Bill Bastian, LAc

Date: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention, which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Height: _____ Weight: _____ Sex: _____

_____ Employer: _____

email: _____ Occupation: _____

Phone: (M) _____ (H) _____ Social Security #: _____

Marital Status: _____ Spouse's Name: _____

Physician: _____ Referred to this office by: _____

In Emergency, Notify: _____ Relationship: _____ Phone: _____

Condition you are experiencing that is an obstacle to you experiencing a feeling of wellness:

_____

_____

When did it begin (be specific): _____

Have you been given a western diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____

Other concurrent therapies: _____

What intention would like to set regarding your current condition and in the area of wellness:_____

_____

Past Medical History – please note dates:

Cancer: _____ HIV/AIDS: _____ Thyroid Disease: _____

Diabetes: _____ High Blood Pressure: _____ Rheumatic Fever: _____

Hepatitis: _____ Heart Disease: _____ Venereal Disease: _____

Surgeries (types & dates): _____

_____

Significant Traumas: _____

_____

Significant Dental Work: _____

Other: Allergies (drugs, chemicals, foods, etc.)_____

_____

Occupational Stress (chemical, physical, psychological) _____

_____

Birth History (prolonged labor, forceps, premature, etc.) _____

Family Medical History

__ Cancer
__ Diabetes
__ High Blood Pressure
__ Heart Disease
__ Stroke
__ Seizures
__ Asthma
__ Allergies
__ Other _____

Medications

What medications and/or supplements are you currently taking please note dosages?

_____ _____

_____ _____

_____ _____

Have you had any courses of antibiotics recently? __ Many __ A few __ 1 or 2 __ None

Habits

Do you have a regular exercise program? Please describe: _____

_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please indicate usage per day or per week:

Cigarettes _____ per _____
Alcohol _____ per _____
Drugs _____ per _____
Coffee _____ per _____
Tea _____per _____
Soft Drinks _____per _____
Sugar _____per _____
Other _____per _____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you suffer from any of the following?

Check all that apply, and for each note if it is current or past.

General

__ Recurrent Infections
__ Night Sweats
__ Sweat easily
__ Bleed or bruise easily
__ Strong thirst (prefer hot or cold?)
__ Thirst with no desire to drink
__ Fatigue
__ Sudden energy drops
Time of day_____
__ Poor Sleep
__ Tremors
__ Poor Balance
__ Edema
__ Underweight
__ Overweight

Skin

__ Rashes
__ Itching
__ Eczema
__ Oozing
__ Pimples
__ Dry skin / scalp
__ Recent moles
__ Changes in hair/skin
__ Other _____

Head/Eyes/Ears/Nose/Throat

__ Headaches
Where _____
When _____
__ Migraines
__ Dizziness
__ Discharge from ear
__ Poor hearing
__ Ringing in ears
__ Blurry vision
__ Night blindness
__ Color blindness
__ Spots in front of eyes
__ Eye Pain
__ Excessive Tearing
__ Squint
__ Glasses
__ Sore eyes
__ Facial Pain
__ Nose bleeds
__ Nasal discharge
__ Blocked nose
__ Snoring
__ Grinding teeth
__ Teeth problems
__ Recurrent sore throat
__ Hoarseness
__ Tonsillitis
__ Swollen glands
__ Sores on lips/mouth
__ Other _____

Cardiovascular

__ Pacemaker
__ High Blood Pressure
__ Low Blood Pressure
__ Chest discomfort/pain
__ Heart Palpitations
__ Cold hands or feet
__ Swelling of hands or feet
__ Blood Clots
__ Spider veins
__ Fainting
__ Other _____

Respiratory

__ Difficulty breathing
__ Pain with breathing
__ Shallow breathing
__ Shortness of breath
__ Production of phlegm
color _____
__ Recurrent cough
__ Bronchitis
__ Pneumonia
__ Asthma/Wheezing
__ Status asthmaticus
__ Other _____

Genito-urinary

__ Pain on urination
__ Urgency with urination
__ Frequent urination
__ Blood in urine
__ Decrease in urinary flow
__ Unable to hold urine
__ Incontinence at night
__ Dribbling urination
__ Kidney stones
__ Prostate problems
__ Impotency
__ Changes in sexual drive
__ Rashes
__ Do you wake at night to urinate?
How many times? _____
__ Other _____

Gynecological

of pregnancies_____
births_____
premature births_____
abortions_____
Age of 1st menses_____
days between menses_____
Duration of menses_____
1st day of last menses_____

Musculoskeletal

__ Neck ache/pain
__ Back ache/pain
__ Knee ache/pain
__ Shoulder pain
__ Elbow/Forearm pain
__ Hand/Wrist pain
__ Foot/Ankle pain
__ Joint/Bone problems
__ Torn tissues
__ Prostheses
__ Muscle pain/weakness
__ Hernia
__ Other _____

Neurological

__ Seizures
__ Nerve damage
__ Paralysis
__ Stroke
__ Sleep disorder
__ Concussion
__ Vertigo
__ Lack of coordination
__ Loss of balance
__ Poor memory
__ Difficulty in concentrating

