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: _____

Your primary doctor Name: _____ Phone: _____

Address: _____

Referred from doctor name: _____ Phone: _____

Address: _____

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?_____

DESCRIPTION OF YOUR PAIN

1. Where have you Pain:

Head, Neck, Shoulder, Arm, Elbow, Wrist, Hand, Back, Lower Back, Hip, Leg, Knee, Ankle, Heel, Foot, Others:_____

2. How long have you had pain or/and such symptoms? Years ____ Months ____ Getting worse_____

3. What brought on your pain/your symptoms?

_____

_____

_____

4. Doctors, treatments and tests received for this condition, past and present.

Treatment and/or operation	Date performed	By whom	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Allergies to drugs: _____

6. Do you smoke? No___ Yes___ 7. Do you drink? No___ Yes___

THE EFFECT OF PAIN ON YOUR LIFE-STYLE

1. Check the box if the pain is better or worse

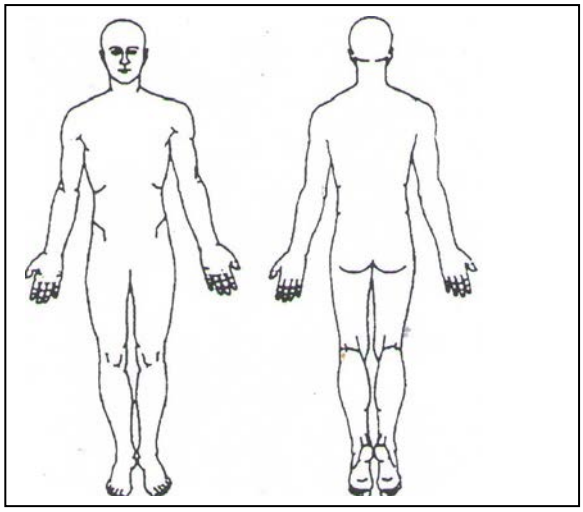
	Better	**Worse**		**Better**	**Worse**
Lying	□	□	Bending	□	□
Sitting	□	□	Exercise	□	□
Standing	□	□	Heat	□	□
Walking	□	□	Weather change	□	□
Intercourse	□	□	Normal work	□	□

2. How has your overall activity level been restricted?

☐ slightly restricted ☐ moderately restricted ☐ severely restricted ☐ unable to do anything for myself

3. Please mark the area of pain or discomfort on the figures.

+++ Sharp or stabbing ○○○Pins and needles
∨∨∨ Dull or aching /// Numbness
ΔΔΔ Spasm



4. Please circle your pain level using a circle "O"

Description Pain intensity according to patient

_____ None 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 Severe
_____ None 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 Severe
_____None 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 Severe
_____ None 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 Severe

My Name:_____ Signature: _____Date: _____

I assign my insurance benefits to be paid directly to my Acupuncturist for services described/rendered.

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 during 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.

I hereby grant Dr. Decheng Chen permission to use my image and video in any and all publications, including website entries, without payment or any other consideration.

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