Health History (Long)

Please list your most important health concerns. Include how long the issue has been going on.

Health Concern #1 *

Please rate the intensity of Concern #1 on a scale of 0-10.

(0 being that it doesn't affect your life at all, 10 being that it causes extremel adverse affects to your quality of life.)

Health Concern #2

Please rate the intensity of Concern #2 on a scale of 0-10.

(0 being that it doesn't affect your life at all, 10 being that it causes extremel adverse affects to your quality of life.)

Health Concern #3

Please rate the intensity of Concern #3 on a scale of 0-10.

(0 being that it doesn't affect your life at all, 10 being that it causes extremel adverse affects to your quality of life.)

General Health

Do you have a pacemaker? *

- ☐ **Yes**
- ☐ **No**

Have you ever had acupuncture? *

- ☐ **Yes**
- ☐ **No**

Are you, or is there any chance, that you are pregnant?

- ☐ **Yes**
- ☐ **No**

If you are pregnant, please include:

1) Your due date and 2) General information about how your pregnancy is going so far

Do you have any known communicable diseases at this time? *

- ☐ **MRSA**
- ☐ **HIV**
- ☐ **Hepatitis A, B, C, D or E**

- [ ] **TB**
- [ ] **other**
- [ ] **NONE**

Please list any communicable disease not listed above

Height *

Weight *

Preferred Weight

Typical Bedtime

Hours of Sleep Per Night

Medications/Supplements/Herbs

Please list any ALLERGIES. If none, please say none. *

Please list all PRESCRIPTION MEDICATIONS and over-the-counter DRUGS.

Please including dose, how often, when you began, and reason for taking.

Please list all VITAMINS, HERBS and SUPPLEMENTS

Please including dose, how often, when you began, and reason for taking.

Diet and Lifestyle

Please check any that apply *

- [ ] **Do feel safe in your home?**
- [ ] **Do you feel unsafe in your home?**
- [ ] **Do you use alcohol?**
- [ ] **Do you smoke tobacco?**
- [ ] **Do you use marijuana?**
- [ ] **Do you use illicit drugs, such as cocaine, meth, heroin, or any other?**
- [ ] **Do you use prescription pain killers?**

Comments

Do you follow a prescribed diet or have food restrictions? If so, please describe.

Do you live alone, married, single, divorced?

Please describe a typical day of meals.

Have you ever taken antibiotics?

- [ ] **Yes**
- [ ] **No**

If yes, please describe:

Medical History

Please list all major traumas/accidents: *

Please include surgeries, breaks/fractures, potentially fatal bites/stings, cuts requiring stitches, scars longer than 1/2 inch, root canals/fillings/tooth extractions/etc, episiotomy or severe tearing, epidural or other spinal procedure, dislocated joints (including spinal vertebra), head trauma, car/bike/pedestrian accident, etc. If no major traumas, state "none".

Please list any major illnesses or diseases, including those that you may have had in childhood

Please include any cancer, kidney disease, tuberculosis, alcoholism or other drug addiction, diabetes, epilepsy, stroke, obesity, reproductive problems, sexually transmitted diseases, heart disease, arthritis, anemia, cholesterol, blood pressure, mental illness, blood disorders and problems with sense organs.

Do you have a family history of any of the following conditions? If so, which condition and who was affected? *

Please include any cancer, kidney disease, tuberculosis, alcoholism or other drug addiction, diabetes, epilepsy, stroke, obesity, reproductive problems, sexually transmitted diseases, heart disease, arthritis, anemia, cholesterol, blood pressure, mental illness, blood disorders and problems with sense organs.

Please include any recent tests (and results) that you've had in the last year.

Review of Systems

Respiration

- [ ] **Asthma**
- [ ] **Allergies**
- [ ] **Chronic bouts of bronchitis**
- [ ] **Frequent colds**
- [ ] **Deep, shallow, unusual breathing**
- [ ] **Phlegm, sputum**
- [ ] **Feels like something is stuck in the throat**
- [ ] **Emphysema**
- [ ] **Cough**
- [ ] **Chest tightness**

Smoker? Yes or No? (If yes, please include the number of packs smoked per day and the total number of years you have smoked.)

Any other notes on respiration?

