

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? _____

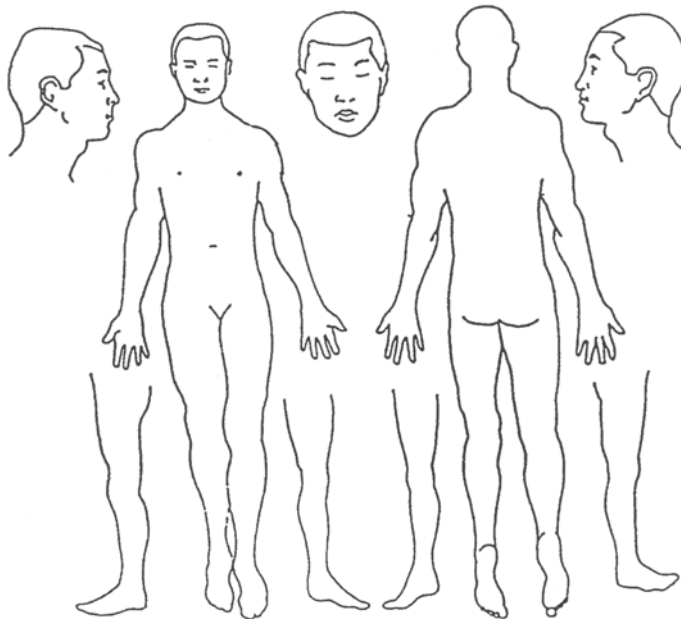
How has this condition affected your daily activities? _____

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.

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Frequent childhood illnesses | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Sugar cravings | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Bloating/gas | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Lymph Nodes removed | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lymph nodes enlarged | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Excess appetite | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Excess thirst | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dry/brittle hair |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Itchy Skin | <input type="checkbox"/> Premature greying |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Other skin rashes | <input type="checkbox"/> Dry eyes, itchy eyes |
| <input type="checkbox"/> Decreased appetite | _____ | <input type="checkbox"/> Eye strain/pain |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Seeing spots |
| <input type="checkbox"/> Stomach cramping/pain | <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Ear pain |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Aches/pains | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Clogged ears |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Numbness | <input type="checkbox"/> Cold sores |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Neuropathies | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Urinary difficulty | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Urinary frequency | _____ |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Water retention | _____ |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Cold hands/feet | |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Cold body temp | |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hot body temp | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hot flashes | |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Excessive sweating | |

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 _____

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