

Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire thoroughly. This information is held in strict confidentiality. If you have any questions, please ask. If there is anything you wish to bring to my attention that isn't asked on this form, please note it in the *Comments* section. Thank you for your help.

Name _____ Date of Birth _____ Age _____
 Address _____ Height _____ Weight _____ Sex _____
 _____ Employer _____
 _____ Occupation _____
 Phone # (H) _____ (W) _____ Marital Status S M D W P
 (C) _____ Spouse / Partner's Name _____
 E-mail Address _____ Emergency Contact _____
 Referred By _____ Relationship _____ Phone _____

Have you ever received acupuncture before? For what reason? _____
 What is the chief health issue you'd like to have treated? _____
 When did the problem begin? _____
 To what extent does it interfere with your daily life? _____
 Have you been given a diagnosis for the problem? If so, what? _____
 What treatment have you been using for relief of this issue? _____
 What other therapies are you currently using? _____

Past Medical History—please elaborate, as appropriate

| | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> HIV/AIDS _____ | <input type="checkbox"/> Other _____ |

Surgeries & Hospitalizations (type & dates) _____

Significant Traumas _____

Known allergies (drugs, chemicals, foods, etc.) _____

Occupational Stress (chemical, physical, psychological) _____

Birth History (prolonged labor, forceps, premature, etc.) _____

What medications / vitamins / supplements are you taking? _____

Have you undergone any courses of antibiotics recently? Many Moderate Few None

Family Medical History—please elaborate, as appropriate, and note which family member(s)

| | | |
|--|--|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Drug/Alcohol Abuse _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |

Habits & Lifestyle

Do you exercise regularly? Please describe: _____

Do you eat fast food? None Some Often Daily

Do you drink soda or eat "junk food"? None Some Often Daily

Please describe the type of foods you eat daily:

Morning _____
 Midday _____
 Afternoon _____
 Evening _____

Please check any of the habits below that apply to you, now or in the past, and indicate your usage per day or week:

Tobacco _____ per _____ Age started _____ Age quit _____
 Alcohol _____ per _____ Age started _____ Age quit _____
 Coffee _____ per _____ Age started _____ Age quit _____
 Marijuana _____ per _____ Age started _____ Age quit _____
 Cocaine _____ per _____ Age started _____ Age quit _____
 Heroin _____ per _____ Age started _____ Age quit _____
 Other _____ per _____ Age started _____ Age quit _____

Do you suffer from any of the following conditions?

please check all that apply

General

Past Current
 Catch cold easily
 Recurrent infections
 Night sweats
 Sweat easily
 Bleed or bruise easily
 Strong thirst (hot cold)
 Thirst, no desire to drink
 Fatigue / low energy
 Sudden energy drops
 Time of day _____
 Sudden change in weight

Sleep

Past Current
 Difficult to fall asleep
 Wake up easily during night
 Times per night? _____
 Wake too early in morning
 What time? _____
 Nightmares
 Vivid dreams
 Grinding teeth
 Talking in sleep
 Sleepwalking
 Snoring
 Sleep apnea
 Other _____

Skin / Hair / Nails

Past Current
 Dry skin / scalp / hair
 Thin / brittle nails
 Rashes / hives
 Itching
 Eczema
 Warts
 Acne
 Change in moles
 Hair loss / thinning hair
 Other _____

Head/Eyes/Ears/Nose/Throat

Past Current
 Headaches
 Where _____
 When _____
 Migraines
 Dizziness / vertigo
 Earache
 Discharge from ear
 Change in hearing
 Ringing in ears
 Blurry vision
 Night blindness
 Color blindness
 Spots before eyes
 Sore eyes
 Eye pain
 Excessive tearing
 Glasses / contacts
 Facial pain
 Facial paralysis
 Nosebleeds
 Nasal discharge
 Recurrent sinus infection
 TMJ
 Teeth / gum problems
 Recurrent sore throat
 Hoarseness / loss of voice
 Tonsillitis / swollen glands
 Sores on lips / mouth / gums
 Other _____

Respiratory

Past Current
 Pain with breathing
 Difficulty breathing
 Shallow breathing
 Shortness of breath
 Production of phlegm
 Recurrent / chronic cough
 Coughing blood
 Asthma / wheezing

Respiratory cont.

