NuWave Acupuncture 703-268-9222
info@nuwaveacu.com

HEALTH HISTORY FORM

Please complete this form as thoroughly as possible.

Today's date

PATIENT INFORMATION

Last name		Date of Birth	Sex ☐ Male ☐ Female
First name	M.I.	Height	Weight
Address		Profession	Phone
		Cell	Email

Married ☐ Yes ☐ No ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant other — Spouse name: — Number of children:

Emergency contact — Relationship — Phone — Cell/Email

How did you hear of our clinic? ☐ Word of mouth ☐ Internet ☐ Walk in ☐ Ads ☐ 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? _____

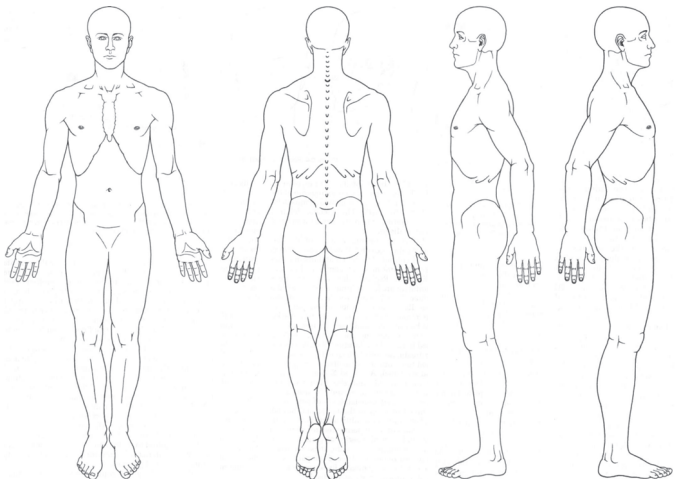
Heat makes it:	*better*	*no change*	*worse*
Cold makes it:	*better*	*no change*	*worse*
Damp weather:	*better*	*no change*	*worse*
Exercise/Activity:	*better*	*no change*	*worse*

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	Using caffeine/stimulants	Shortness of breath	Hard to concentrate
(times of day): _____	Wired/ungrounded feel	Heart palpitations	Poor memory
Energy drop after eating	Heavy body or limbs	Blood pressure High/Low	Dizziness/Lightheaded
Fatigue	Weak body or limbs	Bleed or Bruise easily	Headaches: _____ per wk

Sleep

Hours per night: _____
Difficulty falling asleep
Wake at night
Wake to urinate
Disturbing dreams
Restless sleep
Not rested upon waking

Emotions

Angry
Irritable
Anxious
Worried
Obsessive
Sad
Grief
Depressed

Eyes

Poor vision
Night blindness
Red eyes
Itchy eyes
Spots in front of eyes
Eye pain
Eye discharge
Tearing eyes

Ears, Nose & Throat

Sinus congestion
Stuffy nose
Poor hearing
Ringing or buzzing in ears
Excess earwax
Phlegm
Sore throat
Mouth sores
Cough
Dental problems

Genitourinary

Change of sexual drive
Erectile dysfunction
Premature ejaculation
Sores on genitals
Discharge
Prostate disease
Genital pain
Jock itch
Vasectomy
Hernia
Hemorrhoids
Decrease in flow
Dribbling
Difficulty with urine flow
Incontinence
Kidney stones
Urgency to urinate
Frequent urination
Painful urination (dysuria)
Burning sensation
Cloudy urine
Blood in urine
Urinary tract infection (UTI)

Menstruation

Age at first period: _____
Length of period: _____
Length of full cycle: _____
First day of LMP: _____
# of pregnancies: _____
# of births: _____
# of miscarriages: _____
Heavy periods
Light periods
Painful periods
Irregular periods

PMS
Cramps
Before bleeding
First day
During period
Clots
Breast tenderness
Fatigue with menses
Midcycle spotting
Yeast infections
Birth control pills

Menopausal (age at last menstruation): _____

Allergies/Reactions

Constitution (Body Type)

Family Health History

NuWave Acupuncture LLC

Disclosure of the Risks and Benefits of Acupuncture Care

I consent to acupuncture treatment and other procedures associated with NuWave Acupuncture.

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