Headaches

- [ ] **Stuffy and through the whole head**
- [ ] **Sinus related**
- [ ] **Sides of the head**
- [ ] **Top of the head**
- [ ] **Back of the head**
- [ ] **Brow area, near the bridge of the nose**
- [ ] **Forehead area**
- [ ] **Temples, at the outer part of the eye**

Any other notes on headaches?

Eyes

- [ ] **Painful**
- [ ] **Itchy**
- [ ] **Swollen, puffy, tender**
- [ ] **Bloodshot, red**
- [ ] **Dry, gritty**
- [ ] **Blurry vision**
- [ ] **Night blindness**
- [ ] **Light sensitive**
- [ ] **Cataracts**
- [ ] **Glaucoma**
- [ ] **Glasses, contacts**
- [ ] **Floaters**

Other issues with the eyes?

Nose

- [ ] **Frequent nosebleeds**
- [ ] **Clear, runny discharge**
- [ ] **Chronic sinusitis**

Other issues with your nose?

Ears

- [ ] **Ringing, high pitched**
- [ ] **Constant ringing**
- [ ] **Low buzz, cicada sounds**
- [ ] **Hearing loss**

- [ ] Buildup of ear wax
- [ ] Frequent ear infections
- [ ] Ear pain
- [ ] Swelling

Other issues with your ears?

Mouth, Throat, Teeth

- [ ] Cavities
- [ ] Discoloration on teeth
- [ ] Tooth pain, sensitivity
- [ ] Grinding teeth
- [ ] Bad breath
- [ ] Bleeding gums
- [ ] Gum disease (periodontitis)
- [ ] Abscess
- [ ] Canker sores, ulcers
- [ ] Sore throat
- [ ] Tonsils removed
- [ ] Snoring

Other issues with your mouth, throat or teeth?

Skin

- [ ] Acne
- [ ] Boils
- [ ] Dry, often have to apply lotion
- [ ] Itching
- [ ] Rashes
- [ ] Hives
- [ ] Recent new moles or marks
- [ ] Warts
- [ ] Poor wound healing
- [ ] Lumps, nodules, cysts
- [ ] Bruise easily
- [ ] Cancers

Any other skin issues?

Hair

- [ ] Changing from curly to straight or vice versa
- [ ] Thinning
- [ ] Falling out in clumps
- [ ] Premature gray

- [ ] Dandruff
- [ ] Oily
- [ ] Dry

Other issues with your hair?

Nails

- [ ] Thin, brittle
- [ ] Ridges, pitting
- [ ] Fungus
- [ ] Discoloration
- [ ] White spots
- [ ] Clubbing
- [ ] "Spoon nails"
- [ ] Separating from nail beds

Other issues with your nails?

Blood/Cardiovascular

- [ ] Anemia
- [ ] Palpitations
- [ ] Irregular heartbeat
- [ ] Chest pain
- [ ] Heart disease
- [ ] Rheumatic fever
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Blood clots/thrombi/emboli
- [ ] Swelling hands/feet
- [ ] Stroke
- [ ] Shortness of breath
- [ ] Varicose veins
- [ ] Easy/frequent bruising
- [ ] Fainting

Other issues with blood/cardiovascular?

Do you give blood? How often?

Gastrointestinal

- [ ] Eating disorder
- [ ] Reflux, GERD, heartburn
- [ ] Pain after eating
- [ ] Abdominal pain, cramps

- [ ] Low appetite
- [ ] High appetite
- [ ] Hungry even after eating
- [ ] Gas, bloating, indigestion
- [ ] Bad breath, gas or stool
- [ ] Ulcers
- [ ] Nausea
- [ ] Vomiting

Food SENSITIVITIES (please include TRUE ALLERGIES at the top of the form)

Liver, Gallbladder, Pancreas

- [ ] Gallstones
- [ ] Diabetes
- [ ] Low blood sugar
- [ ] High blood sugar
- [ ] Liver disease
- [ ] Hepatitis

Any other liver, gallbladder or pancreas issues?

