

Vancouver Acupuncture

HEALTH HISTORY QUESTIONNAIRE

Name: _____ Date _____

What is your primary concern, condition, injury or illness? _____

How long has it bothered you? _____

Describe what caused it/how it started: _____

How does this condition affect you? (Interference with work, sleep, appetite, etc.) _____

Have you received treatment for this condition? _____ When? _____

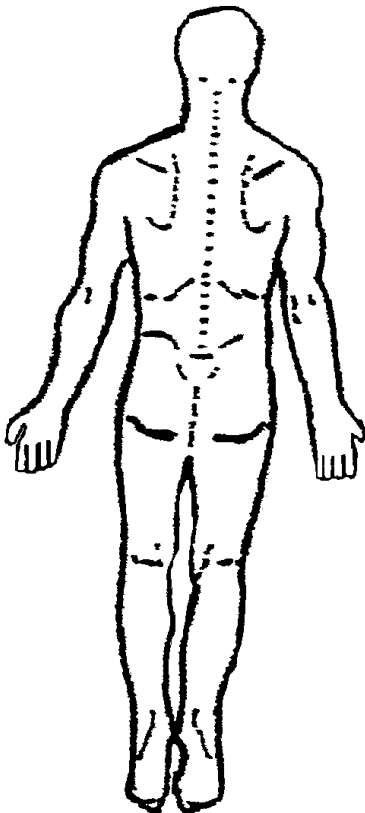
From Whom? _____ Diagnosis? _____

Results of Treatment? _____

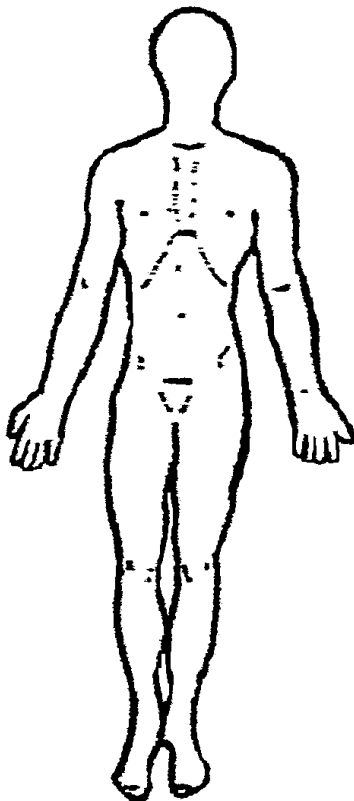
Has the condition gotten: Better: _____ Worse: _____ Same: _____

INDICATE PAINFUL OR DISTRESSED AREAS:

BACK



FRONT



LEFT



RIGHT



Please put a check next to conditions that you have experienced within the last three months. Indicate the length of time you have had this condition.

GENERAL:

- Poor Appetite _____
- Localized Weakness _____
- Weight Gain _____
- Sweating Easily _____
- Night Sweats _____
- Sudden Energy Drop (time of day?) _____
- Other unusual or abnormal conditions you have noticed in your general sense of health? _____
- Insomnia _____
- Cravings _____
- Weight Loss _____
- Tremors _____
- Fever _____
- Disturbed Sleep _____
- Strong Thirst _____
- Changes in Appetite _____
- Bleed or Bruise Easily _____
- Chills _____
- Poor Balance _____

SKIN & HAIR:

- Rashes _____
- Itching _____
- Dandruff _____
- Changes in hair or skin texture _____
- Any other hair or skin problems? _____
- Ulcerations _____
- Eczema _____
- Hair Loss _____
- Hives _____
- Pimples _____
- Recent Moles _____

HEAD, EYES, EARS, NOSE, THROAT:

- Dizziness _____
 - Glasses _____
 - Poor Vision _____
 - Cataracts _____
 - Ringing in Ears _____
 - Sinus Problems _____
 - Grinding Teeth _____
 - Teeth Problems _____
 - Concussions _____
 - Spots in Front of Eyes _____
 - Night Blindness _____
 - Blurry Vision _____
 - Poor Hearing _____
 - Recurrent Sore Throat _____
 - Sores on Lips/Tongue _____
 - Headaches _____
 - Migraines _____
 - Eye Pain _____
 - Color Blindness _____
 - Earaches _____
 - Eyestrain _____
 - Nose Bleeds _____
 - Facial Pain _____
 - Jaw Clicks _____
- Any other head or neck problems? _____

CARDIOVASCULAR:

- Dizziness _____
 - Irregular Heartbeat _____
 - Cold Hands/Feet _____
 - Blood Clots _____
 - Low Blood Pressure _____
 - High Blood Pressure _____
 - Swelling of Hands _____
 - Difficulty Breathing _____
 - Chest Pain _____
 - Fainting _____
 - Swelling of Feet _____
 - Phlebitis _____
- Any other heart or blood vessel problems? _____

RESPIRATORY:

- Cough _____
- Bronchitis _____
- Difficulty Breathing when Lying Down _____
- Production of Phlegm (color?) _____
- Any other lung problems? _____
- Coughing up Blood _____
- Pain w/ Deep Inhalation _____
- Asthma _____
- Pneumonia _____

GASTROINTESTINAL:

- Nausea _____
 - Constipation _____
 - Black Stools _____
 - Bad Breath _____
 - Abdominal Pain/Cramps _____
 - Vomiting _____
 - Gas _____
 - Blood in Stools _____
 - Rectal Pain _____
 - Chronic Laxative Use _____
 - Diarrhea _____
 - Belching _____
 - Indigestion _____
 - Hemorrhoids _____
- Any other problems with stomach or intestines? _____

GENITO-URINARY:

- Pain on Urination _____
 - Urgency to Urinate _____
 - Decrease in Flow _____
 - Frequent Urination _____
 - Unable to Hold Urine _____
 - Impotence _____
 - Blood in Urine _____
 - Kidney Stones _____
 - Sores on genitals _____
- Do you wake up at night to urinate? _____ If so, how often? _____
- Any particular color to your urine? _____
- Any other problems with your genital/urinary functions? _____

REPRODUCTIVE & GYNECOLOGIC:

- Menstrual Clots _____
 - Changes in body/psyche prior to menstruation _____
 - Irregular Menses _____
 - Painful Menses _____
 - Menopause (Age) _____
 - Unusual Menses _____
 - Other Problems _____
- Age at 1st Menses _____ Time between Menses _____ Duration _____
- First day of last Menses _____ # of Pregnancies _____ # of Births _____
- Miscarriages _____ Abortions _____ Premature Births _____
- Birth Control? _____ If so, type? _____ How Long? _____

MUSCULOSKELETAL:

- Neck Pain _____
 - Back Pain _____
 - Hand/Wrist Pain _____
 - Muscle Spasms _____
 - Muscle Weakness _____
 - Shoulder Pain _____
 - Knee Pain _____
 - Foot/Ankle Pain _____
 - Hip Pain _____
- Any other joint/bone problems? _____

NEUROPSYCHOLOGICAL:

- Seizures _____
 - Area of Numbness _____
 - Concussion _____
 - Bad Temper _____
 - Dizziness _____
 - Poor Memory _____
 - Depression _____
 - Easily Susceptible to Stress _____
 - Loss of Balance _____
 - Lack of Coordination _____
 - Anxiety _____
- Have you ever been treated for emotional problems? _____
- Have you ever considered or attempted suicide? _____
- Any other neurological/psychological problems? _____

LIFESTYLE:

- Do you follow a regular exercise program? _____
- Please describe your average daily diet: _____
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- Cigarette Smoking _____ Coffee, Tea & Cola _____ Alcoholic Beverages _____
- Prescription medications taken within the last two months: _____
-
- Other Supplements: _____

Vancouver Acupuncture

PATIENT INFORMATION

Name:	Birthdate:	Age:
Address:	Gender: M F	
City:	State:	Zip:
Home Phone: ()	Height:	
Work Phone: ()	Weight:	
Occupation:	Marital Status: M S D W	
Employer:	Partner name:	
Email Address:	Emergency Contact:	
Referred by:	Emergency Contact Phone:	

CONSENT TO TREATMENT

I hereby authorize my acupuncturist, Edward Chiu, LAc, DAOM, to administer any style of oriental medicine relevant to my diagnosis and treatment, including but not limited to the following procedures:

1. Insertion of acupuncture needles into my body at various depths and locations.
2. Heat treatments using moxibustion or a conventional heat lamp. With any type of heat, there is a risk of burn.
3. Cupping may be used to promote the circulation. Cups may produce a red/purple color on the area cupped, which may remain for 1-5 days.
4. Electrical stimulation of the needles may be used, which produces a vibration/tapping sensation on the needles.

Acupuncture: I have read the information and discussed all questions with my acupuncturist. I understand that I have a right to refuse any form of treatment. I understand that acupuncture might involve certain risks which include bruising, bleeding, fainting, infection, drowsiness, or pneumothorax. I understand that this office does not order lab tests or X-rays, and that my acupuncturist is not responsible for making any western medical diagnosis. I understand that there is a possibility of an unexpected complication, and I understand that no guarantee can be made concerning the results of treatment.

Chinese Herbal Medicine: Chinese herbal substances may be recommended to treat bodily dysfunction or diseases, or to normalize the body's physiological functions. If prescribed these, I will follow the directions for administration and dosage. There may be certain side effects such as: changes in bowel movement, abdominal pain or discomfort. If I experience any discomfort or new symptoms soon after taking the herbs, I understand that I should stop the herbs and that I am responsible for informing the licensed acupuncturist of my symptoms. I accept full responsibility to inform the licensed acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Signature of Patient _____ Date _____

Print Name: _____