Health History Questionnaire and Registration

PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____Birth date _____

Occupation_____

Company name _____

Primary physician _____

Physician phone number_____

How did you hear about us?_____

_____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Another person we may contact if needed:

Name_____

Relationship_____

Home phone _____

Work phone_____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- _____

2 - _____

3 - _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check illnesses that have occurred in blood relatives.

0 Diabetes 0 High blood pressure 0 Stroke
0Cancer 0 Heart disease 0Kidney disease

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes

How long has it been since you have had a complete medical exam? _____

Health History Continued

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- □ Tremors or Cramps
- □ Swollen joints

Pain, weakness, numbness in:

- □ Arms or Hips
- □ Back Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats

GENITO/URINARY

- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Lowered libido

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

FOR MEN ONLY

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble

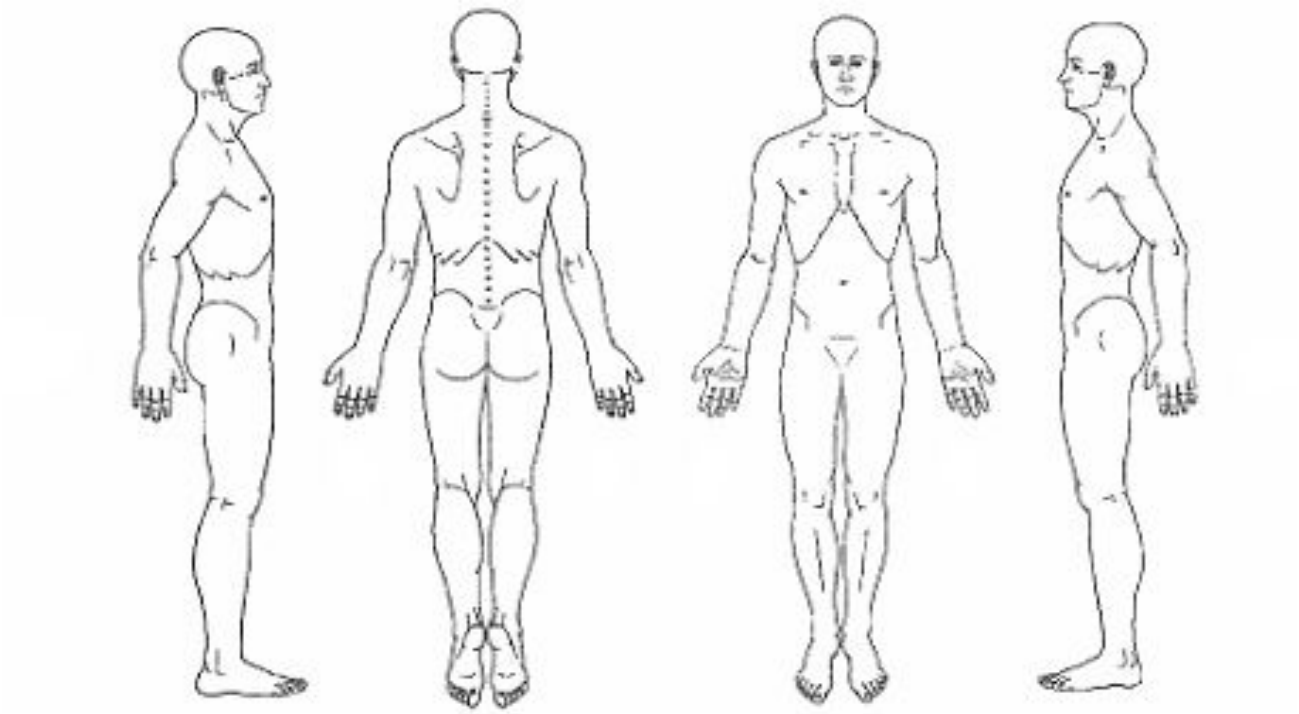
FOR WOMEN ONLY

- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Scanty menstrual flow

Could you be pregnant?_____

Please Mark areas where you feel pain, discomfort, or tension:

(write intensity of pain on 1-10 scale with 1 being no pain and 10 extreme pain)



ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

1 hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this
form or not

I understand that methods of treatment may include, but are not limited to, acupuncture, massage, moxibustion, cupping, electrical stimulation, nutritional supplements, Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Bums and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a dean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who **is** caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest and I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports and all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about therisks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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

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Patient Name_____

Patient Signature_____ Date:_____
(Or Patient Representative – Indicate relationship if signing for patient)

Acupuncturist Name:_____

FOR MASSAGE THERAPY PATIENTS:

Name:_____ **Date:**_____

Have you received Massage Therapy or Bodywork before? **YES** **NO**

What type of Bodywork?_____

When was your last massage?_____ Do you exercise?_____

How often? What types of exercise?_____

What is your goal for today's session?_____

Do you have a preferred type of touch?_____

Are there any areas of the body you do not like touched? For examples glutes, head, face...

_____

Consent Waiver for Massage Therapy:

Draping will be used during the session – only the area being worked on will be uncovered.
Children under the age of 18 need informed written consent by a parent or guardian.

I,_____[print name], understand that this massage is for therapeutic purposes. Massage should not be construed as a substitute for medical examination, please see a qualified specialist for diagnosis of any kind. Because massage should not be performed under certain medical conditions. I affirm I have stated all my known medical conditions and answered all questions honestly. I agree to keep my massage therapist at CALDWELL FAMILY WELLNESS informed and updated of any changes in my health history.
We kindly request your cooperation in helping us provide treatment for those in need. As a result, we have a 24-hour cancellation policy. Any cancellations made less than 24 hours will be charged the full amount. Late arrivals may result in adjusted massage time.

Signature of Client_____

Signature of Parent or Legal Guardian (If under age 18)_____