<u>HEALTH HISTORY for ACUPUNCTURE</u>

Name ________________________________Today's Date (M/D/Y) ________________
Birth Date (M/D/Y) ______________________Age: _________
Mailing Address: ____
City: __________________________________Postal Code: _________________
Phone Number: _________________________Cell number: _______________________
Email Address: ____
Emergency Contact and their phone number: ____________________________________
____
Any recent emergency visits to the hospital? _______What for? _______________________
Have you had acupuncture before? _____________What for? _______________________
Who referred you? ______________________
What brought you here today? ____

Please list the Medications you're currently taking:

Med ______________________________ Dose __________________ Since when?________
Med ______________________________ Dose __________________ Since when?________
Med ______________________________ Dose __________________ Since when?________
Med ______________________________ Dose __________________ Since when?________
Med ______________________________ Dose __________________ Since when?________
Med ______________________________ Dose __________________ Since when? ________

Please list all the Supplements/Vitamins you're currently taking:

Name _____________________________ Since when?_______
Name _____________________________ Since when?_______
Name _____________________________ Since when?_______
Name _____________________________ Since when?_______
Name _____________________________ Since when?_______
Name _____________________________ Since when? _______

Missed appointment fee (without 24 hours' notice): $50 for the first missed appointment and the full appointment fee will be charged for all subsequent missed appointments.

Initials ________

Please list in order of importance each of your health ailments and injuries that you would like help with today, list one item per box (up to 3):

1. ____

When did this start? ______________________________

Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / activity: better no change worse
Other therapies / remedies you're currently using for this:_______________________________

2. ____

When did this start? ______________________________

Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / activity: better no change worse
Other therapies / remedies you're currently using for this:_______________________________

3. ____

When did this start? ______________________________

Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / activity: better no change worse
Other therapies / remedies you're currently using for this:_______________________________

Health History

Please mark any health conditions you or your immediate family has experienced by writing **P** if you had it in the past, write **C** if you currently have it, and write **F** if anyone in your immediate family has it**:**

__Allergies (please list) ___________________
__Anemic
__Arthritis (type) _________________
__Asthma
__Blood Clotting Disorder
__Blood Transfusion
__Cancer
__COPD
__Dementia
Diabetes (list type)

__Heart Disease
__High / Low Blood Pressure
__High Cholesterol
__HIV / Aids
__Irritable Bowel or Ulcerative Colitis
__Kidney Stones
__Lupus or Sjogren's syndrome
__Meningitis
__Migraines
Mental Health Diagnosis

__Depression __Emphysema __Epilepsy __Fibromyalgia __Gender Transition __Goiter __Gout __Head concussions __Herpes (list type) _____________ __Hepatitis (list type) ____________ __Heart Attack Other diagnosis not listed:	__Multiple Sclerosis __Osteoporosis __Pacemaker or Defibrillator __Parkinson Disease __Polio __Rheumatic Fever __Scarlet Fever __Skin condition (type) _______________ __Stroke __Tuberculosis Thyroid __Disease Other health ailment:
List your Injuries & Surgeries: _______________ ____ ____ ____ ____ ____	Physician's Name and phone number:_______________ ____ Date of Last Physical:__________________ Other concurrent therapies i.e. naturopath, chiropractic etc.___________________________________ ______________________________________ ______________________________________

Do you have any implants, pins, staples or artificial joints? If so, when and where __________________

Have you had any Botox injections or skin filler injections? If so, when and where __________________

Habits: Please list amount per day and if quit what year?
Coffee / Tea ________________________
Soda ______________________________
Smoking ___________________________
Recreational Drugs ___________________
Chew Snuff (tobacco) _________________

Exercise:
Do you exercise regularly? ________________________
What do you do and how often? ______________________________

Water:
How much water do you drink daily? ______________________

Stress Level: Low 1 2 3 4 5 6 7 8 9 10 High

How is your energy level? Very Low 1 2 3 4 5 6 7 8 9 10 Very High

How is your body temperature? Very Cold 1 2 3 4 5 6 7 8 9 10 Very Hot

Please answer by checking box □ if you are experiencing the following on a regular basis:

Sleep: Do you sleep well at night? _________ How many hours do you sleep? ____________ What time do you go to bed? ____________ □ trouble falling asleep □ wake frequently? What time? _______ □ if waking, how long does it take to fall back to asleep again? _________ □ wake to urinate?________ How many times each night? ____________ □ wake feeling rested □ restless or cramping legs □ nightmares □ night sweats □ snoring □ other: __________________________	Bowel Movements: How many bowel movements do you have each week? _____________ Laxative use? _______ Are your stools: □ well formed □ hard or dry □ pellet like □ black stool □ alternating loose and hard □ undigested food in stool □ early morning diarrhea □ feels unfinished □ long and thin stools □ blood or mucus on stool □ hemorrhoids or anal fissures □ painful bowel movements □ other ________________________
Bladder: □ clear urine □ cloudy urine □ yellow / light yellow □ painful □ dark yellow □ frequent urination □ urgent urination □ leakage with coughing or exercise □ dribbling urination Men □ impotence □ prostate problems □ premature ejaculation □ infertility □ other: __________________________	Digestion: How is your digestion? ____________________ Please list any special dietary habits or food allergies you have: ________________________ ____ □ poor appetite □ rapid hunger after eating □ abdominal bloating □ stomach or abdominal pain □ acid reflux or heartburn □ belching or hiccups □ hernia □ bad breath □ frequent gas □ ulcers □ other: ________________________
Unusual Thirst: □ thirsty (more than normal) □ thirsty but can't quench thirst □ thirst but no desire to drink □ no thirst	Unusual sweating: □ sweat too easily □ spontaneous sweat without reason □ don't usually sweat □ night sweats □ hot flashes

Which emotions do you experience on a daily basis?	Women:
□ joy / peace □ anger □ depression □ sadness or grief □ fear or anxiety □ guilt □ indifference □ excessive thinking □ moodiness □ easily stressed □ worry □ considered or attempted suicide □ seeing a therapist or counselor □ history of mental illness □ other: ___________________________	How is your menstruation? _________________ Date of last period? ____________________ Are you pregnant? _____________ If so how many weeks? ____________ How many pregnancies have you had? __________ How many live births? ___________ Age at menopause? _______________ □ painful periods □ excessive flow □ bleeding between periods □ irregular cycle □ PMS □ uterine fibroids □ endometriosis □ surgeries: ____________________________ □ other:________________________________

Please check box if you experience any of the following symptoms regularly:

□ headaches, location _____________	□ pain in ribcage	□ poor memory
□ nosebleeds	□ breast lumps or cysts	□ inability to concentrate
□ frequent colds	□ tight chest	□ dry skin or hair
□ sinus congestion	□ chest pain	□ fatigue or tiredness
□ aversion to wind or cold	□ frequent sighing	□ low or high libido
□ runny nose	□ lump in throat	□ pain that comes and goes
□ cough	□ difficulty breathing	□ cold hands and feet
□ poor hearing	□ shortness of breath	□ numbness
□ ear aches	□ heart palpitations	□ ligament/tendon problems
□ ringing in ears	□ grinding teeth or TMJ	□ bleed or bruise easily
□ blurry vision	□ mouth sores or cold sores	□ tremors
□ color blindness	□ gum disease	□ dermatitis
□ night blindness	□ copious saliva	□ psoriasis
□ eyes: redness / pain / dry	□ unusual hair loss	□ fungal infections
□ floaters or spots in vision	□ poor circulation	□ acne
□ bursitis	□ dizziness or vertigo	□ rosacea
□ swollen joints	□ seizures	□ hives
□ carpal tunnel	□ lack of strength	□ skin tags
□ childhood illnesses	□ abuse survivor	□ other___________________
□ bedwetting as a child	□ hypoglycemia	

CONSENT FORM

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to: acupuncture, ear acupuncture, electro-acupuncture, facial rejuvenation acupuncture, cupping massage, Chinese herbal therapy, tuina, guasha, moxibustion, aromatherapy massage, infrared therapy, bodytalk, reiki, sound therapy, LED far infrared therapy and nutritional counseling.

I understand that acupuncture, ear acupuncture, moxibustion, guasha and cupping are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Organ damage from the needle is another extremely rare risk and I understand my practitioner is trained thoroughly to avoid this risk. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and guasha. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse effects.

I understand that all information regarding my health and personal records will be kept confidential.

I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known. I will inform my practitioner of any changes in my health, supplements, medications or insurance coverage.

I recognize that scheduling an appointment involves the reservation of a time specifically for me and that consequently, a minimum of 24-hrs notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, a $50 service fee will be charged for the first missed appointment and the full appointment fee will be charged for all subsequent missed appointments. A deposit may be required for future appointments. Initial ________

Payment is due on day of service. Any dollar amounts not covered by insurance must be paid on day of service. Initial _________

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out by Janis Krause at Dragonfly Acupuncture and Chinese Medicine Clinic.

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Patient Name & Signature Date