MIMI'S FAX: 609-279-1455

PATIENT HISTORY

Name: _____ Phone Home: _____ Work: _____
Cell Phone_____ Fax: _____Email Address: _____
Address: *(street)*_____ Age:_____ Ht:_____ Wt:_____ Sex:_____
(city) _____ Birth Date:_____ Marital status:_____ No. of children: ___
*(state)*_____*(zip)*_____ Occupation: _____ Soc. Sec. No.:_____
Employer's Name and Address: _____
Primary Physician & Phone:_____Referred by: _____
In emergency, contact: _____ Emergency phone number:_____
Their address:_____ Relationship: _____
Insurance Company's Name and Address:_____
Check: ❑ Individual Policy ❑ Group Policy Insurance Policy Number: _____

PURPOSE FOR COMING: _____
_____
_____
_____

MAJOR COMPLAINT only: _____
_____
_____
_____
_____

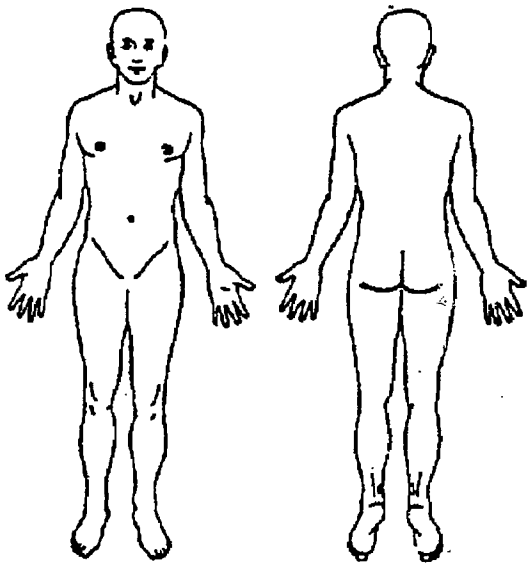
How did this condition develop? (What caused it? How did it start?)_____
_____
_____

When was the first time you were aware of this condition?_____
_____
_____

Have you ever had this condition or similar condition before? If yes, please explain:_____
_____
_____
_____

Have you ever received any treatment for this condition?
❑ Yes ❑ No If yes, where? _____
When? _____
By whom?_____
What was the diagnosis?_____
What were the results of treatment?_____
_____
_____

If you are in pain, please mark the exact location of your pain on the figure below. Describe the type, frequency, intensity and duration of your pain, as well as any activity which brings on or aggravates the pain. (i.e. abdominal sharp pain, every 30 seconds, for the last two hours when standing or sitting.)



Has the condition been getting ❑ better ❑ worse or ❑ staying the same?
Are you experiencing physical, mental, or emotional stress at ❑ home or ❑ at work ❑ other_____
How has this condition affected the following:
Your home life:_____
Your work experience: _____
Your social life:_____
Your ability to exercise: _____
Rest and sleep:_____
Other:_____
State injuries you have had, related or otherwise, to your condition:_____
_____
❑ Broken bones ❑ Concussion or Head Injury ❑ Dislocations ❑ Sprains ❑ Loss of Consciousness

CURRENT AND FORMER CONDITIONS

Name: _____ **Date:** _____

Underline current conditions. Put a check mark in the box for former conditions.
State duration, frequency, intensity and pain in the space beside current symptoms.

GENERAL SYMPTOMS
- ❑ Tremors
- ❑ Headache
- ❑ Fever
- ❑ Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Depression
- ❑ Loss of weight
- ❑ Forgetfulness
- ❑ Numbness or pain in arms, hands, elbows, shoulders, hips, legs, knees, or feet
- ❑ Confusion
- ❑ Auto Immune Deficiency
- ❑ Paralysis

