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 complete this questionnaire as thoroughly as possible. Please check the box next to the symptoms that apply to you and indicate areas of confusion with a question mark. Thank you.

STILLWATER
ACUPUNCTURE & NUTRITION

Date: (/ /)
Name: _____ **Birthdate:** (/ /) **Sex:** (Male / Female)
Address: _____
City, State, Zip Code: _____
Home Telephone Number: _____
Work / Cell Telephone Number: _____
Email Address: _____
Occupation: _____
Emergency Contact: _____
Referred By: _____
Have you ever had an acupuncture or Asian bodywork treatment? (Yes / No)

Primary Complaint: *(Please include: When this complaint first occured, severity and duration)*

_____

_____

_____

Secondary Complaint: *(Please include: When this complaint first occured, severity and duration)*

_____

_____

_____

Family Health History of Diseases: *(Please indicate on which side of your parents)*

_____

_____

Current Treatments and Medications: *(Please indicate what specific treatments and medications are for)*

_____

_____

Do you have a pacemaker and/or implanted defibrillator? (Yes / No)
Do you have a history of a bleeding disorder? *(Please Explain)* _____
Are you allergic to anything? *(Please List)* _____

_____

Do you have any reason to believe you may be pregnant? (Yes / No)
Do you have any infectious Diseases? *(Please List)* _____

Patient Health History:

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STILLWATER
ACUPUNCTURE & NUTRITION

Major Illness:
- Cancer ☐
- Diabetes ☐
- Hepatitis ☐
- Heart Disease ☐
- High Blood Pressure ☐
- Stroke ☐
- Seizures ☐
- HIV/AIDS ☐
- Pneumonia ☐
- Tuberculosis ☐
- Multiple Sclerosis ☐
- Thyroid Disorders ☐

General Symptoms:
- Chills ☐
- Fevers ☐
- Low Energy ☐
- Fatigue ☐
- Dizziness ☐
- Excess Thirst ☐
- Insomnia ☐
- Nervousness ☐
- Numbness ☐
- Sweat Spontaneously ☐
- Night Sweating ☐
- Lack of Sweating ☐
- Weight Loss ☐
- Weight Gain ☐
- Aversion to Heat ☐
- Aversion to Cold ☐
- Frequent Colds ☐

Head & Neck Symptoms:
- Headache ☐
- Heaviness in the Head ☐
- Blurred Vision ☐
- Double Vision ☐
- Night Blindness ☐
- Cataract ☐
- Eye Pain/Strain ☐
- Red/Inflamed Eyes ☐
- Dry Eyes ☐
- Tinnitus/Ringing in Ears ☐
- Hearing Loss ☐
- Earache ☐
- Ear Discharge ☐
- Nasal Obstruction ☐
- Nasal Discharge ☐
- Sinus Problems ☐
- Nosebleeds ☐
- Loss of Sense of Smell ☐
- TMJ ☐
- Teeth Grinding ☐
- Hoarseness ☐
- Sore Throat ☐
- Sores on Lips ☐
- Sores on Tongue ☐
- Bleeding Gums ☐
- Dry Mouth ☐
- Taste change ☐
- Teeth Problems ☐
- Difficulty Swallowing ☐
- Phlegm in throat ☐

Cardiovascular Symptoms:
- Chest Stuffiness ☐
- Chest Pain ☐
- Hypochondriac Pain ☐
- High blood pressure ☐
- Low blood pressure ☐
- Palpitations ☐
- Irregular heart beat ☐
- Poor Circulation ☐
- Swollen Ankles ☐
- Edema ☐

Gastrointestinal Symptoms:
- Difficulty Swallowing ☐
- Nausea ☐
- Vomiting ☐
- Belching ☐
- Heartburn ☐
- Acid Reflux ☐
- Poor Appetite ☐
- Excessive Appetite ☐
- Tired after Eating ☐
- Stomachache ☐
- Indigestion ☐
- Abdominal Pain ☐
- Bloating or Distention ☐
- Gas ☐
- Ulcers ☐
- Cholitis ☐
- Constipation ☐
- Diarrhea or Loose Stools ☐
- Blood in Stools ☐
- Hemorrhoids ☐
- Gout ☐
- Gallstones ☐

Diet/Lifestyle:
- Vegetarian ☐
- Healthy Diet ☐
- Crave Fried Foods ☐
- Crave Sweets ☐
- Preference for Warm Drinks ☐
- Preference for Cold Drinks ☐
- Smoke Cigarettes ☐
- Drink Alcohol ☐
- Drink Coffee ☐
- Use Drugs ☐
- Exercise Regularly ☐
- Exercise Excessively ☐

