Patient Health History

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please print and complete as thoroughly as possible. Your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA) and is held strictly confidential.

Name: _____ **Date**: _____
(first) (middle) (last)

Street _____ City _____ State _____ Zip_____

Phone: Cell _____ Home _____ Work_____

Email: _____**Is it ok to contact you by?** Phone___ Text___ Email___

Date of Birth: _____/_____/_____ **Age**: _____ **Gender**: _____ Height: _____ Weight: _____

Marital Status: M__ S__ D__ W__ P__ **Occupation**:_____ Veteran__ Retired ___Disabled __

Physician: _____ **Referred by**: _____

Emergency Contact: _____ **Relation to you**: _____

Emergency Contact Number: Cell _____ Home _____ Work _____

Have you ever been treated by acupuncture or oriental medicine before? yes _____ no _____

Main problem you would like us to help you with: _____

_____

What makes it better?_____

What makes it worse? _____

How is it affecting your daily activity? _____

When/how did this problem start? _____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom? _____

_____

What other kinds of treatment have you tried? ☐ Western Medicine ☐ Acupuncture ☐ Herbs ☐ Massage

☐ Physical Therapy ☐ Chiropractor ☐ Reiki ☐ Homeopathy ☐ Other:_____

How confident are you that you can resolve the symptoms of your main complaint with acupuncture and Chinese herbal medicine?

☐ Not confident ☐ Slightly confident ☐ Moderately confident ☐ Confident ☐ Very confident

Secondary complaints you would like us to help you with: _____

_____

Past Personal Medical History of Significant Illnesses: ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart Disease ☐ High Blood Pressure ☐ Seizures ☐ Hepatitis ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Venereal Disease ☐ Other: _____

Any history of infectious disease? (Hepatitis, HIV, MRSA, etc.):_____

Hospitalizations/Surgeries (include dates): _____

_____

_____

_____

Significant Trauma (auto accidents, falls, fractures, burns, etc.): _____

_____

_____

Allergies (drugs, chemicals, metals, foods): _____

Family Medical History: ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart Disease ☐ Seizures ☐ High Blood Pressure ☐ Hepatitis ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Other: _____

Medications (prescriptions, vitamins, herbs, etc.): _____

_____

_____

Are there any areas of your life that you find stressful? Please explain: _____

_____

Do you have a regular exercise program? Please describe: _____

_____

Do you follow any type of special diet (vegetarian, gluten free, medical related, other)?: _____

Is the majority of your food processed/pre-made? _____ **Or fresh?** _____

Describe your average daily diet:

Morning: _____

Midday: _____

Evening: _____

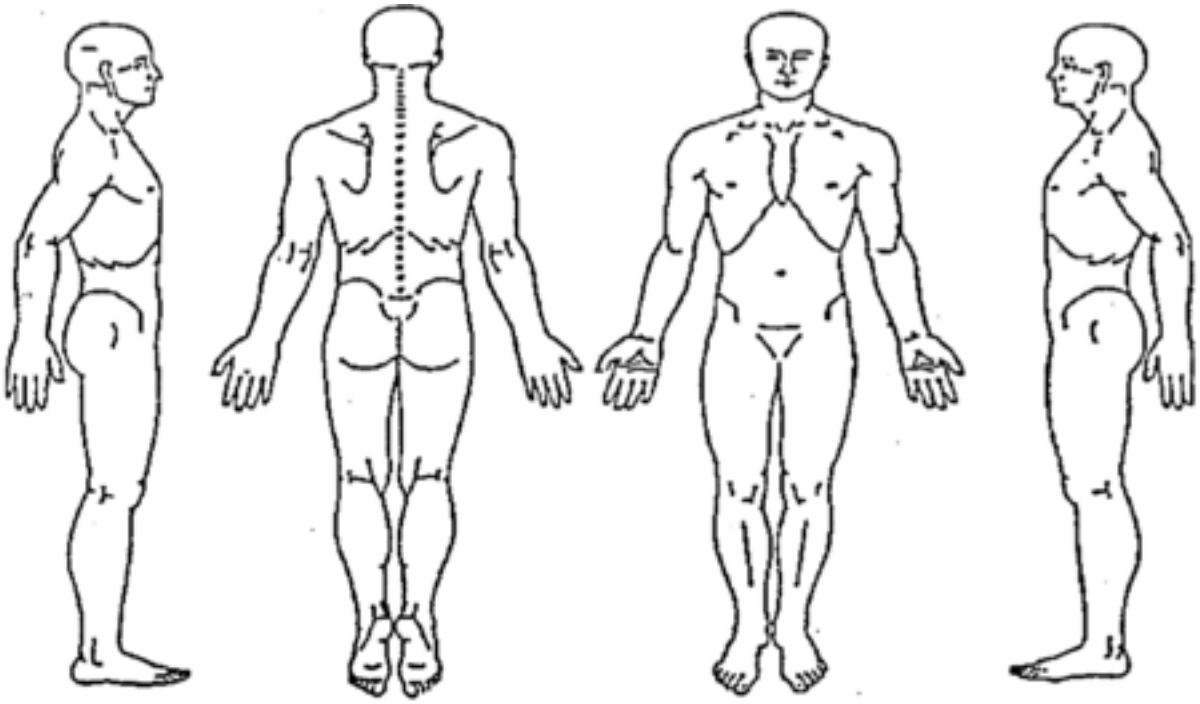
Do you smoke? ☐ No ☐ Yes **How many per day?___How long since quitting? ___Interested in quitting?___**

