Health History Questionnaire

Please help in providing you with the best care by taking the time to fill out this questionnaire. All of your answers will be held absolutely confidential. If you have any questions, please ask. Please include in the "Comments" section anything or any problems that you would like to discuss that are not included in this form.

Date: ___/___/______

Name:			Gender: M ☐ F ☐	Age:	Weight:
Street Address:				Date of Birth:	
City:	State:	Zip:		Place of Birth:	
Best number to contact you?		Email:			
Name of emergency contact (local):	Contact Phone:			Relationship:	
Occupation:	Physician:				
How did you hear about Health Turning Points?					
Have you ever been treated with acupuncture or Oriental medicine before? Y ☐ N ☐ If yes, where?					
Main problem(s) you would like help with:					
When did the problem(s) begin? Please be specific.					
To what extent does the problem(s) interfere with your daily activities, such as work, sleep, recreation, sex?					
How would you like the problem(s) to change?					
Have you been given a diagnosis for this problem? If so, what?					
What other types of treatment have you tried?					

How would you rate the overall stress level in your life? ☐ Low ☐ Moderate ☐ High
Please explain:

Medical History

Allergies (drugs, foods, chemical/ environmental):

Medications/ supplements/ vitamins (in the last two months):

Past medical history (including childhood illnesses):

Surgeries/procedures (and dates):

Significant injuries/trauma (auto accidents, falls, etc.):

Significant diagnoses (please check any that apply):

- ☐ Blood disorder/ bleeding problems
- ☐ Diabetes Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Kidney disease
- ☐ Gastrointestinal problems (reflux, IBD, ulcerative colitis, Crohn's disease)
- ☐ Respiratory problems
- ☐ Cancer [type(s) and date(s)]:
- ☐ Other (please describe):
- ☐ Chemical dependency (alcohol, drugs)
- ☐ Depression/ other mental illness
- ☐ Hepatitis/ liver disease
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Sexually transmitted diseases
- ☐ Epilepsy/ seizures
- ☐ Rheumatoid arthritis
- ☐ Other arthritis
- ☐ Neurological disease (multiple sclerosis, Parkinson'sdisease, etc.)

Family Medical History

- ☐ Asthma
- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Other (please describe):

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

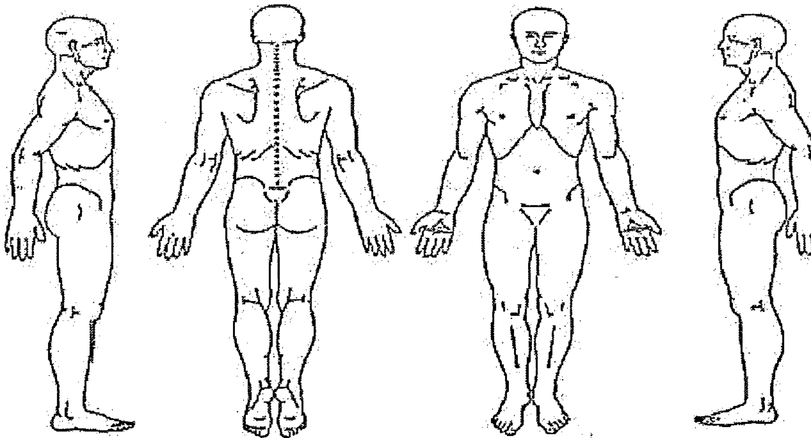
Do you have a regular exercise program (Please describe)? Y ☐ N ☐ ____________

Do you smoke? Y ☐ N ☐
If yes, how much? ____________
Do you drink alcoholic beverages? Y ☐ N ☐
If Yes, How much per week?
How much caffeinated coffee, tea, colas do you drink per week? ____________

Please describe your average daily diet

Morning	Afternoon	Evening	Snacks

Please indicate any painful or distressed areas by circling the area.



General

- ☐ Feeling hot/ fevers
- ☐ Sweats easily
- ☐ Afternoon / night sweats
- ☐ Feeling cold/ chills
- ☐ Fatigue
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Bruise or bleed easily
- ☐ Peculiar tastes or smells
- ☐ Sudden drop in energy
- ☐ Poor sleep

Skin & Hair

- ☐ Rashes /hives
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin
- ☐ texture
- ☐ Eczema
- ☐ Loss of hair
- ☐ Other hair or skin
- ☐ problems?
- ☐ Warts
- ☐ Pimples
- ☐ Recent moles
- ☐ Ulcerations/ unhealed sores

Head, eyes, ears, nose and throat

- ☐ Glasses/ contacts
- ☐ Poor vision
- ☐ Cataracts
- ☐ Eye strain
- ☐ Eye pain
- ☐ Color blindness
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Spots/floaters
- ☐ Any other head or neck problems?
- ☐ Poor hearing
- ☐ Ear aches/ pain
- ☐ Ringing in ears
- ☐ Grinding teeth
- ☐ Gum or teeth problems
- ☐ Sores on lips, gums, tongue
- ☐ Loss of smell/ taste
- ☐ Bitter taste in mouth
- ☐ Sensation of something stuck in throat
- ☐ Recurrent sore throat
- ☐ Sneezing
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks/ locks
- ☐ Concussions
- ☐ Migraines
- ☐ Dizziness
- Headaches (where, when?)

