HEALTH HISTORY QUESTIONNAIRE

Please take the time to fill out this questionnaire carefully. *All of your answers will be held confidential*. If you have questions, please ask. If there is 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_________________

Phone_________________________ E-Mail _______________________________

Date of Birth ________________ Height_________ Weight___________

Marital Status: □ Married □ Never Married □ Widowed □ Divorced/Separated

Occupation: ____________________Retired:_____Disabled:_____Unemployed:____

Emergency Contact: ____

Emergency Contact Relation to you: ______________________________________

Emergency Contact telephone: ____

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

Main Problem you would like us to help you with:

____

____

____

How long ago did this problem begin? Please be specific:

____

____

Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

____

What other kinds of treatment have you tried? □ Western Medicine □ Acupuncture

□ Herbs □ Massage □ Physical Therapy □ Chiropractor □ Reiki □ Homeopathy

□ Other:____

Secondary Complaints you would like us to help you with:

____

____

Past Personal Medical History of Significant Illnesses:

□ Asthma	□ Allergies	□ Diabetes	□ Cancer
□ Stroke	□ Heart disease	□ Seizures	□ Hepatitis
□ Hypertension	□ Thyroid disease	□ Venereal disease	□ Rheumatic Fever
□ Fibromyalgia	□ Blood clots	□ Anemia	□ HIV/AIDS
□ MS	□ Parkinson's	□ Digestive disorder	□ Arthritis

Other: ____

Hospitalizations/Surgeries (including dates):

____

____

Significant Trauma (auto accidents, falls, sports injuries, etc.):

____

____

Allergies (drugs, chemicals, metals, foods):

____

____

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

____

____

Are there any areas of your life that you find stressful? Please describe:

____

Do you have a regular exercise program? □ No □ Yes

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related)?
□ No □ Yes If Yes, what type of diet? ______________________________________

Do you smoke? □ No □ Yes

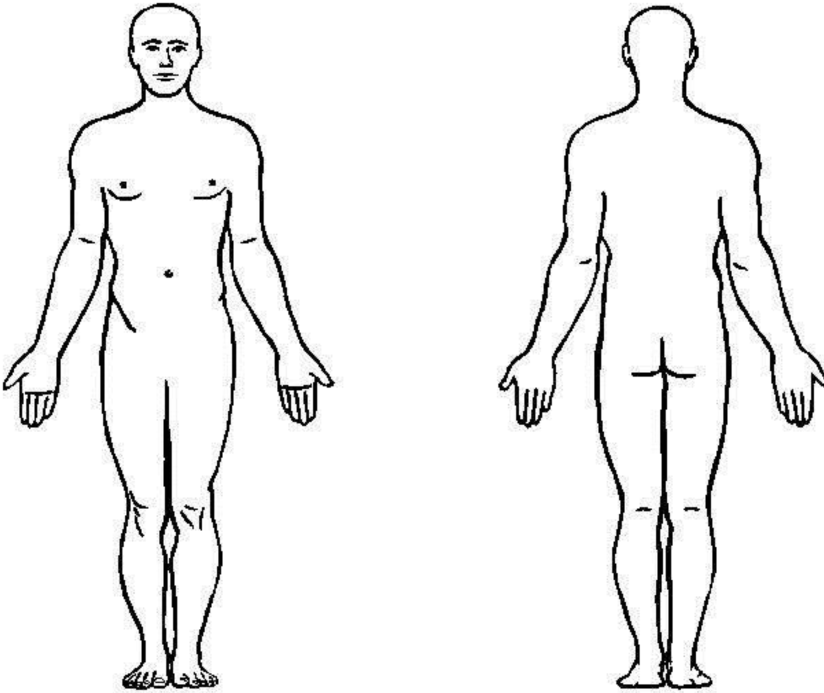
How many cups of caffeinated coffee, tea, or cola do you drink per day? __________