EYES, EARS, NOSE AND THROAT
- ❑ Failing vision
- ❑ Near sighted
- ❑ Eye pain
- ❑ Eye strain
- ❑ Cross eyed
- ❑ Eye inflammation
- ❑ Glaucoma
- ❑ Deafness
- ❑ Earache
- ❑ Loss of hearing
- ❑ Ear discharge
- ❑ Ear noises
- ❑ Nose bleeds
- ❑ Nasal obstruction
- ❑ Nasal drainage
- ❑ Loss of smell
- ❑ Sinus infection
- ❑ Hay fever
- ❑ Allergies
- ❑ Sore throat
- ❑ Hoarseness
- ❑ Difficult speech
- ❑ Difficult swallowing
- ❑ Loss of taste
- ❑ Change in tastes
- ❑ Dental decay
- ❑ Gum troubles
- ❑ Tonsillitis
- ❑ Asthma
- ❑ Frequent colds
- ❑ Enlarged thyroid
- ❑ Enlarged glands

SKIN
- ❑ Skin eruptions
- ❑ Clammy skin
- ❑ Dryness
- ❑ Bruises easily
- ❑ Boils
- ❑ Rashes
- ❑ Sensitive skin
- ❑ Hives or allergy

RESPIRATORY
- ❑ Chronic cough
- ❑ Spitting up phlegm
- ❑ Spitting up blood
- ❑ Chest pain
- ❑ Difficult breathing
- ❑ Wheezing

CARDIOVASCULAR
- ❑ Rapid beating heart
- ❑ Slow beating heart
- ❑ Irregular beating heart
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Pain over heart
- ❑ Previous heart stroke
- ❑ Hardening of arteries
- ❑ Swelling of ankles
- ❑ Poor circulation
- ❑ Paralytic stroke
- ❑ Varicose veins

MUSCLE AND JOINT
- ❑ Stiff neck
- ❑ Pain between shoulders
- ❑ Backache
- ❑ Painful tail bone
- ❑ Foot trouble
- ❑ Hernia
- ❑ Spinal curvature
- ❑ Faulty posture
- ❑ Swollen joints
- ❑ Stiff joints
- ❑ Painful joints
- ❑ Arthritis
- ❑ Sore muscles
- ❑ Weak muscles
- ❑ Walking problems
- ❑ Sciatica

GENITOURINARY
- ❑ Frequent urination
- ❑ Scanty urine
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Pus in urine
- ❑ Kidney infection or stones
- ❑ Bed wetting
- ❑ Inability to control urine
- ❑ Prostrate trouble
- ❑ Bladder trouble
- ❑ Foul smelling urine
- ❑ Discolored urine

GASTROINTESTINAL
- ❑ Poor appetite
- ❑ Excessive hunger
- ❑ Difficult chewing
- ❑ Belching or gas
- ❑ Nausea
- ❑ Gas
- ❑ Vomiting
- ❑ Vomiting of blood
- ❑ Pain over stomach
- ❑ Distention of abdomen
- ❑ Constipation
- ❑ Diarrhea
- ❑ Black stool
- ❑ Blood in stool
- ❑ Colon trouble
- ❑ Hemorrhoids (Piles)
- ❑ Intestinal worms
- ❑ Liver trouble
- ❑ Gall bladder trouble
- ❑ Jaundice
- ❑ Colitis
- ❑ Weight trouble

FEMALE
- ❑ Painful menstrual periods
- ❑ Excessive flow
- ❑ Hot flashes
- ❑ Irregular cycle
- ❑ Cramps or backache
- ❑ Previous miscarriage
- ❑ Vaginal discharge
- ❑ Vaginal pain
- ❑ Congested breast
- ❑ Breast pain
- ❑ Lumps in breast
- ❑ Menopausal symptoms
- ❑ Abnormal bleeding
- ❑ Reduced sexual energy
- ❑ Pregnancy
- ❑ Pregnancy complications

MALE
- ❑ Pain associated with genitals
- ❑ Reduced sexual energies
- ❑ Premature ejaculation
- ❑ Seminal emission
- ❑ Impotence
- ❑ Discharges

Name: _____ Date: _____

FEMALES ONLY

Are you or might you be pregnant? ❑ Yes ❑ No ❑ Maybe If yes, what month? _____
What method of birth control do you use?_____
Are you experiencing reduced sexual energies? ❑ Yes ❑ No Other difficulties? ❑ Yes ❑ No
Explain:_____
Do you have regular PAP tests? ❑ Yes ❑ No How regular? _____