Elimination

- [ ] Constipation
- [ ] Loose stool
- [ ] Diarrhea
- [ ] Liquid diarrhea upon waking up
- [ ] Alternating constipation and diarrhea
- [ ] Floating stool
- [ ] Difficult, slow bowel movements
- [ ] Abnormal colored stool (green, white, clay colored, etc) - please include details in box below
- [ ] Sticky stool (hard to wipe)
- [ ] Bowel movements feel "incomplete"
- [ ] Undigested food in stool
- [ ] Stool like pebbles
- [ ] Pencil thin stool
- [ ] Mucus in stool
- [ ] Bright red blood in stool
- [ ] Coffee colored stool
- [ ] IBS, IBD, Colitis, Crohn's
- [ ] Polyps, fissures, prolapse
- [ ] Hemorrhoids

Anything else about your bowel movements?

Urination

- [ ] Frequent
- [ ] Weak stream
- [ ] Incomplete
- [ ] Incontinence
- [ ] Painful
- [ ] Urgent
- [ ] Waking to pee in the night
- [ ] Bed wetting

Kidney/Bladder

- [ ] Frequent bladder infections
- [ ] Urinary tract infections
- [ ] Kidney stones
- [ ] IC, cystitis
- [ ] Kidney disease
- [ ] Cysts
- [ ] Pain in mid-back

Any other issues with your kidney or bladder?

Immune

- [ ] Epstein Barr Virus
- [ ] MRSA
- [ ] Candidiasis
- [ ] Mononucleosis
- [ ] Frequent colds
- [ ] Complete lack of colds/flu - "never sick"
- [ ] HIV/AIDS
- [ ] Prolonged recovery from illness
- [ ] Chronic fatigue syndrome
- [ ] Swollen lymph nodes
- [ ] Chronic infections

Cancer: Please specify

Other immune issues

Endocrine/Energy

- [ ] Abdomen, cold
- [ ] Easily weak, dizzy
- [ ] Pituitary disorder
- [ ] Addison's disease
- [ ] Night sweating

- [ ] Easily overheated/chilled
- [ ] Spontaneous sweating
- [ ] Cushing's syndrome
- [ ] Weight gain
- [ ] Diabetes Mellitus Type I
- [ ] Diabetes Type II
- [ ] Hot feeling all over
- [ ] Cold feeling all over
- [ ] Significant, unintended weight loss
- [ ] Difficulty rising from bed in the morning
- [ ] Gestational diabetes
- [ ] Hypoglycemia
- [ ] Weakness after sex
- [ ] Hypothyroid
- [ ] Hyperthyroid
- [ ] Lethargy, desire to sleep a lot

Other endocrine/energy issues?

Neurological

- [ ] Concussion, history of
- [ ] Loss of balance, coordination issues
- [ ] Paralysis
- [ ] Dizziness
- [ ] Double vision
- [ ] Stuttering, speech problems
- [ ] Facial ticks
- [ ] Difficulty swallowing
- [ ] Numbness in extremities

Other neurological issues that you have or have had?

Mental-Emotional

- [ ] Agitation
- [ ] Easily frightened
- [ ] Anxiety, excitable
- [ ] Withdrawn socially
- [ ] Overly talkative
- [ ] Bored
- [ ] Panic attacks
- [ ] Insomnia
- [ ] Difficulty falling asleep
- [ ] Restless

- [ ] **Stage fright**
- [ ] **Shy**
- [ ] **Joylessness, hopelessness**
- [ ] **Nervous**
- [ ] **Easily confused**
- [ ] **"Monkey mind," overly busy mind**
- [ ] **Apathetic**
- [ ] **Depression, deep and dark**
- [ ] **Depression, agitated**
- [ ] **Depression, grieving**
- [ ] **Depression, quiet rage**
- [ ] **Dull mind, forgetful**
- [ ] **Manic depressive**
- [ ] **Addictions**
- [ ] **Angry outbursts, bad temper, explosive**
- [ ] **Difficult decision making**
- [ ] **Frustrated easily**
- [ ] **Scared of the dark**
- [ ] **Sad**
- [ ] **Grief, unresolved**
- [ ] **Easily disappointed**
- [ ] **Poor self-esteem**
- [ ] **Poor self-confidence**
- [ ] **Overly sympathetic**
- [ ] **Constant worrying**
- [ ] **Obsessive compulsive**
- [ ] **Clingy**
- [ ] **Emotional Eating**
- [ ] **Want to fix other's problems**
- [ ] **Hoarding**
- [ ] **Decreased motivation**
- [ ] **Disturbing dreams**
- [ ] **Suicide, thoughts**
- [ ] **Suicide, attempted**

Other mental/emotional comments?

