Traditional Acupuncture Clinic Date _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank you.

Name _____ Date of Birth _____ Age _____

Address _____ Height _____ Weight _____ Sex _____

_____ Employer _____

_____ Occupation _____

Phone # (H) _____ (W) _____ Social Security # _____

Marital Status: □S □M □D □W □P Spouse's Name _____

Physician_____ Referred By _____

In Emergency Notify _____ Relationship _____ Phone _____

Main problem you would like help with: _____

_____

When did the problem begin (be specific): _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

_____

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

What kinds of treatments have you tried? _____

Other concurrent therapies: _____

Past Medical History – please note dates:

Cancer _____	HIV/AIDS _____	Thyroid Disease _____
Diabetes _____	High Blood Pressure _____	Rheumatic Fever _____
Hepatitis _____	Heart Disease _____	Venereal Disease _____

Surgeries (type & dates) _____

_____

Significant Traumas _____

_____

Significant Dental Work _____

Other _____

Allergies (drugs, chemicals, foods, etc.) _____

_____

Occupational Stress (chemical, physical, psychological) _____

_____

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

Family Medical History

□ Cancer
□ Diabetes
□ High Blood Pressure
□ Heart Disease
□ Stroke
□ Seizures
□ Asthma
□ Allergies
□ Other _____

Medications

What medications / supplements are you taking?_____

_____

Have you had many courses of antibiotics recently? □ Lots □ Moderate □ Few □ None

Habits

Do you have a regular exercise program? Please describe: _____

_____

Are you or have you been on a restricted diet? What kind & why? _____

_____

Please indicate usage per day or per week:

Cigarettes _____ per _____
Alcohol _____ per _____
Drugs _____ per _____
Coffee _____ per _____
Tea _____ per _____
Soft Drinks _____ per _____
Sugar _____ per _____
Other _____ per _____

Please describe your average daily diet:

Morning _____

Afternoon _____

Evening _____

Do you suffer from any of the following?

Please check all symptoms that apply:

General

□ Recurrent infections
□ Night sweats
□ Sweating easily
□ Bleed or bruise easily
□ Strong thirst (hot or cold)
□ Thirst, no desire to drink
□ Fatigue
□ Sudden energy drops
Time of day _____
□ Poor sleep
□ Tremors
□ Poor balance
□ Edema
□ Underweight
□ Overweight

Skin

□ Rashes
□ Itching
□ Eczema
□ Oozing
□ Pimples
□ Dry skin/scalp
□ Recent moles
□ Change in hair/skin
□ Other _____

Head/Eyes/Ears/Nose/Throat

□ Headaches
Where _____
When _____
□ Migraines
□ Dizziness
□ Earache
□ Discharge from ear
□ Poor hearing
□ Ringing in ears
□ Blurry vision
□ Night blindness
□ Color blindness
□ Spots in front of eyes
□ Eye pain
□ Excessive tearing
□ Squint
□ Glasses
□ Sore eyes
□ Facial pain
□ Nose bleeds
□ Nasal discharge
□ Blocked nose
□ Snoring
□ Grinding teeth
□ Teeth problems
□ Recurrent sore throat
□ Hoarseness
□ Tonsillitis
□ Swollen glands
□ Sores on lips/mouth
□ Other _____

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

Respiratory
□ Difficulty breathing
□ Pain with breathing
□ Shallow breathing
□ Shortness of breath
□ Production of Phlegm
color _____
□ Recurrent cough
□ Coughing blood
□ Bronchitis
□ Pneumonia
□ Asthma/Wheezing
□ Status asthmaticus
□ Other _____

Digestion
□ Bad breath
□ Change in appetite
□ Nausea
□ Vomiting
□ Heartburn
□ Indigestion
□ Belching
□ Abdominal pain or cramps
□ Weight gain
□ Weight loss
□ Loose stools/diarrhea
□ Strong smelling stools
□ Bloody stools
□ Pale stools
□ Green stools
□ Black stools
□ Constipation
(not daily or difficulty)
□ Pain with passing stools
□ Gas
□ Rectal pain
□ Hemorrhoids
□ Anorexia nervosa
□ Bulimia
□ Other _____

Genito-urinary
□ Pain on urination
□ Urgency with urination
□ Frequent urination
□ Blood in urine
□ Decrease in urinary flow
□ Unable to hold urine
□ Incontinence at night
□ Dribbling urination
□ Kidney stones
□ Prostate problems
□ Impotency
□ Change in sexual drive
□ Rashes
□ Do you wake to urinate?
How many times? _____
□ Other _____

Gynecological
# of pregnancies _____
births _____
premature births _____
abortions _____
Age of 1st menses _____
days between menses _____
Duration of menses _____
1st day of last menses _____
Age of menopause _____
Date of last PAP _____

□ PMS
□ Irregular periods
□ Painful periods
□ Light periods
□ Heavy periods
□ Clots
□ Fibroids
□ Endometriosis
□ Infertility
□ Vaginal discharge
□ Vaginal sores
□ Postcoital bleeding
□ Breast lumps
□ Nipple discharge
□ Other _____

Do you practice birth control?
□ yes □ no
what type & how long?
_____

Are you now pregnant?
□ yes □ no

Musculoskeletal
□ Neck ache/pain
□ Back ache/pain
□ Knee ache/pain
□ Shoulder pain
□ Hand/wrist pain
□ Foot/ankle pain
□ Joint/Bone problems
□ Torn tissues
□ Prostheses
□ Muscle pain/weakness
□ Hernia
□ Other _____

