HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential

I. General Patient Information

Date: ____/____/____ Name: Mr. /Mrs. /Ms. _____

Address: _____City/State/Zip:_____

Cell Phone: (_____) _____ Home or Work Phone: (_____) _____

Email: _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18):_____

Gender: □ M □ F Height: ___'____" Weight: _____lbs Social Security Number: _____-_____-_____

Driver's License Number: _____Occupation: _____

Employer: _____How did you hear about us? _____

Emergency Contact (name, relationship, and phone #):_____

II. Major Concerns:

Please list your health complaints in order of significance to you:

1._____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

How do these conditions affect your life on a regular basis?

__Affects Work __Affects House Chores __Affects My Time with My Family/Friends __Canceling Plans

__Tired __Causes More Stress __Low Motivation __Makes Me Feel Older __I Don't Feel Like Myself

__Affects Walking __Affects Driving __Changes My Daily Routines __Affects My Mood __Other

Please Explain:

_____

_____

_____

II. Patient Medical History

How was your childhood health? _____

Recent medical tests: (Please indicate any test results and date of tests)

□ Physical □ Cholesterol □Prostate □ Blood (which?)

□HIV/STD □Pap Smear □Mammography □Other: _____

Test Results and Date: _____

Past Diagnosis:

Check any conditions that you have been diagnosed with in the past.

__Diabetes __Allergies __Rheumatic Fever __Heart Disease __CVA (stroke) __Vein Condition

__Glaucoma __Thyroid Disorder __Asthma __Pneumonia __Tuberculosis __Emphysema

__Jaundice __Gonorrhea __Mumps __Bleeding Disorders __Syphilis __Measles __Chicken Pox

__Nervous Disorder __Meningitis __HIV __Polio __Mononucleosis __Epilepsy __High Fever

__Hepatitis __Paralysis __Multiple Sclerosis __Cancer __Migraines __High Blood Pressure

__Other Lung Illnesses __Other Liver Illnesses __Other Heart Illnesses __Other Kidney Illnesses

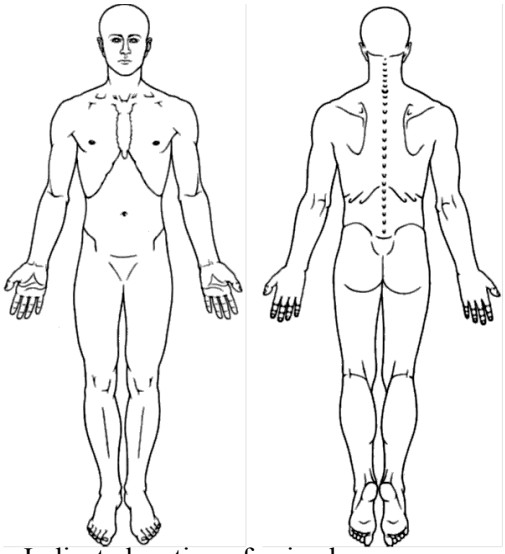
__Other (explain):_____

List your surgical/hospital history including what each was for and dates of occurrence. If you need more space, use the back of this sheet.

Surgery/Hospital Stay?	What for?	Date (approx. is fine)

Immunizations: _____

III. Patient Profile



Indicate location of pain above

If you have pain, how would you describe it:

□Sharp □Burning □Aching

□Cramping □Dull □Moving

□Fixed □Other: _____

Do the following improve the pain?

□Pressure □Cold □Heat

□Exercise □Other:_____

Do the following worsen the pain?

□Pressure □Cold □Heat

□Other:_____

Please check all of the following that currently pertain to you, even if they are not part of your main concerns:

Overall Temperature (Yin & Yang)

The following symptoms indicate an imbalance of Yin and Yang in your body. In Oriental Medicine, Yin is the cool, moist, nourishing aspect of your body. Yang is the hot, dry, invigorating aspect of the body.

□Cold Hands
□Cold Fingers
□Cold Feet
□Cold Toes
□Sweaty Hands
□Sweaty Feet
□Hot Body Temperature (sensation)
□Cold Body Temperature (sensation)
□Afternoon Flushes
□Night Sweats
□Heat in the Hands, Feet, and Chest
□Hot Flashes Any Time of the Day
□Thirsty
□Perspire Easily
□Lack of Perspiration
□Take Water to Bed

Overall Energy (Lung, Kidney Function):

□Shortness of Breath
□Difficulty Keeping Eyes Open in the Daytime
□General Weakness
□Easily Catch Colds
□Low Energy
□Feel Worse After Exercise

Overall Blood (Liver, Spleen, Heart Function):

□Dizziness
□See Floating Black Spots

Heart Function:
The heart governs the blood & blood vessels, manifests on the complexion, governs the emotions and effects speech and taste controls perspiration.

