TO THE New Patient

OUTLINE OF PROCEDURES FOR CARE

STEP ONE:
All new patients are requested to carefully read the included materials and fill out this Health History Questionnaire.

STEP TWO:
A one-on-one evaluation and history will be done to discuss your health problems and to determine what may be the cause. If we can help you, we will go to Step #3 at a follow-up visit.

STEP THREE:
An Oriental Medical examination—including classical pulse diagnosis and tongue diagnosis—will be given to determine the precise cause of your problem(s).

STEP FOUR:
You will go through a series of treatments—called a Report of Findings—during which we will educate you regarding the cause of your problem. It includes a thorough explanation of our treatment recommendations and what results can be obtained. You will also be advised concerning how our office procedures work.

STEP FIVE:
An estimate of the future care that is needed will continue until the personal maximum correction of your problem has been obtained.

STEP SIX:
After maximum correction has been obtained, a schedule of care will be recommended to help prevent future problems and maintain good health.

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Acupuncturist will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Check here if you want the Acupuncturist to select the type of care appropriate for your condition

Date_____ Patient's Signature_____

I understand and agree that all services rendered to me are charged directly to me and that I am directly responsible for payment.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

I understand that the Acupuncturist's office will prepare any necessary reports and forms to assist me in making collection from the insurance company.

I hereby authorize the Acupuncturist to treat my condition as she/he deems appropriate. I also agree that I am responsible for all bills incurred at this office.

Patient's Signature_____ Date_____

Guardian or Spouse's
Signature Authorizing Care_____ Date_____

Child's Name _____

HEALTH HISTORY QUESTIONNAIRE
Information for your Acupuncturists

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *All information is strictly confidential.*

I. General Patient Information

Date: ____/____/____

Name: Mr./Mrs./Ms._____

Address: _____

City, State, Zip Code: _____

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Cell Phone: _(_____)_____ Email Address: _____

Age: _____ Date of Birth: ____/____/____ Place of Birth: _____

Guardian (if under 18): _____

Emergency Contact (name and phone #): _____

Gender: ❑M ❑F Height: ____'____" Weight: _____lbs.

Occupation:_____Employer:_____

How did you hear about our office? _____

Major Complaint(s), in order of significance to you:

1. _____ 4. _____
2. _____ 5. _____
3. _____ Additional:_____

How do these conditions impair your daily activities?_____

_____

II. Patient Medical History

How was your childhood health?_____

Hospital Visits/Stays:_____

_____

Recent tests: (please indicate test results and date below)

❑Physical	❑Cholesterol	❑Prostate	❑Blood (which?)
❑HIV/STD	❑Pap smear	❑Mammography	❑Other:_____

Test Results and Date:_____

Check any you have had in the past:

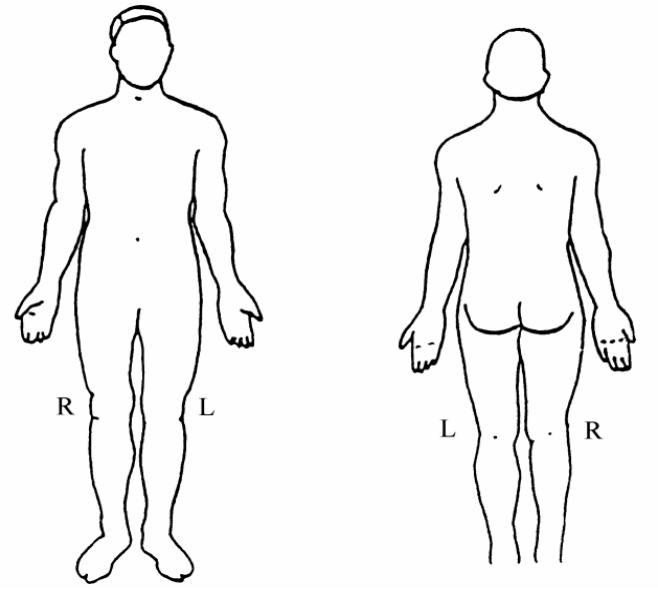
❑Diabetes	❑Allergies	❑Glaucoma	❑Rheumatic Fever
❑Heart Disease	❑CVA (stroke)	❑Vein condition	❑Thyroid disorder
❑Asthma	❑Pneumonia	❑Tuberculosis	❑Emphysema
❑Jaundice	❑Gonorrhea	❑Mumps	❑Bleeding tendency
❑Syphilis	❑Measles	❑Chicken pox	❑Nervous disorder
❑Meningitis	❑HIV	❑Polio	❑Mononucleosis
❑Epilepsy	❑High fever	❑Hepatitis	❑Multiple Sclerosis
❑Paralysis	❑Cancer	❑Migraines	❑High blood pressure
❑other lung illnesses	❑other liver illnesses	❑other heart illnesses	❑other kidney illnesses

❑other:_____

Immunizations:_____

Surgeries:_____

III. **Patient Profile**



Is the pain:

❑Sharp❑Burning ❑Aching

❑Cramping ❑Dull ❑Moving

❑Fixed ❑Other:_____

Do the following improve the pain?