Past Current
 Bronchitis
 Emphysema
 Pneumonia
 Other _____

Cardiovascular

Past Current
 Pacemaker
 High blood pressure
 Low blood pressure
 Chest discomfort / pain
 Heart palpitations
 Arrhythmia
 Cold hands or feet
 Swelling of hands or feet
 Blood clots
 Spider veins
 Fainting
 Other _____

Genito-urinary

Past Current
 Pain on urination
 Urgent urination
 Frequent urination
 Blood in urine
 Cloudy urine
 Change in urinary flow
 Urinary incontinence
 Incontinence at night
 Dribbling urination
 Wake to urinate? # times? _____
 Recurrent bladder infections
 Recurrent yeast infections
 Kidney stones
 Prostate problems
 Change in sexual drive
 Impotence
 Rashes / itching
 Other _____

Gynecological

Past Current

- Irregular periods
- Painful periods
- Premenstrual syndrome
- Menopausal syndrome
- Abnormal PAP smear
- Pain with intercourse
- Postcoital bleeding
- Clots
- Fibroids
- Endometriosis
- Infertility
- Vaginal dryness
- Vaginal discharge
- Vaginal sores
- Breast lumps
- Nipple discharge
- Other _____

Are you now pregnant?

- yes no

Do you practice birth control?

- yes no

what type & how long? _____

of pregnancies _____

births _____

premature births _____

miscarriages _____

abortions _____

Age of first menses _____

days between menses _____

Duration of bleeding _____

1st day of last menses _____

Age of menopause _____

Date of last PAP _____

Digestive

Past Current

- Little appetite
- Strong appetite
- Hunger, no desire to eat
- Bad breath
- Belching

Digestive, cont.

Past Current

- Nausea
- Vomiting
- Heartburn
- Indigestion
- Abdominal pain
- Weight gain
- Weight loss
- Loose stools / diarrhea
- Dysentery
- Strong smelling stools
- Bloody stools
- Pale stools
- Black, tarry stools
- Constipation
 - dry stools
 - not daily
 - with difficulty
- Pain with passing stools
- Gas / flatulence
- Gall bladder problems
- Appendicitis
- Hernia
- Rectal pain
- Hemorrhoids
- Anorexia nervosa
- Bulimia
- Other _____

Musculoskeletal

Past Current

- Neck pain
- Shoulder pain
- Back pain
- Hand / wrist pain
- Knee pain
- Foot / ankle pain
- Joint / bone problems
- Muscle wasting / weakness
- Osteopenia / osteoporosis
- Herniated disc
- Sciatica
- Other _____

Neurological / Mental

Past Current

- Seizures
- Paralysis
- Tremors
- Stroke
- Concussion
- Nerve damage
- Numbness / tingling
- Lack of coordination
- Loss of balance
- Poor memory
- Difficulty concentrating
- Other _____

Psychological / Behavioral

Past Current

- Depression
- Fearfulness
- Manic Behavior
- Anxiety / nervousness
- Panic attacks
- Often stressed
- Easily angered
- Aggressive behavior
- Lose control of emotions
- Substance abuse
- Other _____

Have you ever been treated for emotional problems?

- yes no

Have you ever considered or attempted suicide?

- yes no

Infection Screening

Have you ever tested positive? When?

- HIV _____
- Tuberculosis _____
- Hepatitis _____
- Gonorrhea _____
- Syphilis _____
- Herpes (oral / genital) _____
- Other _____

Please note the degree of severity of your chief complaint today:

No Problem _____ Worst Imaginable

1 2 3 4 5 6 7 8 9 10

Please note the greatest degree of severity of your chief complaint to date:

No Problem _____ Worst Imaginable

1 2 3 4 5 6 7 8 9 10

Comments:

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Mandatory Disclosure of Information & Informed Consent to Treatment

Please read this document carefully and sign where indicated on the reverse side.

You are the most important person on your health-care team and, as such, are entitled to receive clear and comprehensive information about the modalities, techniques, and duration of your therapy. Becoming informed and understanding what to expect from your treatment from the beginning will help make your experience more comfortable and, I believe, more effective overall. If you have questions about your health, your treatment, or any aspect of traditional Chinese medicine (TCM), please feel free to contact me.