Neurological
□ Seizures
□ Nerve damage
□ Paralysis
□ Stroke
□ Sleep disorder
□ Concussion
□ Vertigo
□ Lack of coordination
□ Loss of balance
□ Poor memory
□ Difficulty in concentrating
□ Other _____

Behavioral
□ Vacant
□ Moody
□ Easily susceptible to stress
□ Aggressive/Bad temper
□ Lose control of emotions
□ Anxiety
□ Panic attacks
□ Depression
□ Fear
□ Substance abuse
□ Other _____

Have you ever been treated for emotional problems?
□ yes □ no

Have you ever considered or attempted suicide?
□ yes □ no

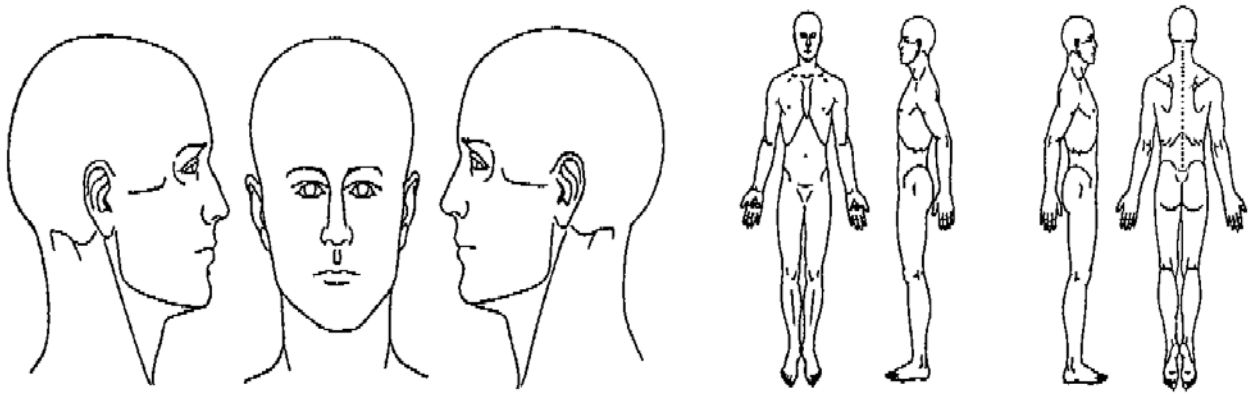
Please note the degree of severity of your problem now:

No Problem — Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No Problem — Worst Imaginable

Indicate areas of pain or distress:



Comments: _____

_____

_____

_____

_____

_____

_____

Traditional Acupuncture Clinic

INFORMED CONSENT TO ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT & CARE

I, the undersigned, hereby request and consent to the performance of acupuncture procedures including, but not limited to moxibustion, cupping, plum blossom, gua sha, electroacupuncture, herbology, and Tuina, on me (or on the patient named below for whom I am legally responsible) by my acupuncturist, Geoffrey Hudson, L.Ac., and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with, or serving as back up for my acupuncturist named above, including those working at the clinic or office listed above or any other office visit, whether signatories to this form or not.

Potential Risks: discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to the treatment, occasional mood changes
Potential Benefits: drugless relief of presenting symptoms and improved balance of body's energies, which may lead to prevention or elimination of the presenting problem

I have had the opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electroacupuncture, herbology, physiotherapy, and other procedures. I understand that there are no guarantees regarding cure or improvement of my condition. I understand and am informed that there are some risks to acupuncture and oriental medicine, such as those listed above. There have also been instances reported of fainting, infections, scarring, spontaneous miscarriage, and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

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.

I hereby release Geoffrey Hudson, L.Ac. from all liability which may occur in connection with the above mentioned 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 am fully aware that the clinic allots a specific amount of time for my treatment, and that if I arrive late, my treatment will be adjusted to fit into that 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 the current rates.

_____ _____ _____

Signature of Patient or Person authorized to consent | Relationship or Authority of Representative | Date

_____

Print Name of Patient or Patient's Representative

_____

Signature of Witness (if patient is a minor)

Financial Policy

- Payment is due at the time of service, unless otherwise arranged.
- **We require a 24 hour notice for any schedule changes**. You are responsible for remembering your own appointments. Those missed appointments without a 24 hour notice will be charged the full fee of a regular appointment; exceptions are made for emergencies only. This "no show" fee is not covered by insurance companies, and must be paid by the patient.

☐ I agree to keep my account balance current by paying for service at each visit.

PLEASE INITIAL:

☐ Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current.

☐ In the event that unpaid fees are sent to collections, the patient agrees to pay all COLLECTIONS FEES. In the event that legal action be filed, the patient agrees to pay reasonable attorney fees, filing fees, and other costs the court deems proper.

Financial Responsibility

I understand and agree that all services rendered to myself are charged directly to me and that I am personally responsible for my account.

An accounting service charge of 1.5% will be added to accounts over 30 days past due. Should this account be turned over to collections for any reason, reasonable collection costs of 20-40% may be added to accounts requiring such third party expenses.

I understand that if I do not adhere to my appointment schedule as agreed upon, and do not make prior arrangements **24 hours in advance, I will be charged for the time reserved.** I understand that rescheduling and canceling appointments must be done during office hours of 10:00 am to 7:00 pm Monday through Friday, and 24 hours in advance of scheduled appointments.

_____ _____

Signature Date

_____

Please Print Name