

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: _____

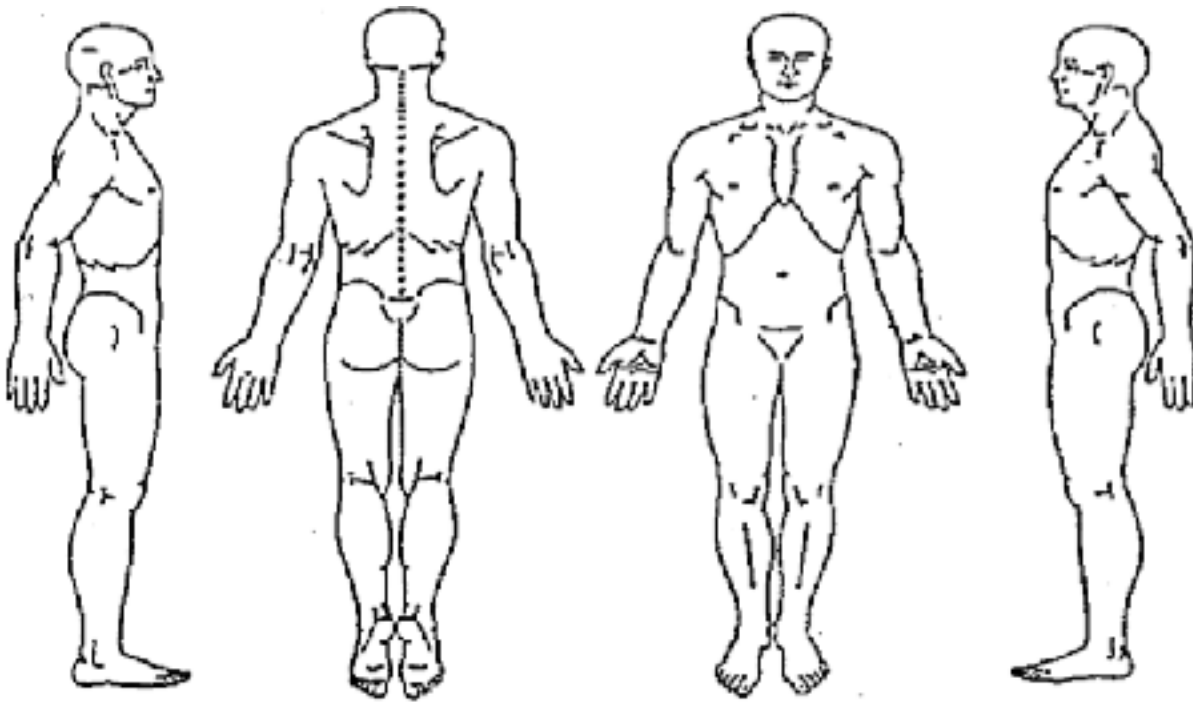
Do you smoke? No Yes How many per day? ___ How long since quitting? ___ Interested in quitting? ___

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. If you **no show**, you will be charged a **\$30** fee. 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 _____

Acknowledgment of COVID-19

As you are probably aware, Coronavirus COVID-19 is a highly contagious virus that is spread from direct contact with any object and is also transmissible through the air from an infected person. By leaving your house you may have already been in contact with this contagious disease. The COVID-19 virus is easily spread and can cause permanent lung problems and even death.

The following is the latest information from the CDC. There is no way to ensure zero risk of infection and it is important to understand potential risks and how to adopt different types of prevention measures to protect yourself and to help reduce the spread of COVID-19 (mask, social distance, hand sanitizer). In general, the more closely you interact with others and the longer that interaction, the higher the risk of COVID-19 spread. Some people have the virus and don't have any symptoms, and it is not yet known how often people without symptoms can transmit the virus to others. Indoor spaces are more risky than outdoor spaces where it might be harder to keep people apart and there's less ventilation.

If you are at higher risk for serious illness from COVID-19 because of your age or because you have a serious long-term health problem, it is extra important for you to take actions to reduce your risk of getting sick with the disease. Based on currently available information and clinical expertise, older adults and people of any age who have serious underlying medical conditions might be at higher risk for severe illness from COVID-19. Per the CDC, those at high-risk for severe illness from COVID-19 are:

- People 65 years and older
- People of all ages with underlying medical conditions, particularly if not well controlled, including:
 - Chronic lung disease or moderate to severe Asthma
 - Serious heart conditions
 - Immunocompromised (cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, prolonged use of corticosteroids/other immune weakening medications)
 - Severe obesity (body mass index [BMI] of 40 or higher)
 - Diabetes
 - Chronic kidney disease undergoing dialysis/Liver disease

Actions to reduce your risk of getting sick with COVID-19:

- Stay home if possible/Wash your hands often.
- Keep space between yourself and others (stay 6 feet away, which is about two arm lengths).
- Keep away from people who are sick.
- Stock up on supplies/Clean and disinfect frequently touched services.
- Avoid all cruise travel and non-essential air travel.
- Call your healthcare professional if you have concerns about COVID-19 and your underlying condition or if you are sick
- ***By signing this form, I acknowledge that I may contract COVID-19 anywhere, including this office, and deem all the healthcare providers and staff harmless for any health-related conditions that may come from Coronavirus COVID-19.***

Patient Signature _____ Date _____

Staff Signature _____ Date _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided)

**Initial
Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
 - *Fever
 - *Dry Cough
 - *Sore Throat
 - *Shortness of Breath
 - *Runny Nose
 - *Loss of Taste or Smell_____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent /	Witness
Signature: _____	Guardian	Signature _____
	Signature _____	Signature _____
Name _____	Name _____	Name: _____
Date _____	Date _____	Date: _____