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 print and complete as thoroughly as possible. Your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA) and is held strictly confidential.

Name: ____ **Date**: ____________
(first) (middle) (last)

Street ______________________________ City ________________ State _____ Zip________

Phone: Cell ____________________ Home ________________ Work__________________

Email: ______________________________**Is it ok to contact you by?** Phone___ Text___ Email___

Date of Birth: _____/_____/_____ **Age**: _____ **Gender**: ____________ Height: ______ Weight: ______

Marital Status: M__ S__ D__ W__ P__ **Occupation**:______________ Veteran__ Retired ___Disabled __

Physician: __________________________ **Referred by**: ___________________________

Emergency Contact: ________________________________ **Relation to you**: ____________

Emergency Contact Number: Cell ____________ Home ____________ Work ______________

Have you ever been treated by acupuncture or oriental medicine before? yes _____ no ______

Main problem you would like us to help you with: ____________________________________

____

What makes it better?____

What makes it worse? ____

How is it affecting your daily activity? ____

When/how did this problem start? ____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom? ____________

____

What other kinds of treatment have you tried? ☐ Western Medicine ☐ Acupuncture ☐ Herbs ☐ Massage

☐ Physical Therapy ☐ Chiropractor ☐ Reiki ☐ Homeopathy ☐ Other:__________________________

How confident are you that you can resolve the symptoms of your main complaint with acupuncture and Chinese herbal medicine?
☐ Not confident ☐ Slightly confident ☐ Moderately confident ☐ Confident ☐ Very confident

Secondary complaints you would like us to help you with: ______________________________

____

Past Personal Medical History of Significant Illnesses: ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Cancer
☐ Stroke ☐ Heart Disease ☐ High Blood Pressure ☐ Seizures ☐ Hepatitis ☐ Rheumatic Fever
☐ Thyroid Disease ☐ Venereal Disease ☐ Other: ____________________

Any history of infectious disease? (Hepatitis, HIV, MRSA, etc.):____________________

Hospitalizations/Surgeries (include dates): ____________________

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____

____

Significant Trauma (auto accidents, falls, fractures, burns, etc.): ____________________

____

____

Allergies (drugs, chemicals, metals, foods): ____________________

Family Medical History: ☐ Asthma ☐ Allergies ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Heart Disease ☐ Seizures
☐ High Blood Pressure ☐ Hepatitis ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Other: ____________________

Medications (prescriptions, vitamins, herbs, etc.): ____________________

____

____

Are there any areas of your life that you find stressful? Please explain: ____________________

____

Do you have a regular exercise program? P**lease describe:** ____________________

____

Do you follow any type of special diet (vegetarian, gluten free, medical related, other)?: ____________________
Is the majority of your food processed/pre-made? ____________________ **Or fresh?** ____________________

Describe your average daily diet:
Morning: ____________________
Midday: ____________________
Evening: ____________________

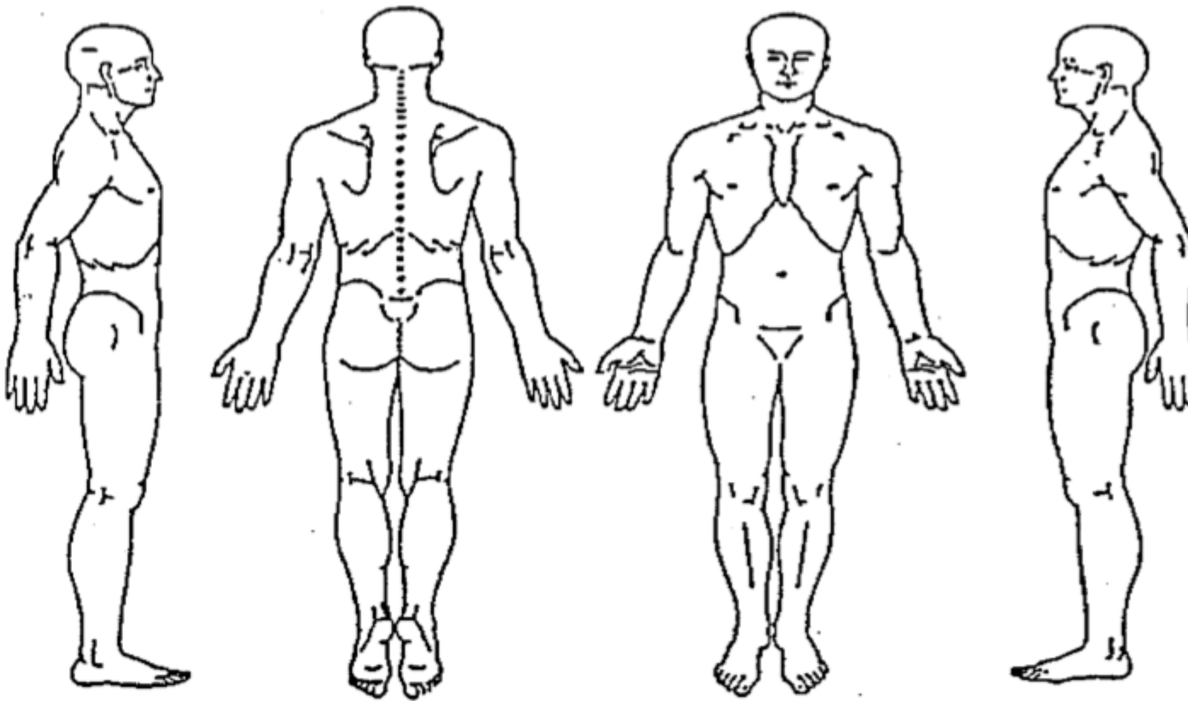
Do you smoke? ☐ No ☐ Yes **How many per day?___How long since quitting? ___Interested in quitting?___**