❑Pressure ❑Cold ❑Heat

❑ Exercise ❑ Other_____

Do the following worsen the pain?

❑Pressure ❑Cold ❑Heat

❑Other:_____

This section: Follow-up Re-exam Only. Mark box to the left of original item if gone for previous two weeks.	Please check the following that currently pertain to you: (Initial Visit: Fill in the section below on pages 5-10. The boxes to the left of this section are for follow-up Re-exams.)

Date:	Date:	Date:	Date:	Date:	Date:	Date:	**Overall Temperature (Yin & Yang)** ***The following symptoms indicate an imbalance of Yin and Yang in your body. In Oriental Medicine, Yin is the cool, moist, nourishing aspect of the body. Yang is the hot, dry, invigorating aspect of the body.***
							❑Cold hands
							❑Cold fingers
							❑Cold toes
							❑Cold feet
							❑Sweaty hands
							❑Sweaty feet
							❑Hot body temperature (sensation)
							❑Cold body temperature (sensation)
							❑Afternoon flushes
							❑Night sweats
							❑Heat in the hands, feet, and chest
							❑Hot flashes any time of the day
							❑Thirsty
							❑Perspire easily
							❑Lack of perspiration
							❑Take water to bed

							Overall energy (Lung, Kidney function):
							❑Shortness of breath
							❑Difficulty keeping eyes open in the daytime
							❑General weakness
							❑Easily catch colds
							❑Low energy
							❑Feel worse after exercise

							Overall function of the blood (Liver, Spleen, Heart function):
							❑Dizziness
							❑See floating black spots

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Date:	Date:	Date:	Date:	Date:	Date:	Date:	**Heart function:** ***The following symptoms are indicators of heart malfunction. The heart governs the blood & blood vessels, manifests on the complexion, governs the emotions, affects speech and taste, and controls perspiration.***
							❑Palpitations
							❑Anxiety
							❑Sores on the tip of the tongue
							❑Restlessness
							❑Mental confusion
							❑Chest pain traveling to shoulder
							❑Frequent dreams
							❑Wake unrefreshed
							❑Drink coffee (# of cups per week: _____)

							Lung function: ***The following symptoms are indicators of lung malfunction. The lungs govern breathing, control the movement of energy, control the immune system, regulate water passages, control the skin and open the nose, throat, and sinuses.***
							❑Nasal Discharge (Color: _____)
							❑Cough
							❑Nose Bleeds
							❑Sinus Congestion
							❑Dry mouth
							❑Dry throat
							❑Dry Nose
							❑Dry Skin
							❑Allergies (To what? _____)
							❑Alternating fever and chills
							❑Sneezing
							❑Headache (Location: _____)
							❑Overall achy feeling in the body
							❑Stiff neck
							❑Stiff shoulders
							❑Sore throat
							❑Difficulty breathing
							❑Smoke cigarettes (# of cigarettes per day: _____)
							❑Sadness
							❑Melancholy

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Date:	Date:	Date:	Date:	Date:	Date:	Date:	
							<u>Spleen function</u>: ***The following symptoms are indicators of spleen malfunction. The spleen assists in breaking food down into usable nutrients and then transports those nutrients throughout the body, keeps the blood in the blood vessels, governs the muscles, manifests in the lips and holds the organs up in the body.***
							❑Low appetite
							❑Abrupt weight gain
							❑Abrupt weight loss
							❑Abdominal bloating
							❑Abdominal gas
							❑Gurgling noise in the stomach
							❑Fatigue after eating
							❑Prolapsed organs (previously diagnosed, which organ? _____)
							❑Easily bruised
							❑Hemorrhoids
							❑Pensive
							❑Over-thinking
							❑Worry

							<u>Spleen, Stomach, Large Intestine, Small Intestine function</u>:
							❑Loose
							❑Constipated
							❑Incomplete
							❑Diarrhea
							❑Blood in stools
							❑Mucous in stools
							❑Undigested food in stools

							<u>Dampness trapped in the body</u>: ***The following symptoms are indicators of "dampness," which simply refers to fluids that are not metabolized effectively and cause health problems in the body.***
							❑General sensation of heaviness in the body
							❑Mental heaviness
							❑Mental sluggishness
							❑Mental fogginess
							❑Swollen hands
							❑Swollen feet
							❑Swollen joints
							❑Chest congestion
							❑Nausea
							❑Snoring

