

HEALTH HISTORY FORM

Please complete this form as thoroughly as possible.

Today's date

PATIENT INFORMATION

Last name		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
First name	M.I.	Height	Weight
Address		Profession	Phone
		Cell	Email
Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse name: <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Significant other		Number of children:
Emergency contact	Relationship	Phone	Cell/Email
How did you hear of our clinic? <input type="checkbox"/> Word of mouth <input type="checkbox"/> Internet <input type="checkbox"/> Walk in <input type="checkbox"/> Ads <input type="checkbox"/> Other			Referred by
Primary Care Physician	Phone	Fax/Email	

1. Have you received acupuncture treatment before? No Yes (*specify date & place*)

2. What would you most like to achieve through our therapies?

3. Chief Concern

Please write in your main concerns in order of importance to you.

Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the current condition (1 = no pain, 10 = worst pain).

When did it start? _____

Heat makes it: *better* *no change* *worse*
 Cold makes it: *better* *no change* *worse*
 Damp weather: *better* *no change* *worse*
 Exercise/Activity: *better* *no change* *worse*

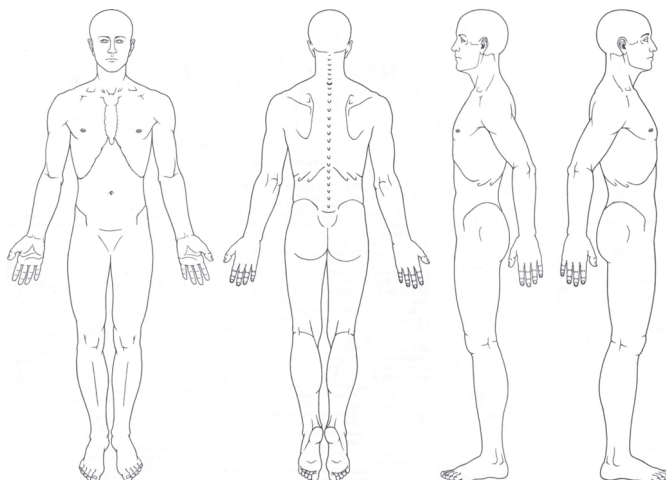
0 1 2 3 4 5 6 7 8 9 10

Describe briefly your current symptoms.

4. Pain Drawings

Where is your pain now?

- Mark the areas on your body where you feel the discomforts.
- Draw the lines /// of radiation including all affected areas.



5. Habits Amount/week If quit, when? Alcohol _____ Tobacco _____ Drugs _____ Soda _____ Coffee/tea _____ Other _____	7. Exercise: Do you exercise regularly?	
	8. Injuries & Surgeries	
	6. Diet: Do you have a special diet now or in the past?	
	9. Medications: Includes herbs or supplements	

10. Health Conditions: Please check all that apply and indicate if it is current.

TEMPERATURE		COLD	1	2	3	4	5	6	7	8	9	10	HOT	
Cold hands or feet	Thirst for cold/hot drink												Night sweats	Hot hands, feet, chest
Chills	Thirst, no desire to drink												Unusual sweats	Hot flashes
Cold in the bones	Absence of thirst												when? _____	Hot in afternoon
Areas of numbness	Excessive thirst												where? _____	Hot at night

MOISTURE		DRY	1	2	3	4	5	6	7	8	9	10	OILY	
Dry skin	Dry mouth												Edema or Swelling	Oily skin
Dry hair	Dry lips												Rashes	Oily hair
Dry eyes	Dry throat												Itching	Pimples
Dry brittle nails	Dry nose or Nosebleeds												Dandruff	Weight gain or loss

DIGESTION		DIARRHEA	1	2	3	4	5	6	7	8	9	10	CONSTIPATION	
BM: # of per day: _____	Gas												Nausea/Vomiting	Dry stools
Loose stools	Bloating												Bad breath	Difficult to pass
Alternating D/C (IBS)	Belching												Heartburn	Tired after BM
Indigestion	Poor appetite												Excessive hunger	Foul smelling stools