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

Menstrual Cycle
Age started: _____ Age stopped: _____
- ❑ Irregular _____
- ❑ Painful _____
- ❑ Excess blood _____
- ❑ Lack of blood _____
- ❑ Dark _____
- ❑ Light _____
- ❑ Heavy clotting _____
- ❑ Water retention _____
- ❑ Painful breast _____

Vaginal Discharge:
- ❑ Liquid _____
- ❑ Yellow _____
- ❑ Thick _____
- ❑ Bad odor _____
- ❑ White _____
- ❑ Other _____

Gynecological History or Operations:
- ❑ Ovaries _____
- ❑ Uterus _____
- ❑ Tubes _____
- ❑ Vagina _____
- ❑ Breast _____
- ❑ Other _____

Pregnancy:
Total Number: _____
Number of children: _____
Number of abortions: _____
Number of miscarriages: _____
Complications: _____

MALES ONLY

PLEASE CHECK OR EXPLAIN IF APPLICABLE:

- ❑ Reduced sexual energies: _____
- ❑ Premature ejaculation: _____
- ❑ Seminal emission: _____
- ❑ Impotence: _____
- ❑ Discharges: _____
- ❑ Pain associated with genitals:_____
- ❑ Other: _____

HABITS, DIET, MEDICINES, ALLERGIES

Name:_____ **Date** _____

LAST PHYSICAL: Date_____Practitioner:_____Results:_____

HABITS: Indicate below: Heavy, Moderate, Light, or None If significant, comment.

Heavy	Moderate	Light	None	
❑	❑	❑	❑	Alcohol:
❑	❑	❑	❑	Coffee:
❑	❑	❑	❑	Tea:
❑	❑	❑	❑	Tobacco:
❑	❑	❑	❑	Exercise:
❑	❑	❑	❑	Sleep:
❑	❑	❑	❑	Appetite:
❑	❑	❑	❑	Energy:
❑	❑	❑	❑	Medication:
❑	❑	❑	❑	Vitamins:
❑	❑	❑	❑	Diet:
❑	❑	❑	❑	Teeth problems:
❑	❑	❑	❑	Drugs:
❑	❑	❑	❑	Salt:
❑	❑	❑	❑	Other:
❑	❑	❑	❑	Stress: _____ (Chemical, physical, psychological)

AVERAGE DAILY DIET

Morning:

Afternoon:

Evening:

Between Meals:

Are you now on (or have you undertaken) a restricted diet? Please describe and indicate when.

_____

_____

MEDICINES taken within the last two months (include vitamins, over-the counter drugs, herbs)

_____

_____

ALLERGIES: (Drugs, chemicals, foods. Type of reaction.)

_____

_____

EMOTIONS AND PREFERENCES

Choose one or two EMOTIONS that seem predominant in your life (frequently experienced, difficult to express, or in some way influential): _____

_____

Please indicate approximate dates and briefly describe the nature of any traumatic experience you have had (e.g., divorce, change of residence, injury, death in family, bankruptcy, etc.):

Date:	Event:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What types of acute illnesses do you get, and roughly how often have you experienced them in the past five years (if not indicated previously)?

What is the most important health change you would like to occur?

Please add any other information about yourself or your condition that might not have been previously mentioned.

Continue on the back if you need additional space.

Disclosure of the Risks and Benefits of Acupuncture Care

The World Health Organization identifies numerous conditions acupuncture has successfully treated—not by attacking the condition, but by restoring the balance in the body, mind and spirit's energy and communication system. Acupuncture practitioners are trained not only in the technical skills, but in healing and centering skills which foster a greater harmony with the self, providing an atmosphere supportive of growth and well-being. Their training and experience utilizes a refined system of corollaries in the inquiry process, assessing, evaluating and treating the imbalances in oneself. Many acupuncture practitioners offer herb, nutritional, and life style counseling, breath techniques, exercise and other approaches to support a person's sense of health and wholeness.