Digestion
__ Bad breath
__ Change in appetite
__ Nausea
__ Vomiting
__ Heartburn
__ Indigestion
__Belching
__ Abdominal pain or cramps
__ Weight gain
__ Weight loss
__ Loose stools / Diarrhea
__ Strong smelling stools
__ Bloody stools
__ Pale stools
__ Green stools
__ Black stools
__ Constipation (not daily, or difficult)
__ Pain with passing stools
__ Gas
__ Rectal pain
__ Hemorrhoids
__ Anorexia nervosa
__ Bulimia
__ Other _____

Age of menopause_____
Date of last PAP_____

__ PMS
__ Irregular periods
__ Painful periods
__ Light periods
__ Heavy periods
__ Clots
__ Fibroids
__ Endometriosis
__ Infertility
__ Vaginal discharge
__ Vaginal sores
__ Postcoital bleeding
__ Breast lumps
__ Nipple discharge
__ Other _____
Do you practice birth control?
__ yes __ no
-What type and for how long?
_____
Are you pregnant now?
__ yes __ no

Behavioral
__ Moody __ Vacant
__ Easily susceptible to stress
__ Aggressive/Bad temper
__ Lose control of emotions
__ Anxiety
__ Panic Attacks
__ Depression
__ Fear
__ Substance abuse
__ Other _____

Have you ever been treated for emotional problems?
__ yes __ no
Have you ever considered or attempted suicide?
__ Yes __ No

Men:
__ Prostatitis
__ Blood/mucous discharge from penis
__ Pain associated with genitals describe:_____
__ Premature ejaculation
__ Reduced sexual energies
__ Seminal emission
__ Testicular pain / Swelling Inguinal Hernia
__ Other:_____

Name:_____

Please note the severity of your problem right now:

|_____|

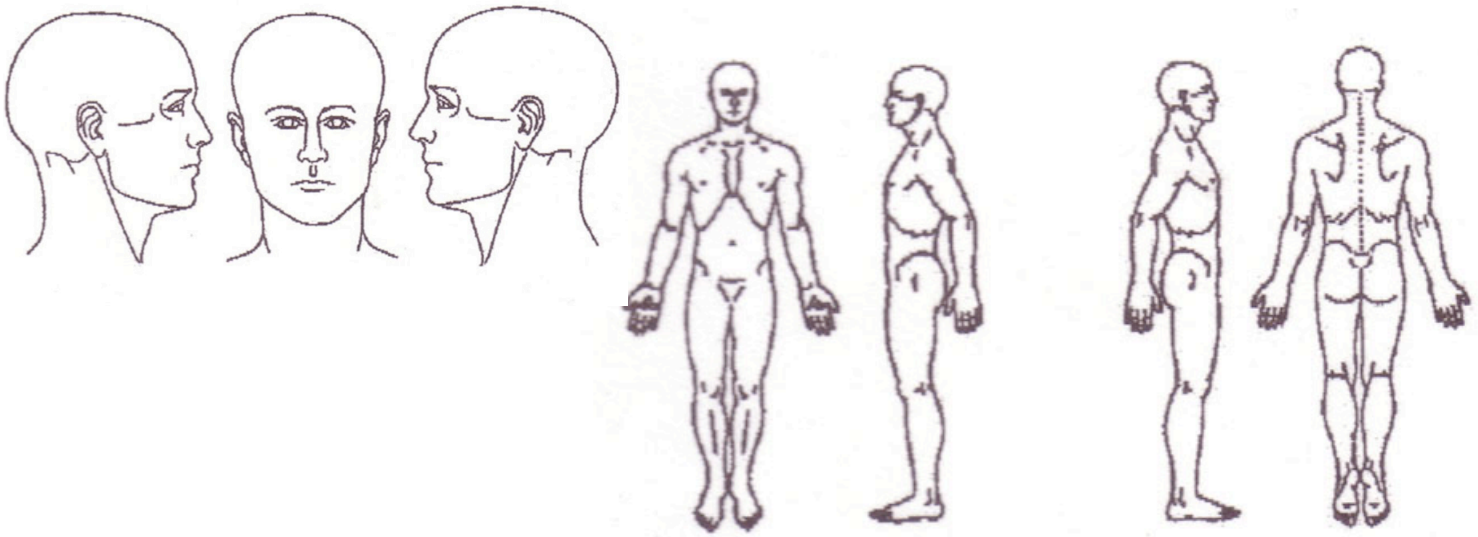
No Problem Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

|_____|

No Problem Worst Imaginable

Please indicate areas of pain or distress:



Comments:_____

_____

_____

_____

_____

Informed Consent for Acupuncture & Chinese Medicine Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible) by the acupuncturist.

I understand that the methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-na (Oriental Massage), Herbal medicine and nutritional counseling. I understand that the herbal teas need to be consumed according to the written and oral instructions given by the acupuncturist. The herbs may have a bitter taste or smell. I will also immediately notify the acupuncturist of any unanticipated or unpleasant side effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising, soreness or discomfort, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax (puncturing of the lung). Even though disposable, sterile single use needles are used in a safe and clean environment, infection is another possible risk. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes 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 safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify the acupuncturist if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all the possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time based upon the facts then known is in my best interest.

I understand that all 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, the above consent to treatment; have been told about the risks and benefits of acupuncture and other procedures and have had the opportunity t ask questions. 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.

_____ _____

Signature of Patient or Person authorized to consent Date

_____ _____

Print Name of Patient or Patient's Representative Date