How many cups of caffeinated coffee/tea/cola do you drink per day? _____

How many 8 oz. glasses of water do you drink per day? _____

How many alcoholic beverages do you drink per day (or week)? _____

Please describe any use of drugs for non-medical purposes: _____



Please indicate any painful or distressed body areas by circling the affected area:

Please explain above if necessary:

_____

_____

***Please check ☐ if you've ever had any of the following (esp. if in the past 3 months)*:**

General

☐ Fevers ☐ Chills ☐ Sweat Easily ☐ Night Sweats ☐ Prefer Hot/Cold Temp. ☐ Poor Sleep

☐ Weight Loss ☐ Weight Gain ☐ Cravings ☐ Change in Appetite ☐ Lack of Thirst ☐ Strong Thirst

☐ Prefer Hot Drinks ☐ Prefer Cold Drinks ☐ Strange Tastes or Smell ☐ Bruise/Bleed Easily ☐ Fatigue

☐ Sudden Energy Drop, if so, what time of day? _____

Skin & Hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema ☐ Dry
☐ Pimples/Acne ☐ Dandruff ☐ Hair Loss ☐ Recent Moles ☐ Psoriasis ☐ Scars
☐ Dermatitis ☐ Bruise Easily ☐ Change in hair/skin texture ☐ Other skin/hair problems? _____

Head, Eyes, Ears, Nose & Throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses ☐ Eye Strain
☐ Eye pain ☐ Poor Vision ☐ Night Blindness ☐ Color Blindness ☐ Cataracts
☐ Blurry Vision ☐ Earaches ☐ Spots in front of eyes ☐ Ringing in ears ☐ Poor Hearing
☐ Sinus Problems ☐ Nosebleeds ☐ Recurrent Sore Throat ☐ Grinding Teeth ☐ Clenching Jaw
☐ Facial Pain ☐ Teeth Problems ☐ Sores on Lips/Tongue ☐ Jaw Clicks ☐ Trouble Swallowing
☐ Headaches, where on head and when? _____
☐ Any other head or neck problems? _____

Cardiovascular

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Fainting ☐ Irregular Heart Beat
☐ Palpitations ☐ Palpitations at Rest ☐ Difficulty Breathing ☐ Blood Clots ☐ Phlebitis
☐ Cold Hands/Feet ☐ Swelling of Hands ☐ Swelling of Feet ☐ Varicose or Spider Veins
☐ Any other heart or blood vessel problems? _____

Respiratory

☐ Cough ☐ Coughing Blood ☐ Asthma ☐ Bronchitis ☐ Pneumonia
☐ Pain with Deep Breath ☐ Chest Tightness ☐ Shortness of Breath ☐ Difficulty Breathing Lying Down
☐ Difficulty Breathing with Exertion ☐ Frequent Colds ☐ Phlegm production, what color? _____ ☐ Other_____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Black Stools
☐ Blood in Stools ☐ Hemorrhoids ☐ Rectal Pain ☐ Gas ☐ Belching
☐ Indigestion ☐ Acid Reflux/GERD ☐ Bloating/Edema ☐ Hernia ☐ Colitis
☐ IBS/Crohn's Disease ☐ Food Stagnation ☐ Poor Appetite ☐ Excess Appetite ☐ Bad Breath
☐ Bleeding Gums ☐ Slow Digestion ☐ Loose Stools > 2x per day ☐ Abdominal pain ☐ Other___

Genitourinary

☐ Frequent Urination ☐ Blood in Urine ☐ Pain with urination ☐ Urgency to Urinate ☐ Unable to Hold Urine
☐ Kidney Stones ☐ Decrease in Flow ☐ Flow Start and Stop ☐ History of UTI ☐ Cloudy Urine
☐ Impotency/ED ☐ Sores on Genitals ☐ Color of Urine _____ ☐ Do you Wake at Night to Urinate?
How many times _____ ☐ Any other problems with genital or urinary system? _____

