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)

☐ Physical	☐ Cholesterol	☐ Prostate exam	☐ Blood test
☐ HIV / STD	☐ Pap smear	☐ Mammogram	☐ Colonscopy
☐ Bone density	☐ Urine test	☐ Eye exam	☐ 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.)

☐ Diabetes	☐ Allergies	☐ Glaucoma	☐ Rheumatic fever
☐ Heart Disease	☐ Stroke	☐ Vein condition	☐ Thyroid disorder
☐ Asthma	☐ Pneumonia	☐ Tuberculosis	☐ Emphysema
☐ Jaundice	☐ Gonorrhea	☐ Mumps	☐ Bleeding or hemorrhage
☐ Syphilis	☐ Measles	☐ Chicken Pox	☐ Nervous disorder
☐ Meningitis	☐ HIV	☐ Polio	☐ Auto Immune Disease
☐ Epilepsy	☐ High Fever	☐ Hepatitis	☐ Hypertension
☐ Paralysis	☐ Cancer	☐ Migraines	☐ Mental Illness
☐ Lung disease	☐ Heart disease	☐ Liver disease	☐ 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)

☐ Cold hands	☐ Hot body temperature	☐ Profuse perspiration	☐ Perspire easily
☐ Cold feet	☐ Cold body temperature	☐ Lack of perspiration	☐ Night time urination
☐ Sweaty palms	☐ Afternoon flushing	☐ Night sweating	
☐ Sweaty feet	☐ Hot flashes	☐ Strong thirst	

Overall Energy (Lung and Kidney System)

☐ Easily fatigued	☐ Lethargy	☐ Prone to illness	☐ Wheezing
☐ Shortness of breath	☐ Sweating without exertion	☐ Frequent colds / flus	☐ Chronic allergies

Blood Function (Liver, Heart and Spleen System)

☐ Dizziness	☐ Tingling in extremities	☐ Itchy or dry	☐ Blurry vision
☐ Poor night vision	☐ Poor memory	☐ Scanty menses	☐ Tinnitus
☐ Floaters	☐ Difficulty concentrating	☐ Fainting	☐ Weak or brittle nails

Heart Function

☐ Heart palpitations	☐ Manic moods	☐ Forgetfulness	☐ Tongue ulcers
☐ Anxiety	☐ Restless dreams	☐ Hallucinations	☐ Speech impediment
☐ Mental restlessness	☐ Insomnia	☐ Depression	☐ Severe shyness

Lung Function

☐ Persistent cough	☐ Chronic allergies	☐ Dry or flaky skin	☐ Headaches
☐ Nosebleeds	☐ Nasal dryness	☐ Sneezing	☐ Difficulty breathing
☐ Sinus congestion	☐ Sore throats	☐ Wheezing	☐ Cigarette smoking

Spleen Function

☐ Low or weak appetite	☐ Abdominal bloating	☐ Gurgling in intestines	☐ Hemorrhoids
☐ Abrupt weight gain	☐ Gas	☐ Fatigue following a meal	☐ Hypoglycemia
☐ Abrupt weight loss	☐ Strong food cravings	☐ Bruise easily	☐ Indigestion

Stomach Function

☐ Stomach ache	☐ Bad breath	☐ Stomach ulcer	☐ Nausea
☐ Acid reflux	☐ Bleeding gums	☐ Belching	☐ Vomiting
☐ Ravenous appetite	☐ Heartburn	☐ Hiccups	☐ 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 Herns, 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