□Palpitations
□Anxiety
□Sores on the Tip of the Tongue
□Restlessness
□Mental Confusion
□Chest Pain Traveling to the Shoulder
□Frequent Dreams
□Wake Unrefreshed
□Drink Coffee (# of cups per week: _____)

Lung Functions:
The lungs govern breathing, control the movement of energy, control the immune system, regulate water passages, control the skin and open the nose, throat, and sinuses.

□Nasal Discharge (Color: _____)
□Cough
□Nose Bleeds
□Sinus Congestion
□Dry Mouth
□Dry Throat
□Dry Nose
□Dry Skin
□Allergies (To what? _____)
□Alternating Fever and Chills
□Sneezing
□Headache (Location: _____)
□Overall Achy Feeling in the Body
□Stiff Neck

□Stiff Shoulders
□Sore Throat
□Difficulty Breathing
□Smoke Cigarettes (# of cigarettes per day: _____)
□Sadness
□Melancholy

Spleen Function:
The spleen assists in breaking food down into usable nutrients and then transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body.

□Low Appetite
□Abrupt Weight Gain
□Abrupt Weight Loss
□Abdominal Bloating
□Abdominal Gas
□Gurgling Noise in the Stomach
□Fatigue After Eating
□Prolapsed Organs (Previously diagnosed which organ? _____)
□Easily Bruised
□Hemorrhoids
□Pensive
□Over-thinking
□Worry

Spleen, Stomach, Large Intestine, Small Intestine Function:
□Loose
□Constipated
□Incomplete
□Diarrhea
□Blood in Stools
□Mucous in Stools
□Undigested Food in Stools

Dampness Trapped in the Body:
Dampness refers to fluids that are not metabolized effectively and cause health problems in the body.

□General Sensation of Heaviness in the Body
□Mental Heaviness
□Mental Sluggishness
□Mental Fogginess
□Swollen Hands
□Swollen Feet
□Swollen Joints
□Chest Congestion
□Nausea
□Snoring

Stomach Function:
The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends the energy and is the origin of the body's fluids.

□Burning Sensation After Eating
□Large Appetite
□Bad Breath
□Mouth (canker) Sores
□Bleeding, Swollen, or Painful Gums
□Heartburn
□Acid Regurgitation
□Ulcer (diagnosed)
□Belching
□Hiccoughs
□Stomach Pain
□Vomiting

Liver, Gallbladder Function:
The liver stores the blood, ensures the smooth flow of energy, nourishes the tendons and ligaments, manifests in the nails and opens in the eyes. The gallbladder stores bile, which breaks down fats.

□Alternating Diarrhea and Constipation
□Chest Pain
□Tight Sensation in the Chest
□Bitter Taste in the Mouth
□Anger Easily
□Frustration
□Depression
□Irritability
□Frequently Unable to Adapt to Stress (What causes the stress? _____)
□Skin Rashes
□Headache at the Top of the Head
□Tingling Sensation
□Numbness
□Muscle Spasms
□Muscle Twitching
□Muscle Cramping
□Seizures
□Convulsions
□Lump in the Throat
□Neck Tension
□Limited Range-of-Motion, Shoulder
□Drink Alcohol (What type? _____, How much per week? _____)
□Recreational Drugs (Which? _____, How much per week? _____)
□Hip Pain
□High Pitched Ringing in the Ears
□Gallstones (History or Current)
□Sexually Transmitted Disease (Which? _____)

Eyes (Liver Function)
□Itchy
□Bloodshot
□Hot
□Dry
□Watery
□Gritty
□Blurry Vision
□Decreased Night Vision
□Near-Sighted
□Far-Sighted

Kidney, Urinary Bladder Function:
The kidney and adrenal system govern birth/growth/reproduction/development, produce the bone marrow, nourish the brain, control the bones, govern water, open the ears, manifest the hair, and control the ureter/spermatic duct and lower section of the large intestine. The urinary bladder stores and eliminates impure fluids from the body.

□Frequent Cavities
□Easily Broken Bones
□Sore Knees
□Weak Knees
□Cold Sensation in the Knees
□Low Back Pain
□Memory Problems
□Excessive Hair Loss
□Low-Pitched Ringing in the Ears
□Kidney Stones
□Bladder Infections
□Wake During the Night Twice or More to Urinate
□Lack of Bladder Control
□Fear
□Easily Startled

Urination (Normal urine is clear to light yellow):

□Dark Yellow	□Reddish
□Cloudy	□Scanty
□Profuse	□Strong Odor
□Burning	□Painful
□Discharge	□Difficult
□Painful	□Urgent
□Frequent	

Libido:
□Normal
□High
□Low

*****Women Only:***

Regular menstrual cycle? □Y □N

Pregnant? □Y □N

Number of children: _____
Age of first Menstruation: _____
Average number of days of flow: _____
□Vaginal Discharge

Number of Pregnancies: _____
Age of Menopause (if applicable): _____
Average number of days of entire cycle: _____
□Bleeding Between Periods

Do you experience any of the following premenstrual symptoms?