Respiratory

- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Cough
- ☐ Coughing blood
- ☐ Any other lung/breathing
- ☐ Difficulty inhaling/exhaling
- ☐ Asthma
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Production of phlegm:
  - ☐ Loose
  - ☐ Thick/Sticky
  - What color? ____________
- ☐ Pain with a deep breath
- ☐ Pulmonary embolism
- ☐
- ☐ Difficult breathing when lying down

Cardiovascular

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Any other heart or blood vessel problems?
- ☐ Fainting
- ☐ Colds hands or feet
- ☐ Swelling of feet/ legs
- Swelling of hands
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Varicose /spider veins
- ☐ Peripheral artery disease

Gastrointestinal

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion/ acid reflux
- ☐ Gall stones
- ☐ Abdominal pain or cramps
- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Diarrhea/ loose stool
- ☐ Constipation
- ☐ Any other stomach or intestinal problems?
- ☐ Blood in stools
- ☐ Black stools
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Incomplete bowel movements
- ☐ Undigested food in stool

Urinary

- ☐ Do you wake up to urinate?
  - ☐ Yes
  - ☐ No
- How Often: ____________
- Urine color:
  - ☐ Light or clear
  - ☐ Amber
  - ☐ Cloudy
  - ☐ Other (specify): ____________
- ☐ Pain on urination
- ☐ Blood in urine
- ☐ Decrease in urine flow
- ☐ Kidney stones
- ☐ Falling (prolapsed) bladder
- ☐ Urgent urination
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Other problems with your urinary system?

Female Reproductive

- Are you pregnant? Y ☐ N ☐
- Is it possible you are pregnant? Y ☐ N ☐
- Menopause? Y ☐ N ☐
- Pregnancies? # ____________
- Live births # ____________
- Do you practice birth control? Y ☐ N ☐
- Type and for how long? ____________
- Age of first menses: ____________
- Duration of menses: ____________
- Time between of menses: ____________
- Menstrual flow (heavy / moderate / light) ____________
- Premature births # ____________
- Miscarriages # ____________
- Any other reproductive problems? ____________

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Clots
- ☐ Premenstrual Symptoms?
- ☐ Vaginal Discharge
- ☐ Sores on Genitals
- ☐ Sexually Transmitted
- ☐ Disease Infertility
- ☐ Western fertility treatments
- ☐ Breast Lumps

Male Reproductive

- ☐ Impotence
- ☐ Prostatitis
- ☐ Prostrate Cancer
- ☐ Enlarged Prostrate
- ☐ Any other reproductive problem?
- ☐ Premature
- ☐ Ejaculation
- ☐ Spermatorrhea
- ☐ Low Sperm Count
- ☐ Low Motility
- ☐ Testicular Pain/Injury
- ☐ Testicular Cancer
- ☐ Sores on Genitals

Musculoskeletal

- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Hand/Wrist Pain
- ☐ Any other muscle, joint or bone problems?
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Foot/Ankle Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Muscle Cramping
- ☐ Back Pain
  - ☐ Upper
  - ☐ Middle
  - ☐ Lower

Neurological

- ☐ Seizures
- ☐ Stroke
- ☐ Concussion
- ☐ Any other neurological problems?
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Lack of Coordination
- ☐ Areas of Numbness
- ☐ Poor Memory
- ☐ Tremors (where?)

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Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Poor concentration
- ☐ Easily angered
- ☐ Easily over worried
- ☐ Easily susceptible to stress
- ☐ ADD/ ADHD
- ☐ Seasonal affective disorder
- ☐ Bipolar disorder
- ☐ Post-traumatic stress disorder (PTSD)

Have you ever been treated for emotional problems? Y ☐ N ☐

Have you ever considered or attempted suicide? Y ☐ N ☐

Any other psychological problems? Y ☐ N ☐

Comments (Is there anything else about your health you would like to discuss?)

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Signature ______________________

Date ______________________

PRINTED NAME____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered 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, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above 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.

Any changes or cancellations made without 24 hours notice will be subject to a $25 fee.

(Or Patient Representative)
PATIENT SIGNATURE: ______________________ ______________________

Date ____________