

**Acupuncture & Alternative Health
Of Brazoria County
111 Circle Way
Lake Jackson, TX 77566
979-297-0270**

HEALTH HISTORY QUESTIONNAIRE

Information for your Acupuncturist

Important: The information on this form will help your Acupuncturist to give you the best and most comprehensive care possible. It is important for you to complete this document as thoroughly as possible. Even though some of the questions may seem completely unrelated to your condition, they may play a contributing, or underlying role in diagnosis and treatment of your problem.

All of the information provided is strictly confidential

I. General Patient Information

Today's Date ____ / ____ / ____

Name: _____ Age: _____ D.O.B. ____ / ____ / ____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____

E-Mail Address _____

Would you like to receive our E-news letter? Yes No

Name of guardian (if under 18) _____

Emergency Contact: _____ Phone: (____) _____

Gender: Male Female Height: ____' ____" Current weight: _____ lbs.

Relationship Status: single living alone ____ single living with others ____ divorced _____

Married ____ Other ____ Children _____ How many? _____

Childrens' names, ages and gender _____

Your Occupation: _____

How did you hear about our office? _____

Major Health Complaint(s). Please list in order of significance to you:

1. _____ 4. _____

2. _____ 5. _____

3. _____ Additional: _____

Please explain how these conditions affect or impair your daily activities. Examples may include your overall quality of life, work or career, family life, hobbies, self-esteem, etc.

Are you currently being treated by other health care providers?

Types of providers: _____

When did you last see a dentist or dental hygienist? _____

How do you rate your current level of health?

(Very poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

II. Patient Medical History

Please describe your childhood health _____

Have you ever been hospitalized? If so, please describe the procedures you had done, and the dates.

If necessary, use back of page.

Recent Medical Tests or Procedures (please indicate test results and dates below)

- | | | | |
|---------------------------------------|--------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Physical | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Prostate exam | <input type="checkbox"/> Blood test |
| <input type="checkbox"/> HIV / STD | <input type="checkbox"/> Pap smear | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Colonscopy |
| <input type="checkbox"/> Bone density | <input type="checkbox"/> Urine test | <input type="checkbox"/> Eye exam | <input type="checkbox"/> Other |

Test Results and Date: _____

Check any conditions that you have had in the past, or are currently experiencing. (Also check any conditions that run in your family and use abbreviations to indicate which family members- m-mother, f-father, gm-grandmother etc.)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding or hemorrhage |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Auto Immune Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Kidney disease |

Other _____

Immunizations: _____

Surgeries (if different from procedures listed in hospitalization record) _____

If you have allergies, please list the substances to which you are most sensitive:

What is your Blood Type? _____

Please list any prescription drugs you currently take _____

(If you take many prescriptions continue on the back of this page)

Please list any non-prescription or recreational drugs you currently take _____

How frequently do you use these drugs? _____

If you are a smoker, # of cigarettes per day _____ How long have you been smoking? _____

Do you drink alcoholic beverages? _____ What kinds? And how much of each?

Do you drink caffeinated beverages? _____ What kinds? And how much of each?

Do you exercise regularly? _____ Please describe _____

Do you meditate? _____

Do you have a social group that you regularly participate in? _____

How many meals a day do you typically eat? _____

Please describe your Typical Day's Diet (breakfast, lunch, dinner, snacks, beverages)

Breakfast _____ When _____

Lunch _____ When _____

Dinner _____ When _____

Snacks _____ When _____ When _____

III. Patient Profile

Please check any of the following symptoms that currently pertain to you (if you have symptoms in the following categories, it indicates that you may have a problem with that organ's function)

Overall Body Temperature (Kidney Organ System)

- | | | | |
|---------------------------------------|--|---|---|
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Profuse perspiration | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Night time urination |
| <input type="checkbox"/> Sweaty palms | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Night sweating | |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Strong thirst | |

Overall Energy (Lung and Kidney System)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Prone to illness | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sweating without exertion | <input type="checkbox"/> Frequent colds / flus | <input type="checkbox"/> Chronic allergies |

Blood Function (Liver, Heart and Spleen System)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Itchy or dry | <input type="checkbox"/> Blurry vision |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weak or brittle nails |

Heart Function

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Manic moods | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Tongue ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Severe shyness |

Lung Function

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Dry or flaky skin | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Cigarette smoking |

