

Natural Acupuncture & Wellness, P.C.

Patient Health History Questionnaire

Welcome to our clinic! Please fill out this questionnaire completely. All of your answers will be held confidential. If you have questions, please ask us. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the "Comments" section. Thank You!

Today's date: _____

Name: _____

Street address: _____
Last First M Apt #:

City: _____ State: _____ Zip code: _____

Birthdate: _____ . Age: _____ Height: _____ Weight: _____

SS#: _____ . M/F: _____ . Marital Status: _____

Home phone: _____ . Cell phone: _____

Employer: _____ . Work phone: _____

Emergency contact: (with phone #): _____

Type of insurance: _____

Referred by: _____

E-mail: _____

Please describe your main complaints: _____

Are you pregnant? _____ Allergies? _____

Are you taking any western medicines, herbs, vitamins? _____ . Please list: _____

Any surgeries or major illnesses? _____

Family health history (parents, siblings, children): _____

Additional comments? _____

In Traditional Chinese Medicine, diagnosis and treatment are based upon a particular complaint within the context of the patient's constitution. Thus, no single part (or complaint) may be understood outside its relation to the whole. An accounting of all signs and symptoms helps to shape the nature of the patient's imbalance, and facilitates appropriate treatment. Please mark all current symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Mental exhaustion | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Physical exhaustion | <input type="checkbox"/> Tendency to bruise | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Abdominal distention | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Nausea | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Mouth/tongue blister |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Difficult speech |
| <input type="checkbox"/> Shortness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Belching | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Dry skin or dry hair | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Chest oppression | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Anemia | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Loss of voice | <input type="checkbox"/> Varicosities | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hernia | <input type="checkbox"/> Feelings of joyfulness |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Leg heaviness | |
| <input type="checkbox"/> Feelings of grief | <input type="checkbox"/> Preference for sweets | |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Unclear thinking | |
| | <input type="checkbox"/> Sinus headaches | |
| | <input type="checkbox"/> Tendency to worry | |

- | | |
|--|---|
| <input type="checkbox"/> Difficult inhalation | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Sore lower back | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weak lower back | <input type="checkbox"/> Temporal headache |
| <input type="checkbox"/> Diarrhea at dawn | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Flank pain |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Loss of teeth | <input type="checkbox"/> Irregular menstruation |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Premenstrual syndrome |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Genital pain |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Hearing changes | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Premature graying | <input type="checkbox"/> Red, irritated eyes |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Brittle nails |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Very early waking |
| <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Frustration |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Anger or irritability |
| <input type="checkbox"/> Occipital headaches | <input type="checkbox"/> Indecision |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Bitter taste |
| <input type="checkbox"/> Whole head pain | <input type="checkbox"/> Crave sour foods |
| <input type="checkbox"/> Crave salty foods | |
| <input type="checkbox"/> Feelings of fearfulness | |

Natural Acupuncture & Wellness P.C.

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

We are committed to your health and well-being. All of us affiliated with this center believe that while Oriental medicine, has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1(b) of NYS Education law, we request that you read and sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT _____(Patient) HAS BEEN ADVISED BY AN ACUPUNCTURIST TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT, AND ANY CONDITIONS WHICH MAY BE DISCLOSED DURNIG THE EXAMINATION AND TREATMENT SESSIONS.

X _____
Patient Signature

Date

Licensed Acupuncturist

Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental medicine provided by Natural Acupuncture & Wellness P.C. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below. I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, microneedleand, facial work and Chinese Tui Na. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness of tingling near the needling sites, and dizziness or fainting. Bruising is a common side effect of cupping. Although this site uses sterile, disposable needles and maintains a clear and safe environment, infection is another possible risk. Burns and/or scarring are a potential risk of the heating lamp and moxa. Bleeding, infection and/or swollen are potential risk of the microneedle therapy. I understanding that while this document describes the major risks of treatment, other side effects and risks may occur.

Initial: X _____

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) which may be recommended are traditionally considered to be 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, as stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbal preparations.

Initial: X _____

As of today's date, I (circle one) AM/AM NOT pregnant. I will notify each clinical staff member who is caring for me if I am or become pregnant.

Initial: X _____

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. 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 known to them, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for research purposes, however, my name and identifying information will not be disclosed. Otherwise any of my records will be kept confidential and will not be released to any party without my written consent.

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.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated) and clinical staff providing information and obtaining consent.

X _____
Signature of patient or representative

Date

Licensed Acupuncturist