Acupuncture is quite safe. Acupuncture practitioners are trained in strict standards set by the National Commission for the Certification of Acupuncturists for clean needle technique and must abide by the standards set by Occupational Safety and Health Administration regarding proper hygiene and sterilization of equipment, disposal of hazardous materials, as well as precautions regarding blood borne pathogens and clean needle technique. With disposable needles, there is no risk of AIDS from the needles or hepatitis. Acupuncture practitioners and assistants are required by law to obtain hepatitis vaccinations.

The risk of side effects could include some pain in the treatment area, minor bruising, moxa burn or scarring, fainting, infection, needle sickness or broken needle. Occasionally a treatment can produce a temporary flare-up of symptoms, but these are almost always limited to no more than a few days. Awareness of the patient's condition can avert most harms. The risks of moxa use can be averted by good technique and communication with the patient. Fainting can be most easily avoided if the patient takes care not to come for treatment when he or she is exhausted, tired or hungry. Fainting also can be avoided by working with breath, guided movement, and proper positioning on the table. To avoid needle breakage, patients must limit their movement while on the table and be careful if needles are legally permitted out of the practitioner's range. Timely needle removal and instructions regarding such while the patients are at home can avert infection. By following the instructions of the acupuncture practitioner before and after treatment, the patient can avoid difficulty.

Most acupuncture practitioners work well with conventional medical physicians in a coordination of care situation which may be either required by state law or simply needed with patients. Regarding the recommendations of herbs, acupuncturists are trained in the contraindication of herbs with drugs and often work closely with medical doctors when there are questions. Furthermore, acupuncturists and oriental medical practitioners are required to be versed in the FDA safe standards of herbal use, particularly since there are hazards with non standardized herbal preparations. Except where state and federal law coincide, an acupuncture practitioner may not legally prescribe, dispense or administer herbs as prescription medication or controlled substance for medical disease diagnoses; however, herbs may be given, provided or recommended with the specific intended purpose of promoting health and well-being.

An incautious acupuncture practitioner can puncture the lung or other vital organs or produce bleeding by piercing a large blood vessel; therefore, it is recommended to receive acupuncture in situations where you trust your gut level feelings about the practitioner, can receive acupuncture from an experienced acupuncturist or by trustworthy referral. Serious consequences of acupuncture are rare. The statistics in the field of acupuncture for safety are far higher than for allopathic medical practices.

The acupuncture practitioner must be advised if the patient has a pacemaker or bleeding disorder, might be pregnant or has a contagious disease. Patients who take blood thinners such as coumadin (warfarin) should probably not get acupuncture, due to the increased risk of internal bleeding. If the patient has a potentially serious disorder, the practitioner shall be in alignment with state law and training in conditions contraindicative to acupuncture care and refer the patient as is appropriate to either the emergency room or request consultation or written diagnosis from a licensed physician with regard but not limited to cardiac conditions including uncontrolled hypertension; acute, severe abdominal pain; acute undiagnosed neurological changes; unexplained weight loss or gain in excess of 15% body weight in less than a three month period; suspected fracture or dislocation; suspected systemic infections; any serious undiagnosed hemorrhagic disorder; and acute respiratory distress without previous history.

While there are a number of alternatives that exist, the prognosis of acupuncture care depends upon the skill, knowledge, experience, and intuitive ability of the practitioner, the patient's condition, the duration and frequency of treatment and the responsiveness of the patient to both treatment and the treatment plan. There is always a risk that acupuncture will fail. The benefit is that it could succeed. The patient must weigh the benefits with the risks, consider the alternatives, and prognosis of acupuncture care. The practitioner will consider other alternatives and options with you as needed for your specific situation. An informed consent release statement shall accompany this form.

CONSENT FOR ACUPUNCTURE TREATMENT

I, the undersigned, am aware of both the benefits and risks of acupuncture treatment. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment. I realize that acupuncture care may /may not be covered at this time by Medicare or my insurance companies and I am advised to speak with my insurance agent. I am hereby advised to consult with my primary care medical physician (if this practitioner is not such) on medical issues and that acupuncture, oriental medicine or alternative care is not substituting for appropriate medical advice and care from a medical doctor.

Printed Name _____

Signature_____ _____ Date_____

❑ Patient ❑ Client ❑ Parent ❑ Guardian