ENERGY		LOW	1	2	3	4	5	6	7	8	9	10	HIGH	
Sudden energy drop (times of day): _____	Using caffeine/stimulants												Shortness of breath	Hard to concentrate
Energy drop after eating	Wired/ungrounded feel												Heart palpitations	Poor memory
Fatigue	Heavy body or limbs												Blood pressure High/Low	Dizziness/Lightheaded
	Weak body or limbs												Bleed or Bruise easily	Headaches: _____ per wk

SLEEP		EMOTIONS	
Hours per night: _____	Disturbing dreams	Angry	Obsessive
Difficulty falling asleep	Restless sleep	Irritable	Sad
Wake at night	Not rested upon waking	Anxious	Grief
Wake to urinate		Worried	Depressed

EYES		EARS, NOSE & THROAT	
Poor vision	Eye pain	Sinus congestion	Phlegm
Night blindness	Eye discharge	Stuffy nose	Sore throat
Red eyes	Tearing eyes	Poor hearing	Mouth sores
Itchy eyes		Ringing or buzzing in ears	Cough
Spots in front of eyes		Excess earwax	Dental problems

GENITOURINARY		MENSTRUATION	
Change of sexual drive	Decrease in flow	Age at first period: _____	PMS
Erectile dysfunction	Dribbling	Length of period: _____	Cramps
Premature ejaculation	Difficulty with urine flow	Length of full cycle: _____	Before bleeding
Sores on genitals	Incontinence	First day of LMP: _____	First day
Discharge	Kidney stones	# of pregnancies: _____	During period
Prostate disease	Urgency to urinate	# of births: _____	Clots
Genital pain	Frequent urination	# of miscarriages: _____	Breast tenderness
Jock itch	Painful urination (dysuria)	Heavy periods	Fatigue with menses
Vasectomy	Burning sensation	Light periods	Midcycle spotting
Hernia	Cloudy urine	Painful periods	Yeast infections
Hemorrhoids	Blood in urine	Irregular periods	Birth control pills
	Urinary tract infection (UTI)	Menopausal (age at last menstruation): _____	

ALLERGIES/REACTIONS	FAMILY HEALTH HISTORY
CONSTITUTION (BODY TYPE)	

NuWave Acupuncture LLC

Disclosure of the Risks and Benefits of Acupuncture Care

I consent to acupuncture treatment and other procedures associated with ACUPUNCTURE PARK CENTER.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and *Tui na* therapeutic massage.

Acupuncture practitioners are trained in strict standards for clean needle technique and must abide by the standards set by Occupational Safety and Health Administration regarding proper hygiene and sterilization of equipment, disposal of hazardous materials, as well as precautions regarding blood borne pathogens and clean needle technique. With disposable needles, there is no risk of AIDS from the needles or hepatitis.

The risk of side effects could include some pain in the treatment area, minor bruising, moxa burn or scarring, fainting, infection, needle sickness or broken needle. Occasionally a treatment can produce a temporary flare-up of symptoms, but these are almost always limited to no more than a few days. Awareness of the patient's condition can avert most harms. The risks of moxa use can be averted by good technique and communication with the patient. Fainting can be most easily avoided if the patient takes care not to come for treatment when he or she is exhausted, tired or hungry. Fainting also can be avoided by working with breath, guided movement, and proper positioning on the table. To avoid needle breakage, patients must limit their movement while on the table and be careful if needles are legally permitted out of the practitioner's range. Timely needle removal and instructions regarding such while the patients are at home can avert infection. By following the instructions of the acupuncture practitioner before and after treatment, the patient can avoid difficulty.

The acupuncture practitioner must be advised if the patient has a pacemaker or bleeding disorder, might be pregnant or has a contagious disease. Patients who take blood thinners such as Coumadin (Warfarin) should probably not get acupuncture, due to the increased risk of internal bleeding.

Consent For Acupuncture Treatment

I am hereby advised to consult with my primary care medical physician on medical issues and that acupuncture, herbal medicine or alternative care is not substituting for appropriate medical advice and care from a medical doctor.

By voluntarily signing below, I show that I have read, or have read to me, this consent to treatment, have been told the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient name

Signature

Date

Witness

Signature

Date