Palisades Acupuncture Center

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.

All answers are confidential. Please print clearly in ink.

Name _____ Sex _____ Da te_____

Address _____

Date of Birth _____ Place of Birth _____

Telephone: Home(_____)_____ Work(_____)_____ Fax(_____)_____

Occupation _____ Marital Status _____ Ht _____ Wt _____

Social Security# _____

Have you ever received Oriental Medical Treatments before? _____

Referred By _____

Chief Complaint _____

Medical History of Chief Complaint: Date of Onset _____

Have you ever experienced this before? _____

List any previous treatments for this condition including any hospitalizations, surgeries, medications, physical therapy, exams, lab test s (blood analysis, X-Ray, MRI, etc.)._____

_____

Does this condition interfere with your daily activities (work, exercise, sleep, sex, etc.)? _____

_____

Medical doctor's name, address & phone number: _____

_____

Date of last visit & diagnosis: _____

Family History

Illness	Father	Mother	Siblings	Spouse	Children
Cancer					
Diabetes					
High Blood Pressure/Heart Disease					
Allergies					
Drug Abuse					
Mental Illness					
Other					

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Lifestyle Habits

Please state below how much, how many, or how often.

Cigarettes (packs) _____ Coffee/Tea (cups) _____ Alcohol (type – per week) _____

Drugs: Prescription _____

Over -the -Counter _____ Recreational _____

Vitamins & /or H erbs _____

Dietary Restrictions _____

Food Cravings _____

Exercise (type) _____

Other Regular Activities r eading, TV, meditation, etc.) _____

_____

Please check any of the symptoms experienced in the last 3 months.

	Often	Seldom	Severe	Mild		Often	Seldom	Severe	Mild
General					**Nose/Throat/Mouth**				
Insomnia					Nosebleeds				
Dreams					Sinus Infection				
Irritability					Dry Nose				
Depression					Nasal Congestion				
Mood Swings					Sore Throat				
Fatigue					Loss of Voice				
Poor Memory					Difficulty Swallowing				
Fever					Mouth Sores				
Chills					Bleeding Gums				
Weight Loss					Dry Mouth				
Weight Gain					Thirst				
Head & Neck					**Eyes**				
Headaches					Blurred Vision				
Migraines					Floaters				
Stiff Neck					Burning				
Dizziness					Dry				
Fainting					Tearing				
Swollen Glands					Infammation				
Skin					Itchy				
Dry Skin					Styes				
Bruising Easily					**Ears**				
Rashes					Ringing				
Itching					Hearing Loss				
Changes in Moles					Infections				
Night Sweating					Earaches				

	Often	Seldom	Severe	Mild		Often	Seldom	Severe	Mild
Respir atory					**Cardio-Vascular**				
Chronic Cough					Palpiations				
Coughing Blood/Phlegm					Chest Pain/Tightness				
Difficulty Breathing					Cold Hands/Feet				
Wheezing/ Asthma					Swollen Ankles				
Frequent Colds					Low Blood Pressure				
Pneumonia/Bronchitis					High Blood Pressure				
Other					Blood Vessel Problems				
Genito-Urinary					Other				
Pain on Urination					**Neurological**				
Frequent Urination					Seizures				
Blood in Urine					Tremors				
Urgency to Urinate					Numbness				
Unable to Hold Urine					Tingling				
Other					Pain				
Muscles & Joints					Paralysis				
Sore Muscles					Poor Coordination				
Weak Musc les					Other				
Back ache					**Gastro-Intestinal**				
Back Pain					Poor Appetite				
Joint Disorders					Excessive Appetite				
Difficulty Walking					Nausea				
Other					Vomiting/Belching				
Male					Indig estion				
Pain/Itching of Ge nitalia					Stomach Pain				
Genital Lesions					Abdominal Pain				
Discharges					Diarrhea				
Impotence					Blood in the Stool				
Premature E jaculation					Black Stool				
Weak Urinary Stream					Hemorroids				
Lumps on Testicles					Other				
Other									

Infectious Screening – Please Check if True

__ _ Engage in Safe Sex ___HIV Risk – Self or Partner __ _ TB Risk – S elf or Partner

__ _ Hepatitis – Self or Partner ___ Blood Transfusions

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Past Medical History (with Dates)

Significant Illnesses:

Major Hospitalizations:

Significant Traumas (Auto Accidents, Falls, etc.):

History of Sexually Transmitted Diseases: Self or Partner

__ _ Gonorrhea ___ Chlamydia __ _ Herpes (Oral / Genital)

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Please state any other concerns you would like to discuss and what you expect to gain from treatments.

Patient Signature _____ Date _____

Palisades Acupuncture Center

Acupuncture Informed Consent

I, the undersigned, agree to acupuncture treatment and have read and understood the following possible ill-effects that occur in some people at some times, despite all usual care.

Fainting may occur, particularly if the patient is very hungry, very tired, very nervous, or under the influence of alcohol or drugs. You will usually be treated lying down to minimize this possibility. Arriving rested, fed and sober helps prevent this.

Tiny bruising occurs if the acupuncture site is moved by the patient during treatment or if a vessel is nicked during insertion. Rest still and ask your therapist to remove any needles if you need to move yourself for any reason.

All infection is avoided by use of sterile equipment. Sterility of needles is guaranteed by your acupuncturist or by the manufacturer of disposable equipment.

Cupping or gwasha will leave skin discoloration but not bruising that resolves itself in three days to one week. These techniques are used to relieve muscular pain and release trapped metabolic solids; i.e. lactic acid. This discoloration is the expected result of cupping or gwasha, not ill-effect.

Moxibustion is a heat therapy. A stray ash may cause a pin point burn on a fair skinned person. If kept clean this resolves by itself in a few days. Care is exercised to minimize this occurrence.

_____

Print Name

_____

Signature

_____

Date