How many cups of caffeinated coffee/tea/cola do you drink per day? ________________________________

How many 8 oz. glasses of water do you drink per day? ____

How many alcoholic beverages do you drink per day (or week)? ____________________________________

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



Please indicate any painful or distressed body areas by circling the affected area:

Please explain above if necessary:

____

____

***<u>Please check ☐ if you've ever had any of the following (esp. if in the past 3 months)</u>*:**

<u>General</u>

☐ Fevers ☐ Chills ☐ Sweat Easily ☐ Night Sweats ☐ Prefer Hot/Cold Temp. ☐ Poor Sleep

☐ Weight Loss ☐ Weight Gain ☐ Cravings ☐ Change in Appetite ☐ Lack of Thirst ☐ Strong Thirst

☐ Prefer Hot Drinks ☐ Prefer Cold Drinks ☐ Strange Tastes or Smell ☐ Bruise/Bleed Easily ☐ Fatigue

☐ Sudden Energy Drop, if so, what time of day? ____

Skin & Hair

☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema ☐ Dry
☐ Pimples/Acne ☐ Dandruff ☐ Hair Loss ☐ Recent Moles ☐ Psoriasis ☐ Scars
☐ Dermatitis ☐ Bruise Easily ☐ Change in hair/skin texture ☐ Other skin/hair problems? ___________

Head, Eyes, Ears, Nose & Throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses ☐ Eye Strain
☐ Eye pain ☐ Poor Vision ☐ Night Blindness ☐ Color Blindness ☐ Cataracts
☐ Blurry Vision ☐ Earaches ☐ Spots in front of eyes ☐ Ringing in ears ☐ Poor Hearing
☐ Sinus Problems ☐ Nosebleeds ☐ Recurrent Sore Throat ☐ Grinding Teeth ☐ Clenching Jaw
☐ Facial Pain ☐ Teeth Problems ☐ Sores on Lips/Tongue ☐ Jaw Clicks ☐ Trouble Swallowing
☐ Headaches, where on head and when? ____
☐ Any other head or neck problems? ____

Cardiovascular

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Fainting ☐ Irregular Heart Beat
☐ Palpitations ☐ Palpitations at Rest ☐ Difficulty Breathing ☐ Blood Clots ☐ Phlebitis
☐ Cold Hands/Feet ☐ Swelling of Hands ☐ Swelling of Feet ☐ Varicose or Spider Veins
☐ Any other heart or blood vessel problems? ____

Respiratory

☐ Cough ☐ Coughing Blood ☐ Asthma ☐ Bronchitis ☐ Pneumonia
☐ Pain with Deep Breath ☐ Chest Tightness ☐ Shortness of Breath ☐ Difficulty Breathing Lying Down
☐ Difficulty Breathing with Exertion ☐ Frequent Colds ☐ Phlegm production, what color? _____ ☐ Other_______

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Black Stools
☐ Blood in Stools ☐ Hemorrhoids ☐ Rectal Pain ☐ Gas ☐ Belching
☐ Indigestion ☐ Acid Reflux/GERD ☐ Bloating/Edema ☐ Hernia ☐ Colitis
☐ IBS/Crohn’s Disease ☐ Food Stagnation ☐ Poor Appetite ☐ Excess Appetite ☐ Bad Breath
☐ Bleeding Gums ☐ Slow Digestion ☐ Loose Stools > 2x per day ☐ Abdominal pain ☐ Other___

Genitourinary

☐ Frequent Urination ☐ Blood in Urine ☐ Pain with urination ☐ Urgency to Urinate ☐ Unable to Hold Urine
☐ Kidney Stones ☐ Decrease in Flow ☐ Flow Start and Stop ☐ History of UTI ☐ Cloudy Urine
☐ Impotency/ED ☐ Sores on Genitals ☐ Color of Urine ___________ ☐ Do you Wake at Night to Urinate?
How many times ______ ☐ Any other problems with genital or urinary system? _____________________________