GYN or Male Concerns (please fill out even if post menopause)

Are you pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Is it possible you are pregnant? ☐ Yes ☐ No

Do you use Birth Control? ☐ Yes ☐ No ☐ What type? _____ How long using?_____

Number of Pregnancies ____ Live Births ____ Premature Births _____ Miscarriages _____ Abortions ____

Any problem with pregnancies or fertility?_____

Age at First Menses ____ Duration of Menses ____ Time Between each Cycle _____ Age at Menopause_____

Color of Menstrual Blood (dark, bright, red, purple, etc.) _____

Character of Blood (heavy, scanty, etc.) _____

☐ Cramps/Painful Periods, which days? _____ ☐ Clots, Size, Color, which days? _____

☐ PMS Symptoms _____

☐ Irregular Periods ☐ Breast Lumps ☐ Vaginal Discharge, color _____ ☐ Vaginal Dryness

☐ Vaginal Sores ☐ Uterine Fibroids ☐ Polycystic Ovarian Syndrome ☐ Fibrocystic Breasts

☐ Any Male concerns? _____

☐ Erectile Dysfunction ☐ Prostatitis ☐ BPH ☐ Other _____

Musculoskeletal

☐ Neck Pain ☐ Shoulder Pain ☐ Rotator Cuff ☐ Elbow Pain ☐ Hand/Wrist Pain

☐ Carpal Tunnel ☐ Hip Pain ☐ Sciatica ☐ Knee Pain ☐ Foot/Ankle Pain

☐ Morton's Neuroma ☐ Plantar Fasciitis ☐ Muscle Pain/Spasm ☐ Sprains/Strains ☐ Tendonitis

☐ Bursitis ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Lyme Disease

☐ Soreness/Weakness of lower body. Where?_____ ☐ Back Pain: Low ____ Middle___ Upper___

☐ Other_____

Neurological & Psychological

☐ Seizures ☐ Dizziness ☐ Loss of Balance ☐ Numbness ☐ Poor Memory

☐ Concussion ☐ Poor Coordination ☐ Bad Temper ☐ Anxiety ☐ Depression

☐ Bipolar ☐ Nervousness ☐ ADD/ADHD ☐ Easily Susceptible to Stress

☐ Have you ever been treated for Emotional Problems? ☐ Yes ☐ No

☐ Have you ever considered or attempted suicide? ☐ Yes ☐ No

☐ Any other neurological or psychological problems? _____

_____

Other Problem/Concern: _____

_____

_____

Cancellation Policy

All appointments must be cancelled a ***minimum of 24 hours*** prior to the appointment time. If this is not possible, you may be charged a nominal fee for your missed appointment. Our time is valuable and we have other clients who may have been able to use that time if we'd known early enough to be able to offer it to them.

This policy does not apply during inclement weather (safety first!) and life's emergencies sometimes get in the way of a policy and that will certainly be taken into consideration. Thank you for understanding!
Please initial:_____

Consent to Treat

I, _____, hereby authorize Valerie Ketch, Lic. Ac., to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

(*Please circle any you **DO NOT GIVE** your consent for*)

1) **Acupuncture needles** of various styles and lengths are used for insertion into the body at various depths and locations.

2) **Heat** treatments are administered using Artemesia vulgaris (mugwort, moxa, moxibustion) or a conventional heat lamp. *Indirect* moxibustion treatments involve putting moxa on the head of a needle or on top of a barrier such as salt or a slice of ginger. When *direct* moxibustion is used, the moxa is placed on the skin over a thin layer of barrier cream. 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 treatment, there is always a risk of a burn.

3) **Gua sha,** a massage/scraping technique to relieve stagnation, may leave a red/purple discoloration on the skin that can last 1-5 days. Slight "bruising"/discoloration and tenderness may persist after the treatment.

4) **Cupping** may be used to promote the circulation of Qi (energy) through the meridians. Cups may produce a red/purple discoloration on the treated areas lasting for 1-5 days.

5) **Electrical stimulation** of the needles may be used which produces a vibrating or tapping sensation. **Ion pumping cords** (*non-electrical*) may be attached to the needles to facilitate the flow of energy in the body.

6) **Bloodletting**, alone or in conjunction with cupping, may be used to improve circulation in specific meridians. Sterile lancets are inserted into the skin and a small amount of blood is expressed from the puncture.

7) **Chinese Herbal Medicine** in various forms (pills, capsules, extract powders, and raw herbs) may be administered orally and/or topically. Some patients may experience side effects from their particular prescription. Please inform your acupuncturist of any adverse effects you may be experiencing no matter how minor.

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 the treatment.

Signature of Patient/Guardian: _____

Print Name/Relationship_____