry

_____Insomnia
_____Palpitations
_____Anxiety
_____Forgetfulness
_____Irregular heart beat
_____Chest pain
_____Mouth/tongue blister
_____Difficult speech
_____Low blood pressure
_____High blood pressure
_____Panic attacks
_____Sweat easily
_____Shoulder pain
_____Burning urination
_____Feelings of joyfulness

_____Difficult inhalation
_____Sore lower back
_____Weak lower back
_____Diarrhea at dawn
_____Knee pain
_____Osteoporosis
_____Loss of teeth
_____Sexual dysfunction
_____Infertility
_____Edema
_____Tinnitus
_____Hearing changes
_____Memory loss
_____Premature graying
_____Hair loss
_____Incontinence
_____Nighttime urination
_____Kidney stones
_____Painful urination
_____Frequent urination
_____Occipital headaches
_____Neck pain or stiffness
_____Whole head pain
_____Crave salty foods
_____Feelings of fearfulness

_____Migraine
_____Dizziness
_____Temporal headache
_____Seizure
_____Flank pain
_____Jaundice
_____Irregular menstruation
_____Premenstrual syndrome
_____Genital pain
_____Stroke
_____Tremors
_____Irritable bowel syndrome
_____Acid reflux
_____Red, irritated eyes
_____Brittle nails
_____Very early waking
_____Muscle cramps
_____Frustration
_____Tension
_____Anger or irritability
_____Indecision
_____Bitter taste
_____Crave sour foods

Natural Acupuncture & Wellness P.C.

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

We are committed to your health and well-being. All of us affiliated with this center believe that while Oriental medicine, has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1(b) of NYS Education law, we request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT _____(Patient) HAS BEEN ADVISED BY AN ACUPUNCTURIST TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT, AND ANY CONDITIONS WHICH MAY BE DISCLOSED DURNIG THE EXAMINATION AND TREATMENT SESSIONS.

X_____ _____

Patient Signature Date

_____ _____

Licensed Acupuncturist Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental medicine provided by Natural Acupuncture & Wellness P.C. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below. I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, microneedleand, facial work and Chinese Tui Na. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness of tingling near the needling sites, and dizziness or fainting. Bruising is a common side effect of cupping. Although this site uses sterile, disposable needles and maintains a clear and safe environment, infection is another possible risk. Burns and/or scarring are a potential risk of the heating lamp and moxa. Bleeding, infection and/or swollen are potential risk of the microneedle therapy. I understanding that while this document describes the major risks of treatment, other side effects and risks may occur. **Initial: X**_____

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) which may be recommended are traditionally considered to be safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, as stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbal preparations. **Initial: X**_____

As of today's date, I (circle one) AM/AM NOT pregnant. I will notify each clinical staff member who is caring for me if I am or become pregnant. **Initial: X**_____

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. 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 known to them, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for research purposes, however, my name and identifying information will not be disclosed. Otherwise any of 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 condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated) and clinical staff providing information and obtaining consent.

X_____ _____

Signature of patient or representative Date

_____

Licensed Acupuncturist