Genitourinary Symptoms:
- Dilute Urine ☐
- Dark Urine ☐
- Blood in Urine ☐
- Cloudy Urine ☐
- Burning Urination ☐
- Urinary Stones ☐
- Scanty Urine ☐
- Profuse Urine ☐
- Frequent Urination ☐
- Poor Bladder Control ☐
- Urgency to Urinate ☐

Women Only:
- Age of First Menses: _____
- Menses Duration/How long: _____
- Heavy Periods ☐
- Light Periods ☐
- Long Periods ☐
- Short Periods ☐
- Irregular Periods ☐
- Bleed Between Periods ☐
- Painful Periods ☐
- Clots with Periods ☐
- Pain during Ovulation ☐
- Vaginal Discharges ☐
- Premenstrual Symptoms ☐
- Endometriosis ☐
- Cysts ☐
- Fibroids ☐
- Candida/yeast Infection ☐
- Breast Lumps ☐
- Sores on Genitalia ☐
- Herpes / STD's ☐
- Uterine Prolapse ☐
- Use of Contraceptives ☐
- Low Sexual Energy ☐
- High Sexual Energy ☐
- Premenopausal ☐
- Postmenopausal ☐
- Currently Pregnant ☐
- Number of Pregnancies: _____
- Number of Miscarriages: _____
- Number of Abortions: _____
- Number of Children: _____

Men Only:
- Impotence ☐
- Hernia ☐
- Genital Pain ☐
- Genital Itching ☐
- Genital Sores ☐
- Lump in Testicles ☐
- Penis Discharge ☐
- Nocturnal Emissions ☐
- Low Sexual Energy ☐
- High Sexual Energy ☐

Skin Symptoms:
- Dry Skin ☐
- Itchiness ☐
- Rashes/Hives ☐
- Eczema ☐
- Psoriasis ☐
- Sores ☐
- Shingles / Herpes Zoster ☐
- Discoloration ☐
- Dark Circles Around Eyes ☐
- Bags Under Eyes ☐
- Thick Skin / Thin Skin ☐
- Blood not Clotting ☐
- Bruise Easily ☐
- Acne ☐
- Brittle Nails ☐
- Premature Gray Hair ☐
- Dry, Brittle Hair ☐
- Hair Loss ☐

Musculoskeletal Symptoms:
(Pain, Weakness, Numbness in:)
- Head and Neck ☐
- Shoulders ☐
- Upper Back ☐
- Low Back ☐
- Arms ☐
- Hands ☐
- Hips ☐
- Knees ☐
- Legs ☐
- Feet ☐
- Joints ☐
- Vertabral Disc Herniation ☐
- Vertabral Disc Degeneration ☐
- Pain all Over ☐
- Fibromyalgia ☐
- Arthritis ☐
- Osteoporosis ☐
- General Weakness ☐
- Cold Limbs ☐

Neurological Symptoms:
- Fainting ☐
- Convulsions ☐
- Handwriting Changes ☐
- Paralysis ☐
- Stroke ☐
- Seizures ☐
- Tics ☐
- Tremor ☐
- Recent Clumsiness ☐
- Drowsiness ☐
- Vertigo ☐

Emotional Symptoms:
- Insomnia ☐
- Difficulty Falling Asleep ☐
- Waking at Night ☐
- Waking Early ☐
- Many Dreams ☐
- Forgetfulness ☐
- Poor Memory ☐
- Trouble Thinking ☐
- Stress ☐
- Irritability ☐
- Often Feel Angry ☐
- Sadness ☐
- Crying ☐
- Anxiety ☐
- Much Fear ☐
- Unrestrained Joy ☐
- Terrors ☐

Weight:
- Underweight ☐
- Normal Weight for Height ☐
- Overweight ☐
- Very Overweight ☐

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, breathing techniques, exercise therapy, Tuina (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. By voluntarily signing below I show that I have read, or have had read to me, this 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.

_____	_____
Print Name of Patient	Print Name of Acupuncturist
X_____	X_____
Signature of Patient (or Representative)	Signature of Acupuncturist
_____	_____
(Print Name of Patient Representative)	(Print Name of Witness/Translator)
X_____	X_____
Date Consent Completed	(Signature of Witness/Translator)

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have read, reviewed, understand and agree to the statement of the Privacy Practices and policies for healthcare services in this office.

This practice has attempted to provide each patient with a statement of its Privacy Policies.

Patient Signature: _____

Date: _____