Acu – Herbs Oriental Medicine Clinic, LLC.

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HEALTH HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Phone: H- _____C- _____

Address: _____ City: _____State: _____ ZIP: _____

Age: _____ Date of Birth: _____Country of Birth: _____ Male □ Female □

Height: _____Weight: _____Marital Status: _____

Employer (if insured through employer): _____

Insurance Company: _____ Referred by: _____

Primary Person Insured:_____ Primary Person's Date of Birth: _____

In Emergency, Notify: _____ Phone: _____

Have you been treated by acupuncture or oriental medicine before? Yes □ No □

Main Problem(s) you would like us to help you with: _____

_____

How long ago did this problem begin (be specific)? _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

_____

What kind of treatments have you tried? _____

_____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____

High Blood pressure _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____

Seizures _____ Venereal Disease _____ Other _____

Surgeries (type of and date): _____

_____

Significant Trauma (auto accidents, falls etc.): _____

_____

Family Medical History (check): □ Diabetes □ Cancer □ High Blood pressure □ Heart Disease
□ Stroke □ Seizures □ Asthma □ Allergies □ Other:_____

Allergies (drugs, chemicals, food/result): _____

_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

Please check any you have had in the last three months:

GENERAL:

- ☐ Poor appetite
- ☐ Fatigue
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot)
- ☐ Thirst, no desire to drink
- ☐ Sudden energy drop
  What time of day?_____
- ☐ Poor sleeping
- ☐ Poor balance
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

SKIN AND HAIR:

- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Loss of hair
- ☐ Hives
- ☐ Other Hair or Skin Problem:

CARDIOVASCULAR:

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Chest pain
- ☐ Swelling of feet
- ☐ Difficulty in breathing

RESPIRATORY:

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm _____ what color _____
- ☐ Asthma
- ☐ Pain with a deep breath

GASTROINTESTINAL:

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion

GENTO-URINARY:

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Kidney stones

Do you wake up to urinate?
☐Yes ☐No. How often? ___

PREGANCY & GYNECOLOGY:

Number of pregnancies: ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Period between menses ____
Duration _____
First date of last menses

- ☐ Unusual character (heavy or light)
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Clots
- ☐ Vaginal sores _____
- ☐ Irregular periods
- ☐ Breast lumps

HEAD,EYES, EARS, NOSE, THROAT:

- ☐ Dizziness
- ☐ Poor vision
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Night Blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw Clicks
- ☐ Migraines
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Headaches. Where and When:_____
- ☐ Other head or neck problem:__

MUSCULOSKELETAL:

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain

NEUROPSYCHOLOGICAL:

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Bad temper
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety

CONSENT FORM FOR TRADITIONAL CHINESE METHODS & PRIVACY PRACTICES

I, the undersigned, hereby authorize the following Certified Acupuncturist: Li-Juan (Leah) Chen L. Ac. EAMP. OMD. To perform the following specific procedures:

Herbal Prescriptions: may be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

*** **If you do not want animal-based products used in your formula, please notify your practitioner at every visit when herbs are prescribed.** ***

Acupuncture: Insertions of special sterilized needles through the skin into the underlying tissues at specific points on the surfaces of the body.

Cupping: Cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Mild bruising may result.

Moxa: Indirect burning on an acupoint using stick, string, or ball moxa to create a warming effect.

I recognize the potential risks and benefits of those procedures as described below:

Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruises, weakness, fainting, nausea, area of anesthesia and even aggravation of symptoms existing prior to the treatment.

Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energies, which may lead to the prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures, realizing that I have been given no guarantees by the practitioner, Li-Juan (Leah) Chen L. Ac. EAMP. OMD. regarding cure or improvement of my condition.

I also release Li-Juan (Leah) Chen L. Ac. EAMP. OMD. from any and all liability, which may occur in connection with the above-mentioned procedures, except for failing to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that, under the Health Insurance Portability & Accountability Act or 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my medical records may be used and disclosed only for the purposes of treatment, payment, and health care options. By signing below, I acknowledge that I have read and understand the **Notice of Privacy Practices** of Acu-Herbs Oriental Medicine Clinic, LLC. I am aware I may request a copy of my health record from this practitioner and may ask to correct this record. I may also request a copy of the Notice of Privacy Practices for my record.

I understand that if my insurance does not pay for the services and treatment performed by Li-Juan (Leah) Chen L. Ac. EAMP. OMD., I am responsible for payment of the charges incurred.

I am fully aware that the clinic allows a specific amount of time for treatment and that if I arrive late, my treatment will be adjusted to fit in that time schedule. I also understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment. Late arrivals and appointments missed without proper notice will be billed at current clinic rates.

_____ _____

Signature of Patient or witness or Person Authorized Date