Male reproductive

- [ ] **Swollen testes**
- [ ] **Testicular pain**
- [ ] **Penile pain**
- [ ] **Penile discharge**

- [ ] **Penile sores**
- [ ] **Rashes, skin issues in groin**
- [ ] **Erectile difficulty**
- [ ] **Premature ejaculation**
- [ ] **Pain after sex**
- [ ] **Feeling of coldness in genitalia**
- [ ] **Feeling of numbness in genitalia**
- [ ] **Hernia**
- [ ] **Prostate disease**
- [ ] **Blunt trauma to groin**
- [ ] **Low libido**
- [ ] **High libido**
- [ ] **Lack of responsiveness/sensitivity**
- [ ] **Frequent (daily) bicycle riding**
- [ ] **Inability to conceive**

Other male reproductive comments?

Men are done here, the rest of the form is for Female Reproductive

Female Reproductive

Menstruation

- [ ] **Bright red blood**
- [ ] **Brown blood**
- [ ] **Darkly colored blood**
- [ ] **Clots**
- [ ] **Excessive bleeding**
- [ ] **Very little bleeding**
- [ ] **Tampons**
- [ ] **Breast tenderness**
- [ ] **Moodiness beforehand**

Age of first menses?

Average # of days of bleeding?

Average length of cycle (from first day of bleeding (Day 1) until the day before bleeding starts again).

Cramping/Pain during menses? If so, please rate on a scale of 0-10:

Ovaries, Uterus, Fallopian tubes, Vagina

- [ ] **Ovarian cysts**
- [ ] **Uterine prolapse**
- [ ] **Vaginal discharge**
- [ ] **Yeast infections**

- [ ] Vaginal odor
- [ ] Vaginal dryness
- [ ] Endometriosis

C-section? If so, how long ago?

Hysterectomy? If yes, reason and type.

Fibroids? If yes, size?

Breasts

- [ ] Tenderness
- [ ] Lumps
- [ ] Fibrocystic breast changes
- [ ] Discharge

Intercourse

- [ ] Sexually active
- [ ] Pain during intercourse
- [ ] Pain after intercourse
- [ ] High libido
- [ ] Low libido
- [ ] Lack of responsiveness/sensation

Fertility

- [ ] Difficulty conceiving?
- [ ] In-vitro fertilization
- [ ] Traumatic Birth
- [ ] Postpartum problems

Other female reproductive comments?

# of pregnancies?

Live births? Vaginal births? C-sections? VBAC?

Miscarriages?

Abortions?

Menopause

- [ ] Hot flashes
- [ ] Emotional swings
- [ ] Night sweats
- [ ] Dizziness

- [ ] **Fatigue**
- [ ] **Absent minded**
- [ ] **Restless sleep, insomnia**
- [ ] **Cold pain at waist or knees**
- [ ] **Headaches**
- [ ] **Breast distention**
- [ ] **Thirst**
- [ ] **Vaginal dryness**
- [ ] **Hot palms and soles of feet**
- [ ] **Cold limbs**
- [ ] **Tinnitus**
- [ ] **Loose teeth**
- [ ] **spontaneous sweats, night**

Age at which menopause started?

Other menopausal symptoms you experienced or are experiencing?

AAC ARBITRATION AGREEMENT

ARBITRATION AGREEMENT

PATIENT NAME *

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here.

Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE *

(Or Patient Representative: Indicate relationship if signing for patient.)

(Date) *

OFFICE SIGNATURE

(Date)

Acupuncture Informed Consent to Treat

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist,that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with,or serving as back-up for the acupuncturist named below, including those working at the clinic or office.

I understand that methods of treatment may include, but are not limited to acupuncture, acupuncture points injections, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, and Low Level Laser Therapy (Biophotomodulation).

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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. I will notify a clinical staff member who is caring for me if I am, or become pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While 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 then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform this office of any medical history, family history, medications and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME: _____

ACUPUNCTURIST NAME: _____
Patient (or Patient representative) Signature and Date: *

Date *

(Indicate relationship if signing for patient)