□Nausea □Vomiting □Water Retention □Breast Swelling
□Food Cravings □Headaches □Migraines □Breast Tenderness
□Depression □Irritability □Anxiety □Other Emotions: _____
□Dull Pain, Where? _____ □Sharp Pain, Where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, brightened, red, pale, brown, rust, dark purple, other							
Amount of flow (normal, heavy, light)							
Pain/ cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

*****Men Only:***

□Swollen Testes □Testicular Pain □Impotence □Premature Ejaculation
□Feeling of Coldness or Numbness in External Genitalia □Other:_____

EVERYONE:

MEDICATIONS, VITAMINS AND SUPPLEMENT LOG

Name: _____ Medical/Allergy Alerts: _____

DATE STARTED	MEDICATION/VITAMIN/ SUPPLEMENT	REASON FOR TAKING	DOSAGE	QUANTITY	FREQUENCY

NOTES: _____

_____

_____

Dietary:

Please list typical foods eaten for each meal and amount of beverage consumed each day of the following:

Diet: List the typical foods you eat for each meal.	Beverages per Day: List the amount of each beverage you consume on a typical day. (Include weekly amounts if consumed less than daily)
Breakfast:	Water:
Lunch:	Soda:
Dinner:	Milk:
Snacks:	Juice:
	Coffee:
	Tea:
	Alcohol:

Sleep:

How long does it take you to fall asleep? _____

How many times do you wake up through the night? _____

Can you normally fall back asleep? How long does it take?_____

How many hours of sleep do you get in a night? _____

Do you feel rested most days, or are you tired most days? _____

Anything else we should know about your sleep? (Use CPAP, frequent nightmares/terrors, frequent night sweats, etc)

_____

Other Trauma History:

All of our experiences have a profound impact on our bodies and well-being. Even if these things are not directly related to your current health conditions, your experiences will give us better insight as to what you've dealt with in your life and what your body has had to heal from. This can indicate to us what could be contributing to some weaknesses in your body that can be affecting your health now.

Please know we greatly value and respect any information provided in the following sections. We follow all HIPA Laws and your privacy will be protected.

Check any stresses or traumas you have experienced throughout your life. Please elaborate on the most impactful of each in the lines following each category, including approximate dates of these incidents. If you need more space, please use a separate sheet of paper and attach it to this packet.

PHYSICAL:

__Broken Bones __Major Muscle Injuries __Vehicle Accidents __Big Falls __Concussions
__Injuries Requiring Stitches/Staples/Glue __Complications w/ Pregnancies or Childbirths __Other
Please Explain:_____
_____
_____
_____
_____
_____

EMOTIONAL:

__Major family issues (as a child or through adulthood) __Impactful Divorces (yours or your parents)
__Major Relationship Issues (intimate partners or friends) __Abuse of Any Kind __Death/Grief
__Major Financial or Work Stresses __Other
Please Explain:_____
_____
_____
_____
_____
_____

CHEMICAL:

__Prolonged Exposure to Chemicals, Molds, or Mildew __Long-term Medications (No longer taking)
__Prolonged Poor Diet (any time in life) __Caffeine Usage (excessive or consistent)
__Tobacco Use, Currently or Previous __Drug Use, Current or Previous
__Excessive Alcohol Consumption, Current or Previous __Other
Please Explain:
_____
_____
_____
_____
_____
_____

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 licensed acupuncturists practicing at the Clinics of East Wind Wellness, and East Wind Acupuncture, Inc.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, low-current electrical stimulation, Tui Na (Chinese medical massage), Korean hand acupressure/acupuncture (Sooji), Chinese herbal medicine, and nutritional/diet therapy. I understand that the herbs may be in tea pill or capsule form, or may need to be prepared and consumed according to the instructions provided orally and in writing. The medicinal herb teas may have an unpleasant aroma or taste. I will immediately notify the Clinic 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, temporary numbness or tingling near the needling sites that may last up to a day or two after treatment, and dizziness or fainting. Temporary discoloration is a common side effect of both cupping and guasha. Unusual side effects of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the Clinic uses sterile, single-use disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 have been used on humans for several centuries and 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, stomach-ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a Clinic Staff member who is caring for me if I am or become pregnant.

It is common to have points that can be hard to see once inserted, especially in hair/shirts/towels. On a rare occasion a needle can be forgotten. You have two options: 1. Remove the needle yourself and place it in the center of the acupuncture table and let a staff member know. **NEVER PLACE NEEDLE INTO THE MEDICAL WASTE BUCKET YOURSELF**. 2. Call out for a staff member to come in and remove the needle.

I do not expect the Clinic Staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the Clinic Staff to exercise judgment during the course of treatment which the Clinic Staff thinks at the time, based on the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the Clinic Staff and Administration may review my patient records and 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.

Patient signature Date (Relationship if signing for Patient)