Confidential Acupuncture Health History

Client Information

Name: _____D.O.B(D/M/Y) _____

Address: _____Postal Code: _____

City: _____ Home Phone #: _____

Cell Phone #: _____Occupation:_____

Family Doctor: _____

Emergency Contact: _____Phone #:_____

Massage History/Treatment Information:

Have you had Acupuncture before? **YES/NO**

If yes, when?_____ What for? _____

Please list your major health concerns in order of importance:

Complaint:	**Since:**	**Possible Cause:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have these conditions/complaints been diagnosed by a physician, or other provider? **YES/NO**

Are you currently seeing a Medical Practitioner, Chiropractor or Physiotherapist etc? **YES/NO**

If yes please explain: _____

Are you currently taking any medication? (Prescription/Herbal/Over the Counter/Supplements) **YES/NO**

If yes, what and how often? _____

Do you have allergies to Detergents/Scents/Nuts etc.? **YES/NO**

If yes, please list all: _____

Lifestyle: ☐Smoking ☐Alcohol ☐Coffee/Caffeine ☐High Stress Level

General Health ☐Good ☐Fair ☐Poor

Previous History: ***Include Year and Treatment received***

Surgeries: _____

Accidents: _____

Please check all symptoms which are current in the last three months:

☐ Diarrhea/Loose Stool/IBS
☐ Constipation/Bloating/Gas
☐ Ulcers
☐ Acid Reflux
☐ Cough
☐ Epigastic (Stomach) Pain
☐ Nausea/Vomiting
☐ Weight Loss/Gain
☐ Headaches
☐ Numbness/Tingling
☐ Shortness of Breath
☐ Insomnia
☐ Dizziness/Vertigo
☐ Dribbling Urine
☐ Low Back/Knee Pain
☐ Persistent Thirst/Hunger
☐ Poor Memory
☐ High/Low Blood Pressure
☐ Chest Pain
☐ Heart Palpitations
☐ Anxiety
☐ Edema
☐ Dry Skin
☐ Tiredness/Fatigue
☐ Blurred/Double Vision
☐ Depression
☐ Hot/Cold Intolerances
☐ Night Sweats
☐ Irritability
☐ Frequent Colds/Flus
☐ Incontinence
☐ Frequent Urination
☐ Dry Eyes
☐ Tinnitus

Please check/circle any other conditions or symptom(s) presently or recently experienced:

Musculo-Skeletal

☐ Bone or joint disease
☐ Tendonitis/Bursitis
☐ Flat Feet
☐ Dislocation
☐ Arthritis
☐ Sprains/Strains
☐ Low Back/Hip/Leg Pain
☐ Neck Pain/Arm Pain
☐ Spasms/Cramps
☐ TMJ/Jaw Pain
☐ Lupus/Fibromyalgia
☐ Osteoarthritis
☐ Tension Headaches/Migraines
☐ Scoliosis
☐ Mid back/Shoulder Pain
☐ Sciatica

Circulatory/Nervous System

☐ Heart Disease
☐ Varicose Veins
☐ Blood Clots
☐ Shingles/Herpes
☐ Heart Attack
☐ Swelling/Lymphedema
☐ Bruises Easy
☐ Phlebitis
☐ Paralysis
☐ Stroke
☐ Neurological Disorder
☐ Other _____

Digestive System

☐ Diverticulitis
☐ Acute Stomach Pain
☐ Hernia
☐ Liver/Gallbladder Issues _____

Skin

☐ Psoriasis ☐ Warts
☐ Hives/Rash ☐ Eczema
☐ Athletes Foot ☐ Open Sores/Cuts
Infectious Disease(s) _____

Other

☐ HIV/AIDS ☐ Epilepsy
☐ Cancer/Tumors ☐ Diabetes
☐ Hepatitis ☐ Hemophilia
☐ Tuberculosis ☐ Pacemaker
☐ Concussion ☐ Asthma
☐ Anaphylaxis ☐ Hearing Loss
☐ Altered Taste/Smell ☐ Drug/Alcohol Abuse
☐ Glaucoma ☐ Mental Illness
☐ Hyper/Hypothyroid ☐ Paralysis

Female Only:

Are you Pregnant? ☐ YES, How many months? _____ ☐ NO ☐ Trying ☐ Maybe

Method of Birth Control? _____

Age of First Menses? _____ Date of Last Menses? _____

Typical Length of Menses? _____ Typical Length of Cycle? _____

Number of: Pregnancies _____ Births _____ Abortions _____ Miscarriages _____

Menopause? **YES/NO** If yes, Age of Menopause _____ Hysterectomy? **YES/NO**

Please Check all that Apply to you:

☐ Scanty Flow ☐ Heavy Flow
☐ Clotting ☐ Vaginal Discharge
☐ Painful Periods ☐ Breast Tenderness
☐ Breast Lumps ☐ Infertility
☐ PMS ☐ Bleeding Between Cycles
☐ Endometriosis ☐ Ovarian Cysts
☐ Painful Intercourse ☐ Fibroids/ Fibrocystic Breasts
☐ Menopausal Symptoms ☐ Low Libido
☐ Excessive Libido ☐ Nipple Discharge
☐ UTI ☐ Morning Sickness
☐ Irregular/Early/Late Cycles Other: _____

Men Only:

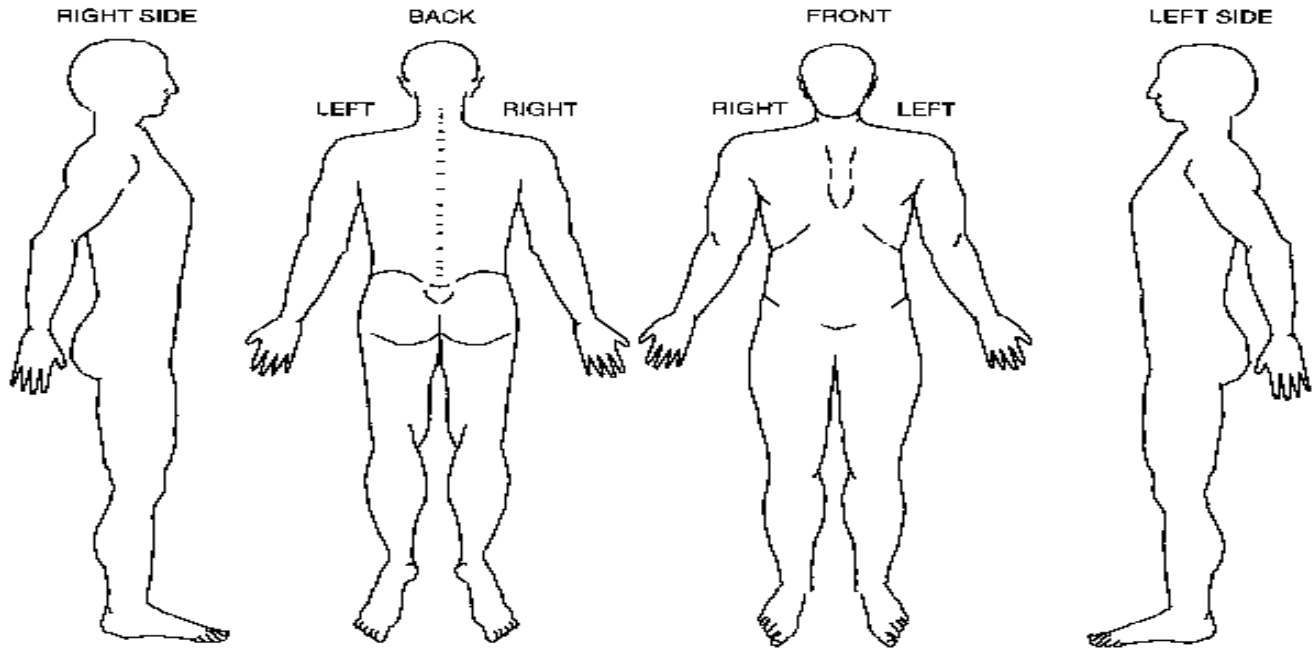
Please Check all that Apply to you:

☐ Low Libido ☐ Excessive Libido
☐ Impotence ☐ Seminal Emissions
☐ Premature Ejaculation ☐ Painful Intercourse
☐ Prostate Problems ☐ Testicular Pain
☐ Testicular Swelling ☐ Vasectomy? **YES/NO** If Yes, Date? _____
Other: _____

Family History:
Please Check any Illness that run in your Family (Parents/Siblings/Grandparents)

☐ Alcoholism	☐ Cancer	☐ Allergies	☐ Diabetes
☐ Epilepsy	☐ Kidney Disease	☐ Heart Disease	☐ Mental Illness
☐ Obesity	☐ Stroke	☐ Hemophilia	☐ High Blood Pressure

Please mark areas of pain, tension or stiffness with a circle:



Any other Information I need to know before your treatment?

_____

_____

_____

_____

Patient Waiver and Consent to Acupuncture Treatment

To the best of my knowledge, the above information is complete and correct. I understand that acupuncture treatments are in no way a substitute for examination, diagnosis or treatment by a physician.

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, including moxibustion, cupping, and/or electo acupuncture by Amanda Zoethout. I have had an opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. I understand and I'm informed that in practice of acupuncture there are some risks to treatment, including but not limited to, minor bleeding, minor bruising, soreness, numbness, infection, nausea,, fainting and stuck/bent needles. I do not expect the doctor to be able to anticipate and explain all possible risks and complications. I wish to rely on Amanda Zoethout who has been trained in Clean Needle Technique and who will exercise good judgment during the course of treatment and care provided.

I understand that it is my responsibility to keep the information regarding changes to my medical history current with regards to my condition, medication and any changes in therapies.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition(s) for which I seek treatment.

I understand that acupuncture is a medical treatment performed by the insertion of single use, sterile needles through the skin to stimulate certain points to regulate "Qi." I hereby authorize Amanda Zoethout to perform acupuncture and have read and understood the potential risks involved. I have been informed that I have the right to refuse treatment and withdraw consent at anytime and that Amanda has answered all questions satisfactorily. I also understand that no guarantee can be made regarding the results of my acupuncture treatment.

Sexual Harassment is taken very seriously. Let it be understood that any illicit, sexually suggestive, inappropriate and/or physical touching of the acupuncturist will result in immediate termination of the session and services at the clinic will be terminated.

I understand that my appointment time has been reserved for my benefit and that if I neglect to give 24 hours notice I will be billed for the full amount of the treatment.

I have read this form carefully and by signing below I am signifying agreement to this consent form.

Read Before Signing

Patient Name _____ **Patient Signature** _____

Date (m/d/y) _____