Purpose and Benefit of Treatment

Acupuncture and herbal medicine have been used to treat disease for thousands of years. The World Health Organization cites dozens of conditions that can be effectively treated by Chinese medical methods. These include musculoskeletal injuries, digestive disorders, respiratory diseases, women's health issues, and many more.

About the Clinic

In my practice, I comply with all rules and regulations with respect to the practice of acupuncture, including those related to the proper sterilization and maintenance of equipment and the sanitization of acupuncture clinics. To prevent cross-contamination and infection, I use only sterile, single-use, disposable needles in my practice.

Before Your Treatment

To facilitate your treatment, please wear loose, comfortable clothing that can be pulled high enough to expose your elbows and knees. It's a good idea to have a light meal before acupuncture, but don't arrive uncomfortably full. Avoid consuming alcohol before and immediately after your visit; likewise with strenuous exercise.

Please do not brush or scrape your tongue before coming in for treatment—the tongue's natural coating is one of our primary diagnostic tools and, once brushed off, is lost to us for the day. Coffee, cigarettes, and artificially colored foods, while not advisable under most circumstances, can also stain your tongue coat and are best avoided in the hours before a treatment.

Please try to arrive a few minutes before your treatment is scheduled to begin so as to be relaxed and receptive at the appropriate time.

After Your Treatment

Though most people feel extremely relaxed after acupuncture, some report feeling a bit lightheaded. If this happens to you, please rest awhile in the waiting room. It will pass in short order.

Some patients occasionally experience a worsening of their symptoms after an acupuncture treatment. This can be a part of the healing process and is usually soon followed by a marked improvement in overall wellbeing. Please contact our office if you have any concerns or feel any unpleasant effects after your visit.

Herbal prescriptions and herbal patent medicines are intended solely for the person for whom they are dispensed. Please do not share your prescriptions with others, as even identical symptoms may stem from very different root causes. As with pharmaceuticals, Chinese herbs constitute a powerful medicine, and as such it's unwise to self-diagnose, especially without proper background training.

Cancellation & Late Arrival

If you need to cancel or reschedule your appointment, please give me at least twenty-four hours' notice. Without such notice, and except in emergency situations, I reserve the right to charge for missed appointments. Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

Your Privacy

I believe absolutely in the right to privacy of my patients and will never disclose any of your personal information without your express consent, unless required to do so by law.

Informed Consent to Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of traditional Chinese medicine, including but not limited to herbology, moxibustion, cupping, electro-acupuncture, acupressure, dermal friction (gua sha), infra-red (heat lamps), and massage (tui na), on me (or on the patient named below, for whom I am legally responsible) by Don Gates and/or other licensed acupuncturists who may treat me now or in the future while working with or associated with Don Gates, or who may serve as a substitute for Don Gates.

I understand that there are some minor risks attendant to acupuncture treatment, including but not limited to slight bruising of the skin (hematoma) and/or bleeding, dizziness, nausea, and occasional aggravation of symptoms existing prior to the treatment. Bruising is a common side effect of cupping. Burns and scarring are potential risks of moxibustion. I understand that the risk of infection in acupuncture is negligible when all needles are sterile.

I understand that the herbs and nutritional supplements (which may come from plant, animal, or mineral sources) recommended in this clinic are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, indigestion, vomiting, diarrhea, headache, hives, and tingling of the tongue.

I understand that some herbs and acupuncture points may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform Don Gates. Additionally, I will inform Don Gates if I have a severe bleeding disorder or if I am wearing a pacemaker or other electronic medical device.

I have had an opportunity to discuss with Don Gates and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect Don Gates to be able to anticipate and explain all risks and complications, and I wish to rely on Don Gates to exercise judgment during the course of my treatment, based upon the facts then known, and to proceed in a manner that he determines is in my best interests.

I hereby release Don Gates from all liability that may occur in connection with the abovementioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Please sign and date below to indicate that you have read and understood this form.

Signature of patient
(or patient's representative, if the patient is a
minor or is physically or legally incapacitated)

Date

Print name of patient (and representative, if applicable)

Street address of patient (and representative, if applicable)

City, state, ZIP code

Telephone number

Email address