Spleen Function

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gas | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Strong food cravings | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Indigestion |

Stomach Function

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |

Bowel Function and Elimination (Intestinal Function)

- Loose stools
- Constipation
- Difficulty moving bowels
- Diarrhea
- Blood in stools
- Small, hard, dry stools
- Incomplete stools
- Mucous in stools
- Less than 1 BM/ Day

Accumulated Dampness

- Mental fogginess
- Swollen hands
- Edema in the legs
- Mental sluggishness
- Swollen feet
- Edema in the abdomen
- Poor mental focus
- Joint stiffness / ache
- Chest congestion
- Heaviness of the head, the limbs, or of the whole body
- Symptoms worsen in rainy weather

Liver and Gall Bladder Function

- Chest pain
- Irritability
- Depression
- Skin rashes
- Chest tightness
- Easy to anger
- Pain in the ribcage
- Acne
- All over body tension
- Easily frustrated
- Heaviness in ribcage
- Headaches
- Muscle spasms
- Convulsions
- Chronic neck tension
- Migraines
- Muscle cramps
- Numbness / tingling
- Shoulder tension
- Gall stones
- Seizures
- Lump in throat
- Ringing in ears
- Eye pain / dryness
- Alternating diarrhea and constipation
- Easily overwhelmed by stressful circumstances

Eyes (Liver Function)

- Itchy eyes
- Grittiness
- Bloodshot
- Far sighted
- Dry eyes
- Poor night vision
- Seeing spots
- Astigmatism
- Watery eyes
- Red and irritated
- Near sighted
- Glaucoma

Kidney and Urinary Bladder Function

- Frequent cavities
- Weak knees
- Cold lower back
- Hair loss
- Broken / loose teeth
- Knee soreness
- Cold hips / buttocks
- Early graying of hair
- Weak bones
- Low back pain
- Cold knees
- Hearing loss
- Low-pitched ringing in the ears
- Incontinence
- Quick to fear / fright

Urinary Function

- Normal color
- Reddish color
- Small amount
- Night-time urination
- Dark Yellow
- Cloudy
- Large amount
- Pain or burning
- Clear color
- Strong odor
- Very frequent
- Hesitancy
- Difficulty initiating the stream of urination
- Dribbling
- Weak stream

Libido Function

- Normal
- High sex drive
- Diminished sex drive
- Vaginal dryness
- Early ejaculation
- Spermatorrhea
- Nocturnal emissions
- Infertility
- Difficulty getting or maintaining an erection
- Fatigue following sexual activity

Patient Notification to Acupuncturist of Physician's Evaluation Status and other information.

[Pursuant to the requirement of 183.6(e) of this title (relating to Denial of License; Discipline of License) and Tex. Occ Code Ann., 205.351, governing the practice of Acupuncture.]

I (patient's name) _____ hereby notify Marc Hems, the
Acupuncturist, of the following: (Check One Best Applicable Below)

I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognized that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

_____ Patient Initials Date: _____ Yes _____ No _____

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 2 months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. It is my responsibility and choice whether to follow this advice.

_____ Patient Initials Date: _____ Yes _____ No _____

Patient's Signature: _____ Date: _____

Note

Exemptions according to Rule 183.6(e) Scope of Practice

...an Acupuncturist holding a current and valid license may without an evaluation or a referral from a physician, dentist, or chiropractor perform acupuncture on a person for **smoking addiction, weight loss, alcoholism, chronic pain, or substance abuse.**

Acupuncture & Alternative Health Clinic of Brazoria County Informed Consent to Oriental Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below for whom I am legally responsible) by Acupuncture & Alternative Health Clinic of Brazoria County (AAHCBC). for today and in the future: acupuncture and other oriental health procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation, cupping, mild bleeding therapy; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations, exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with an acupuncturist the nature and purpose of acupuncture and the other Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures have helped many people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pain or other strong sensation at the location where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries, and strokes. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish the acupuncturist to exercise such judgment, during the course of my treatment, based on the facts known, to be in my interest. I authorize the acupuncturist to perform any necessary services needed during the diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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 from Acupuncture & Alternative Health Clinic of Brazoria County.

Patient's name (please print)

Patient's name (signature)

Date signed

Witness

If patients is a minor or has a legal guardian, a parent or guardian needs to sign below:

Print name of patient's representative

Relationship or authority

Signature of patient's representative

Date signed