HEALTH HISTORY QUESTIONNAIRE

*DATE:*____________________

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on the form, please note it in the COMMENTS section. Thank you.

NAME:______________________________ Phone: H______________ W____________

ADDRESS:________________________ CITY:______________ STATE:____ ZIP:________

AGE:____ DATE OF BIRTH:__________ PLACE OF BIRTH:________________________

HEIGHT:______ WEIGHT:______ MARITAL STATUS:_______

EMPLOYER NAME:________________________ OCCUPATION:____________________

FAMILY PHYSICIAN:________________________ REFERRED BY:__________________

IN EMERGENCY NOTIFY:______________________________ PHONE:______________

E-MAIL ADDRESS (optional)____

Have you been treated by Acupuncture or Oriental Medicine before? Yes____ No____

Main problem(s) you would like us to help you with:______________________________

____

How long ago did this problem begin (be specific)?________________________________

____

To what extent does this problem interfere with your daily activities (work, sleep, sex)?__________

____

Have you been given a diagnosis for this problem? If so, what?______________________

__________________________ Date of last physician visit?__________________________

What kinds of treatment have you tried?______________________________________

____

PAST MEDICAL HISTORY: (please include date):

Cancer________________ Diabetes________________ Hepatitis________________

High Blood Pressure______________ Heart Disease____________ Rheumatic Fever__________

Thyroid Disease_____________ Venereal Disease_________ Other____________________

Surgeries (type and date):____

____

Significant Trauma (auto accidents, falls, etc.)__________________________________

____

Significant Dental Work (type and date):_____________________________________

Birth History (prolonged labor, forceps delivery, etc.):___________________________

Allergies (drugs, chemicals, foods/result):____________________________________

____

Family Medical History (check): **Diabetes**____ **Cancer**____ **Heart Disease**____ **Stroke**____ **Seizures**____ **Asthma**____ **Allergies**____ **High Blood Pressure**____ **Other**________________

Medicines taken within the last two months (vitamins, drugs, herbs, etc.)________________

____

____

Occupational Stress (chemical, physical, psychological, etc.)________________

____

Do you have a regular exercise program? Yes___ **No**___ **Please describe:**________________

____

Have you ever been on a restricted diet? Yes___ **No**___ **Please describe:**________________

____

PLEASE DESCRIBE YOUR AVERAGE DAILY DIET:

Morning:________________________________

Afternoon:________________________________

Evening:________________________________

How many packs of cigarettes do you smoke per day?________________

How much coffee, tea or cola do you drink per week?________________

How much alcohol do you drink per week?________________

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

PLEASE CHECK ANY YOU HAVE HAD IN THE LAST 3 MONTHS

GENERAL

- ___ Chills
- ___ Fevers
- ___ Sweat easily
- ___ Night sweats
- ___ Localized weakness
- ___ Bleed or bruise easily
- ___ Peculiar tastes or smells
- ___ Strong thirst (cold or hot)
- ___ Thirst, no desire to drink
- ___ Fatigue
- ___ Sudden energy drop
  - Time of day?________
- ___ Edema
  - Where?________
- ___ Poor sleeping
- ___ Tremors
- ___ Poor balance
- ___ Cravings
- ___ Change in appetite
- ___ Poor appetite
- ___ Weight gain
- ___ Weight loss

SKIN AND HAIR

- ___ Rashes
- ___ Itching
- ___ Change in hair or skin
- ___ Ulcerations
- ___ Eczema
- ___ Oozing on skin lesion
- ___ Hives
- ___ Pimples
- ___ Recent moles
- ___ Loss of hair
- ___ Dandruff
- ___ Other hair or skin problems:________

HEAD, EYES, EARS, NOSE AND THROAT

- ___ Dizziness
- ___ Migraines
- ___ Headaches
  - When:________
  - Where:________
- ___ Facial pain
- ___ Glasses
- ___ Poor vision
- ___ Night blindness
- ___ Blurry vision
- ___ Color blindness
- ___ Blind field
- ___ Spots in front of eyes
- ___ Eye pain
- ___ Eye strain
- ___ Cataracts
- ___ Eye dryness

