CONFIDENTIAL HEALTH HISTORY

Welcome! Please take the time to fill out this questionnaire fully. Your answers are strictly confidential. If you have any questions, please feel free to ask.

Today's Date _____

Name _____ Date of Birth _____

Address_____ City _____ State _____ Zip _____

Tel: Work _____ Home _____ Cell _____

E-mail _____ Age _____ Gender _____

Occupation_____ Referred by _____

Emergency Contact Name & Tel# _____ Relationship _____

What would you like treated by acupuncture? _____

How and when did this condition develop? _____

_____

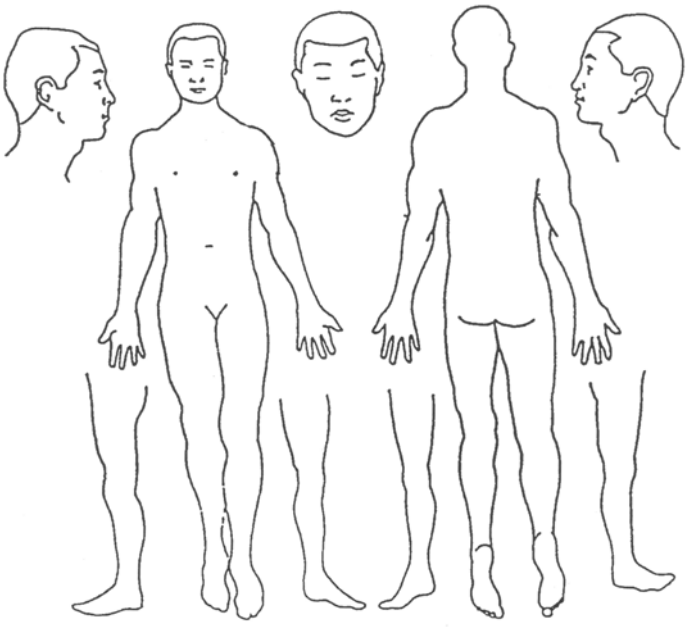
How has this condition affected your daily activities? _____

What medical diagnosis have you received, if any? _____

What kinds of treatment or therapy have you tried? _____

Are you currently pregnant? _____ Are you presently trying to become pregnant? _____

Please shade any areas of pain or distress on the diagram below:



Medical History: Please check off any current or former conditions and include dates as well as any relevant information.

- ❑ Allergies
- ❑ Asthma
- ❑ Sinusitis
- ❑ Frequent colds
- ❑ Frequent childhood illnesses
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Sugar cravings
- ❑ Food cravings
- ❑ Bloating/gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excess appetite
- ❑ Excess thirst
- ❑ Dry mouth
- ❑ Weight loss
- ❑ Weight gain
- ❑ Decreased appetite
- ❑ Increased appetite
- ❑ Stomach cramping/pain
- ❑ Acid reflux
- ❑ Hiatal hernia
- ❑ Hyperthyroid
- ❑ Hypothyroid
- ❑ Seizures
- ❑ Headaches
- ❑ Migraines
- ❑ Hepatitis A/B/C
- ❑ Herpes
- ❑ Venereal disease
- ❑ AIDS/HIV
- ❑ Tuberculosis
- ❑ Alcoholism
- ❑ Multiple Sclerosis
- ❑ Heart Disease
- ❑ Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ Hypertension
- ❑ Hypotension
- ❑ Varicose veins
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Nose bleeds
- ❑ Lymph Nodes removed
- ❑ Lymph nodes enlarged
- ❑ Eczema
- ❑ Psoriasis
- ❑ Itchy Skin
- ❑ Dry skin
- ❑ Other skin rashes

_____

- ❑ Latex allergy
- ❑ Brittle nails
- ❑ Aches/pains
- ❑ Muscle spasms
- ❑ Arthritis
- ❑ Numbness
- ❑ Neuropathies
- ❑ Urinary difficulty
- ❑ Urinary frequency
- ❑ Water retention
- ❑ Cold hands/feet
- ❑ Cold body temp
- ❑ Hot body temp
- ❑ Night sweats
- ❑ Hot flashes
- ❑ Excessive sweating
- ❑ Insomnia
- ❑ Fatigue
- ❑ Anxiety
- ❑ Depression
- ❑ Mood swings
- ❑ Irritability
- ❑ Panic attacks
- ❑ Palpitations
- ❑ Dizziness
- ❑ Vertigo
- ❑ Difficulty concentrating
- ❑ Forgetful
- ❑ Hair loss
- ❑ Dry/brittle hair
- ❑ Premature greying
- ❑ Poor vision
- ❑ Dry eyes, itchy eyes
- ❑ Eye strain/pain
- ❑ Seeing spots
- ❑ Ear pain
- ❑ Ringing in ears
- ❑ Clogged ears
- ❑ Dental problems
- ❑ Cold sores
- ❑ Bleeding gums
- ❑ Other: _____

_____

_____

Vaccination History: Any reaction that you remember? Any unusual vaccinations?

_____

Please describe any significant injuries/trauma, illnesses, or surgeries:

Birth trauma, if any _____

Age _____

Age _____

Age _____

Age _____

Age _____

Age _____

Scars: from injury/surgery (even minor): _____

Medications: Please list all medications (including over-the counter), herbs, vitamins and minerals you are taking.

_____

_____

_____

Family Medical History: Please list all major illnesses in your close family such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorder, orthopedic disorders, etc.

_____

_____

_____

Men:

❑ Prostatitis ❑ Impotence

Other _____

Women:

Age at first menses _____ days between cycles _____ duration of flow _____
Color/quality of blood_____ birth control type _____

Check all that apply:

❑ PMS, symptoms _____
❑ Heavy flow
❑ Light flow
❑ No flow
❑ Pain/discomfort before period
❑ Pain/discomfort during period

Number of pregnancies _____ deliveries _____
Pregnancy complications _____

Age at menopause (if applicable)_____ Symptoms, if any _____
Hormone replacement (if applicable) _____

PLEASE NOTE: This office has a 24 hour cancellation policy. Please notify us well in advance if you need to change or cancel your appointment. Thank you!

Informed Consent

I consent to Acupuncture treatments and related procedures associated with Oriental Medicine, by Heidi Botnick, L.Ac. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, Tui-Na, electrical stimulation, Chinese herbology and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have minor side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. This office uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of moxibustion. There may be some bruising after cupping and gua sha that may last a few days. There have been very rare instances reported of spontaneous miscarriage and pneumothorax. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements that are used are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will stop taking them and immediately inform the acupuncturist.

I will notify the acupuncturist should I become pregnant or if I am trying to become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I have been told about the risks and benefits of acupuncture and other procedures and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____

Signature of Patient or Patient's Representative

_____

Date