GYN or Male Concerns (please fill out even if post menopause)

Are you pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Is it possible you are pregnant? ☐ Yes ☐ No

Do you use Birth Control? ☐ Yes ☐ No ☐ What type? ____________ How long using?_____

Number of Pregnancies _____ Live Births _____ Premature Births ______ Miscarriages _______ Abortions _____

Any problem with pregnancies or fertility?____

Age at First Menses _____ Duration of Menses _____ Time Between each Cycle ______ Age at Menopause______

Color of Menstrual Blood (dark, bright, red, purple, etc.) ____

Character of Blood (heavy, scanty, etc.) ____

☐ Cramps/Painful Periods, which days? _________________ ☐ Clots, Size, Color, which days? _______________

☐ PMS Symptoms ____

☐ Irregular Periods ☐ Breast Lumps ☐ Vaginal Discharge, color ___________ ☐ Vaginal Dryness

☐ Vaginal Sores ☐ Uterine Fibroids ☐ Polycystic Ovarian Syndrome ☐ Fibrocystic Breasts

☐ Any Male concerns? ____

☐ Erectile Dysfunction ☐ Prostatitis ☐ BPH ☐ Other ____

Musculoskeletal

☐ Neck Pain ☐ Shoulder Pain ☐ Rotator Cuff ☐ Elbow Pain ☐ Hand/Wrist Pain

☐ Carpal Tunnel ☐ Hip Pain ☐ Sciatica ☐ Knee Pain ☐ Foot/Ankle Pain

☐ Morton's Neuroma ☐ Plantar Fasciitis ☐ Muscle Pain/Spasm ☐ Sprains/Strains ☐ Tendonitis

☐ Bursitis ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Lyme Disease

☐ Soreness/Weakness of lower body. Where?________________ ☐ Back Pain: Low _____ Middle____ Upper____

☐ Other____

Neurological & Psychological

☐ Seizures ☐ Dizziness ☐ Loss of Balance ☐ Numbness ☐ Poor Memory

☐ Concussion ☐ Poor Coordination ☐ Bad Temper ☐ Anxiety ☐ Depression

☐ Bipolar ☐ Nervousness ☐ ADD/ADHD ☐ Easily Susceptible to Stress

☐ Have you ever been treated for Emotional Problems? ☐ Yes ☐ No

☐ Have you ever considered or attempted suicide? ☐ Yes ☐ No

☐ Any other neurological or psychological problems? ____

____

Other Problem/Concern: ____

____

____

Cancellation Policy

All appointments must be **cancelled** a ***minimum of 24 hours*** prior to the appointment time. If this is not possible, you may be charged a nominal fee for your missed appointment. Our time is valuable and we have other clients who may have been able to use that time if we'd known early enough to be able to offer it to them. This policy does not apply during inclement weather (safety first!) and life's emergencies sometimes get in the way of a policy and that will certainly be taken into consideration. If you ***no show***, you will be charged a **$30** fee. Thank you for understanding! *Please initial:*_____

Consent to Treat

I, ____, hereby authorize Valerie Ketch, Lic. Ac., to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

(*Please circle any you **DO NOT GIVE** your consent for*)

1) **Acupuncture needles** of various styles and lengths are used for insertion into the body at various depths and locations.

2) **Heat** treatments are administered using Artemesia vulgaris (mugwort, moxa, moxibustion) or a conventional heat lamp. *Indirect* moxibustion treatments involve putting moxa on the head of a needle or on top of a barrier such as salt or a slice of ginger. When *direct* moxibustion is used, the moxa is placed on the skin over a thin layer of barrier cream. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat treatment, there is always a risk of a burn.

3) **Gua sha,** a massage/scraping technique to relieve stagnation, may leave a red/purple discoloration on the skin that can last 1-5 days. Slight "bruising"/discoloration and tenderness may persist after the treatment.

4) **Cupping** may be used to promote the circulation of Qi (energy) through the meridians. Cups may produce a red/purple discoloration on the treated areas lasting for 1-5 days.

5) **Electrical stimulation** of the needles may be used which produces a vibrating or tapping sensation. **Ion pumping cords** (*non-electrical*) may be attached to the needles to facilitate the flow of energy in the body.

6) **Bloodletting**, alone or in conjunction with cupping, may be used to improve circulation in specific meridians. Sterile lancets are inserted into the skin and a small amount of blood is expressed from the puncture.

7) **Chinese Herbal Medicine** in various forms (pills, capsules, extract powders, and raw herbs) may be administered orally and/or topically. Some patients may experience side effects from their particular prescription. Please inform your acupuncturist of any adverse effects you may be experiencing no matter how minor.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of the treatment.

Signature of Patient/Guardian: ____

Print Name/Relationship____