___ Excessive tearing
___ Discharge from eyes
___ Poor hearing
___ Ringing in ears
___ Earaches
___ Discharge from ear
___ Nose bleeds
___ Sinus congestion
___ Nasal drainage
___ Grinding teeth
___ Teeth problems
___ Jaw clicks
___ Concussions
___ Recurrent sore throats
___ Hoarseness
___ Sores on lips or tongue
Other head or neck problems: ______________________

CARDIOVASCULAR

___ High blood pressure
___ Low blood pressure
___ Chest discomfort/pain
___ Heart palpitations
___ Cold hands or feet
___ Swelling of hands
___ Swelling of feet
___ Blood clots
___ Fainting
___ Difficulty in breathing
Other heart or blood vessel problems: ______________________

RESPIRATORY

___ Cough
___ Asthma/wheezing
___ Pain with deep breath
___ Difficulty breathing when lying down
___ Production of phlegm
What color? __________
___ Coughing blood
___ Pneumonia
___ Bronchitis
Other lung problems: ______________________

GASTROINTESTINAL

___ Bad breath
___ Nausea
___ Vomiting
___ Belching
___ Indigestion
___ Diarrhea
___ Constipation
___ Chronic laxative use
___ Blood in stools
___ Black stools
___ Abdominal pain or cramps
___ Gas
___ Rectal pain
___ Hemorrhoids
Other stomach or intestinal problems: ______________________

GENITOURINARY

___ Pain on urination
___ Urgency to urinate
___ Frequent urination
___ Blood in the urine
___ Decrease in flow
___ Unable to hold urine
___ Dribbling
___ Kidney stones
___ Impotency
___ Change of sexual drive
___ Sores on genitals
Other genital or urinary system problems: ______________________

Do you wake up to urine?
Yes___ No___ How often? ______________________

Any particular color to your urine? ______________________

PREGNANCY/GYNECOLOGY

___ Number of pregnancies
___ Number of births
___ Premature births
___ Miscarriages
___ Abortions
___ Age at first menses
___ Period between menses
___ Duration
___ First date of last menses
___ Usual character (heavy or light)
___ Painful periods
___ Irregular periods
___ Changes in body/psyche prior to menstruation
___ Clots
___ Menopause: Age_____ yrs
___ Vaginal discharge
___ Postcoital bleeding
___ Vaginal sores
___ Last Pap
___ Breast lumps
___ Nipple discharge
Do you practice birth control
Yes____ No___
What type and for how long?
____

MUSCULOSKELETAL

___ Neck pain
___ Shoulder pain
___ Back pain
___ Elbow pain
___ Hand/wrist pain
___ Hip pain
___ Knee pain
___ Foot/ankle pain
___ Muscle pain
___ Muscle weakness

NEUROPSYCHOLOGICAL

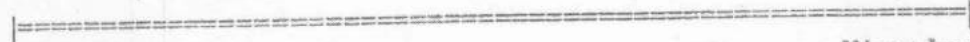
___ Seizures
___ Areas of numbness
___ Weakness
___ Sleep disorder
___ Concussion
___ Bad temper
___ Loss of control/violence potential
___ Vertigo
___ Lack of coordination
___ Depression
___ Easily susceptible to stress
___ Loss of balance
___ Poor memory
___ Anxiety
___ Substance abuse
Other neurological or psychological problems: ______________________

Have you ever been treated for emotional problems?
Yes____ No____
Have you ever considered or attempted suicide?
Yes____ No____

PLEASE NOTE THE DEGREE OF SEVERITY OF YOUR PROBLEM NOW:

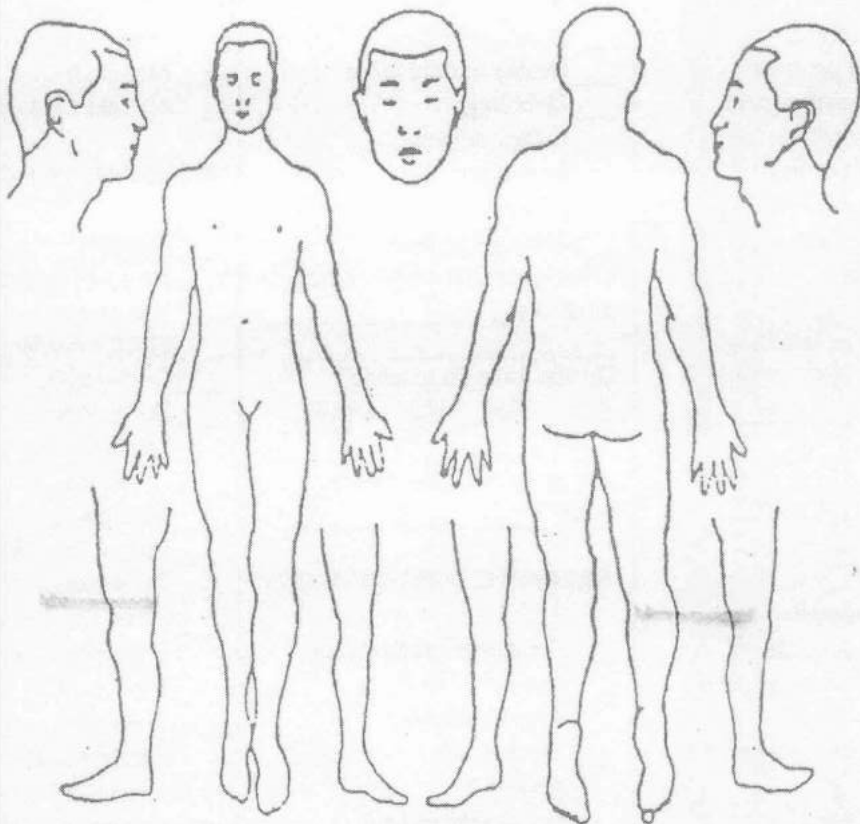
No Problem — Worst Imaginable

PLEASE NOTE THE GREATEST DEGREE OF SEVERITY OF YOUR PROBLEM WITHIN THE LAST WEEK:



No Problem — Worst Imaginable

INDICATE PAINFUL OR STRESSED AREAS:



COMMENTS: (Please tell us any other problems you would like to discuss):______

______

______

______

Informed Consent Agreement, please sign.

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 named below, and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as backup for the acupuncturist named below, including those at the clinic or office listed below, or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Oriental herbal medicine, nutritional counseling, and Tui-Na (Oriental massage). I understand that the herbs may need to be prepared, and the teas consumed according to the instructions provided orally or in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical 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 may have some side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, 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. 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, animal, or mineral source) that may be recommended are traditionally considered safe in the practice of Oriental 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 will notify a clinical staff member who is caring for me if I am, or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed.

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.

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 X____________________ Date____________
(Or Patient representative) (Indicate relationship if signing for patient)

Office Signature____________________ Date____________

Complementary Medicine & Healing Arts 31 Adams Ave Endicott, NY 13760

Patient Advisory to Consult Physician

As your acupuncturist, your health and well being are my greatest concern. While I believe strongly in, and committed to Oriental Medicine as a proven, safe and effective health care system, in some cases it cannot replace the resources available through a biomedical physician. I therefore recommend that you consult with a western allopathic physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 8211.1(b) of the N.Y. Education Law, I request that you read and sign the following statement:

We the undersigned, do affirm that x ____________________ has been advised by

(Patient)

Shaul Hendel, L. Ac., and/ or Neil Weinberg, L. Ac. to consult a physician regarding the condition for which such patient seeks acupuncture treatment.

X____________________ x____________________ ____________

Signature of Patient   Signature of Acupuncturist   Date

Payment Policy Agreement- Missed and Cancelled Appointments

I, the undersigned do affirm that I am financially responsible for payment of all medical services and products received at this office, and that full payment for all services and products is required at the time of service. I also understand that all scheduled appointments are my responsibility and I will give the courtesy of at least 24 hours prior notice for cancellation or rescheduling. Otherwise I am responsible for all fees associated with any missed appointments.

Signature of Patient____________________ Date____________

Printed Name ____________________