How many 8 oz. glasses of water do you drink per day? _________________________

How many alcoholic beverages do you drink per day? __________________________

How many hours per night do you sleep? _________ Do you sleep well? ___________

Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the **last three months**:

<u>GENERAL:</u>

□ Fevers	□ Chills	□ Fatigue	□ Sweat easily
□ Poor sleeping	□ Night sweats	□ Weight loss	□ Weight gain
□ Cravings	□ Change in appetite	□ Strong thirst	□ Bleed or bruise easily

□ Sudden energy drop, if so what time of day? ________________________________

<u>SKIN & HAIR:</u>

□ Rashes	□ Shingles	□ Hives	□ Itching
□ Eczema	□ Psoriasis	□ Dermatitis	□ Recent moles
□ Loss of hair	□ Dandruff	□ Dry skin	□ Pimples

□ Any other skin or hair problems? ____

HEAD, EYES, EARS, NOSE & THROAT:

□ Dizziness	□ Concussions	□ Floaters in eyes	□ Dry eyes
□ Glasses	□ Eye strain	□ Eye pain	□ Poor vision
□ Night blindness	□ Color blindness	□ Blurry vision	□ Cataracts
□ Earaches	□ Ringing in ears	□ Poor hearing	□ Sinus problems
□ Nose bleeds	□ Sore throats	□ Grinding teeth	□ Clenching jaw
□ Teeth problems	□ Jaw clicks	□ Sores on lips/tongue	□ Facial pain

□ Migraines/Headaches If so, where and when? ________________________________

□ Any other head or neck problems?____

CARDIOVASCULAR:

□ Fainting	□ Blood clots	□ Cold hands/feet	□ Swelling of hands
□ Chest pain	□ Heart Palpitations	□ Spider veins	□ Swelling of feet
□ High blood pressure	□ Low blood pressure	□ Irregular heart beat	□ Difficulty in breathing

□ Any other cardiovascular problems? ____

RESPIRATORY:

□ Cough	□ Asthma	□ Bronchitis	□ Pneumonia
□ Pain with deep breath	□ Chest tightness	□ Difficulty breathing when lying down	□ Phlegm production

□ Any other respiratory problems? ____

GASTROINTESTINAL:

□ Nausea	□ Vomiting	□ Acid reflux/GERD	□ Indigestion
□ Gas	□ Belching	□ Diarrhea	□ Constipation
□ Black stools	□ Blood in stools	□ Bloating	□ Abdominal pain
□ Slow digestion	□ Hemorrhoids	□ Hernia	□ Colitis
□ Excessive appetite	□ Poor appetite	□ IBS/Crohn’s disease	

□ Any other problem with stomach or intestines? _______________________________

GENITO-URINARY:

□ Frequent urination	□ Blood in urine	□ Pain with urination	□ Urgency to urinate
□ Kidney stones	□ Decrease in flow	□ Impotency	□ Unable to hold urine

□ Do you wake up at night to urinate? If yes, how many times a night? ______________

□ Any other problems with your genital or urinary systems? _______________________

REPRODUCTIVE & GYNECOLOGIC:

Are you pregnant? □ Yes □ No
Is it possible that you are pregnant? □ Yes □ No

# of pregnancies __	□ Menopause: age_	□ Vaginal discharge	□ PMS symptoms
# of live births ____	□ Painful periods	□ Vaginal dryness	□ Menstrual clots
# of miscarriages __	□ Irregular periods	□ Endometriosis	□ Heavy period
# of abortions ____	□ Infertility	□ Uterine fibroids	□ Light period
□ Polycystic Ovarian disease	□ Fibrocystic breast tissue	□ Cramping at ovulation	□ Spotting between periods

Date of last period: __________
Time period between menses: ________ Number of days period lasts: _________

Do you practice birth control? □ Yes □ No If yes, what type? _______ How long? _____

MUSCULOSKELETAL:

□ Neck pain	□ Shoulder pain	□ Hand/wrist pain	□ Foot/ankle pain
□ Knee pain	□ Arthritis	□ Hip pain	□ Sciatica
□ Bursitis	□ Carpal tunnel	□ Sprains/strains	□ Tendonitis
□ Muscle pain	□ Muscle weakness	□ Muscle spasm	□ Numbness

□ Back pain: Low_____ Middle______ Upper_____
□ Any other musculoskeletal problems? ______________________________________

NEUROLOGICAL & PSYCHOLOGICAL:

□ Seizures	□ Dizziness	□ Loss of balance	□ Poor memory
□ Poor coordination	□ Bad temper	□ Anxiety	□ Depression
□ ADD/ADHD	□ Bipolar	□ Easily susceptible to stress	

□ Any other neurological or psychological problems? ___________________________

Have you ever been treated for emotional problems? □ Yes □ No
Have you ever considered or attempted suicide? □ Yes □ No

COMMENTS: *Please tell us briefly of any other problems you would like to discuss.*

____

____

____

Acupuncture Consent to Treatment

I, ____________________________(print name), hereby authorize Lisa Facinelli, Lic. Ac., to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following.

- ☐ Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
- ☐ Heat treatments using Artemesia vulgaris (moxibustion, "moxa") or a conventional heat lamp. Indirect moxibustion treatments involve putting moxa on the head of the needle or on top of a barrier such as salt or a slice of ginger. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.
- ☐ A massage technique called "gwa sha." This treatment leaves redness on the skin that can last for 1-5 days. Slight bruising and tenderness may persist after the treatment.
- ☐ Cupping may be used to promote circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area treated lasting for 1-5 days.
- ☐ Electrical stimulation of the needles may be used which produces a vibration or tapping sensation.
- ☐ Bloodletting, alone or in conjunction with cupping, may be used to improve circulation in specific meridians. Lancets are inserted into the skin and a small amount of blood is expressed from the puncture.
- ☐ Chinese Herbal Medicine, in various forms such as pills, capsules, extract powders, and raw herbs, to be administered orally and /or topically. Some patients may experience side effects from their particular prescription. Please inform your practitioner of any adverse effects you may be experiencing.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

Patient Signature: ____

Printed name of patient: ____

Date: __________

Client Agreement

HIPPA regulations require the following signed authorization:

I (name)____________________________(address)___________________________________
give permission for my practitioner to take notes about me, including health history/medical and/or personal information I choose to disclose. I understand that this information will be kept strictly confidential. I also understand:

- That acupuncture is for the purpose of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow and is not a substitute for medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I might have.

- That the acupuncturist does not diagnose illness, disease or any other physical or mental disorder and does not prescribe medical treatment or pharmaceuticals.

- That any and all of my appointment times are reserved exclusively for me and that I am responsible to remember them and to pay for appointments that I miss or cancel with less than 24 hours notice.

I have stated all my known medical conditions and take it upon myself to keep the acupuncturist updated on my physical health.

Patient Signature ______________________________________ Date: _____________

Recommendation for a Diagnostic Examination

Your licensed acupuncturist shall perform an acupuncture or Oriental medicine evaluation and develop an acupuncture or Oriental medicine treatment plan accordingly. Your acupuncturist may not diagnose a physical or mental ailment or condition or prescribe or dispense a drug. As a precaution, your licensed acupuncturist recommends that you receive a diagnostic examination from a licensed physician, dentist or podiatrist with regard to the ailment or condition to be treated.

We, the undersigned, do affirm that __________________________________ (Name of patient) has been advised by Lisa Facinelli (Licensed Acupuncturist), to consult a physician regarding the condition for which acupuncture treatment is being sought

Patient Signature ______________________________________ Date: _____________

Acupuncturist Signature ______________________________________ Date: _____________

The patient will promptly be referred to a physician, dentist or podiatrist, as appropriate to the patient's condition, if the acupuncturist determines that further acupuncture or Oriental medicine treatment is contraindicated for the patient or determines that the patient's symptoms have worsened.