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Date:	Date:	Date:	Date:	Date:	Date:	Date:	**<u>Stomach function</u>:** ***The following symptoms are indicators of stomach malfunction. The stomach controls the breakdown of food and nutrients, descends the energy and is the origin of the body's fluids.***
							❑Burning sensation after eating
							❑Large appetite
							❑Bad breath
							❑Mouth (canker) sores
							❑Bleeding, swollen or painful gums
							❑Heartburn
							❑Acid regurgitation
							❑Ulcer (diagnosed)
							❑Belching
							❑Hiccoughs
							❑Stomach pain
							❑Vomiting

							<u>Liver, Gall Bladder function</u>: ***The following symptoms are indicators of liver malfunction. The liver stores the blood, ensures the smooth flow of energy throughout the body, nourishes the tendons and ligaments, manifests in the nails and opens in the eyes. The gall bladder stores bile, which breaks down fats.***
							❑Alternating diarrhea and constipation
							❑Chest pain
							❑Tight sensation in the chest
							❑Bitter taste in the mouth
							❑Anger easily
							❑Frustration
							❑Depression
							❑Irritability
							❑Frequently unable to adapt to stress (What causes the stress? _____)
							❑Skin rashes
							❑Headache at the top of the head
							❑Tingling sensation
							❑Numbness
							❑Muscle spasms
							❑Muscle twitching
							❑Muscle cramping
							❑Seizures
							❑Convulsions
							❑Lump in the throat
							❑Neck tension
							❑Limited Range-of-Motion, Neck

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Date:	Date:	Date:	Date:	Date:	Date:	Date:	**Liver, Gall Bladder function (continued)**
							❑Shoulder tension
							❑Limited Range-of-Motion, Shoulder
							❑Drink alcohol (What type?_____, How much per week?_____)
							❑Hip pain
							❑Recreational drugs (Which? _____, How much per week? _____)
							❑High-pitched ringing in the ears
							❑Gall stones (history or current)
							❑Sexually transmitted disease (Which? _____)

							Eyes (Liver function):
							❑Itchy
							❑Bloodshot
							❑Hot
							❑Dry
							❑Watery
							❑Gritty
							❑Blurry vision
							❑Decreased night vision
							❑Near-sighted
							❑Far-sighted

							Kidney, Urinary Bladder function: ***The following symptoms are indicators of kidney or urinary bladder malfunction. The kidney and adrenal system govern birth/growth/reproduction/development, produce the bone marrow, nourish the brain, control the bones, govern water, open to the ears, manifest the hair, and control the ureter/ spermatic duct and lower section of the large intestine. The urinary bladder stores and eliminates impure fluids from the body.***
							❑Frequent cavities
							❑Easily broken bones
							❑Sore knees
							❑Weak knees
							❑Cold sensation in the knees
							❑Low back pain
							❑Memory problems
							❑Excessive hair loss

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Date:	Date:	Date:	Date:	Date:	Date:	Date:	**Kidney, Urinary Bladder function (continued)**
							❑Low-pitched ringing in the ears
							❑Kidney stones
							❑Bladder infections
							❑Wake during the night twice or more to urinate
							❑Lack of bladder control
							❑Fear
							❑Easily startled

							Urination:
							❑Normal color
							❑Dark yellow
							❑Clear
							❑Reddish
							❑Cloudy
							❑Scanty
							❑Profuse
							❑Strong odor
							❑Burning
							❑Painful
							❑Discharge
							❑Difficult
							❑Urgent
							❑Frequent

							Libido (Sex Drive):
							❑Normal
							❑High
							❑Low

WOMEN ONLY::

Regular menstrual cycle? ❑Y ❑N
Number of children:_____
Age of first menstruation:_____
Average number of days of flow:_____
❑Vaginal discharge

Pregnant? ❑Y ❑N
Number of pregnancies:_____
Age of menopause (if applicable):_____
Average number of days of entire cycle:_____
❑Bleeding or spotting between periods

Do you experience any of the following pre-menstrual syndromes?

❑nausea ❑vomiting ❑water retention ❑breast swelling
❑food cravings ❑headaches ❑migraines ❑breast tenderness
❑depression ❑irritability ❑anxiety ❑other emotions:_____
❑dull pain, where?_____ ❑sharp pain, where?_____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

MEN ONLY:

❑Swollen testes ❑Testicular pain ❑Impotence ❑Premature ejaculation
❑Feeling of coldness or numbness in external genitalia ❑Other_____

ALL PLEASE FILL OUT:

Other Comments:_____

_____

Patient Signature:_____

Acupuncturist Signature:_____