180° Acupuncture

Information Form & Health History

Please complete this form as thoroughly as possible. All information is confidential.

Date: ____ / ____ / ________

Name:			Sex:	Age:
Address:	City:		State:	Zip Code:
Phone #1: Home Cell Other	Phone #2: Home Cell Other	eMail:		
Date of Birth:	Emergency Contact: *(name & relationship)*		Phone #:	
Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other: ________		
Occupation:		Employer:		
How did you hear of our clinic?: ☐ Word of Mouth ☐ Internet/Website ☐ Walk/Drive By ☐ Other: ________		Referred By:		
Physician:	Phone #:	Have you been treated by Acupuncture or Oriental Medicine before? ☐ No ☐ Yes ____ / ____ / ____		
INSURANCE INFORMATION - Name of Primary Insured:		Policy/Group Number:		
Name of Insurance Provider:				
Address & Phone Number:				

Insurance Patients: I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize the release of any medical information necessary to process this claim and authorize payment of services to this office. I understand any amount paid directly to the office will be credited to my account. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and I am personally responsible for payment. Please make payment for your portion of charges at each visit unless other arrangements are made.

Patient's Signature: ______________________ Date: ____ / ____ / ____

Patients Without Insurance: Please pay for services at the time of each visit. We accept Visa, MasterCard, checks or cash. If you prefer, a payment plan will be set up for your convenience. Let us know which one you prefer (check one).

☐ Payment at time of service ☐ Payment plan

Patient's Signature: ______________________ Date: ____ / ____ / ____

(signature of parent or guardian if the patient is a minor)

MAIN COMPLAINTS

Please write your top 3 health complaints/concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition. (1=no symptoms, 10=worst ever)

1 ______________________

When did this start? ______________ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/Activity:	better	no change	worse

1 |————|————| 10

2 ______________________

When did this start? ______________ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/Activity:	better	no change	worse

1 |————|————| 10

3 ______________________

When did this start? ______________ ago.

Heat makes it:	better	no change	worse
Cold makes it:	better	no change	worse
Damp weather:	better	no change	worse
Exercise/Activity:	better	no change	worse

1 |————|————| 10

HEALTH HISTORY

Circle the (person icon) if you have / had the condition and note the year it started.
Circle (family icon) if there is a family history of the condition.

Condition	YOU	Year	FAMILY	Condition	YOU	Year	FAMILY
Cancer *type(s)?* ________		____		Osteoporosis		____	
Diabetes		____		Herpes		____	
Hepatitis		____		AIDS / HIV		____	
High Blood Pressure		____		Other STD		____	
Heart Disease		____		Rheumatic Fever		____	
Stroke		____		Alcoholism		____	
Seizure Disorder		____		Allergies *type(s)?* ________		____	
Thyroid Disorder		____		Mental Illness		____	
Asthma		____		Kidney Disease		____	
Pacemaker		____		Anemia		____	

HABITS

	Amount Week	If Quit, Year?
Coffee / Tea		
Soda		
Tobacco		
Alcohol		
Drugs		

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:

____

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly.

____

INJURIES & SURGERIES

Please note what happened to what body area and when it occurred.

____

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TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD |—————|—————| HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks
- ☐ Thirst, but no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Unusual sweats

When ______ am /pm
Where on the body __________

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY |—————|—————| OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails

- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

Where on the body?
- ☐ Edema / Swelling ____________
- ☐ Rashes ____________________
- ☐ Itching ____________________
- ☐ Dandruff ___________________

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA |—————|—————| CONSTIPATION

BM: How often? ___x / every ___ days
Stools keep shape? ☐ Y ☐ N
- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion

- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite

- ☐ Nausea / vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger

- ☐ Dry stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW |—————|—————| HIGH

- ☐ Sudden energy drop

Time of day: ____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue

- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / limbs feel heavy
- ☐ Body / limbs feel weak

- ☐ Shortness of breath
- ☐ Heart palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easily

- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches ____x / week

SLEEP

hours per night ________
- ☐ Difficulty falling asleep
- ☐ Wake ___x/night @ ____ am / pm
- ☐ Wake to urinate *How often?* _________
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness

- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS, NOSE, THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (color______)

- ☐ Poor hearing
- ☐ Ringing in the ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

FOR MEN

URINARY

Fluid in = fluid out? ☐ Y ☐ N
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stoping
- ☐ Incontinence
- ☐ Kidney stones

- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

REPRODUCTIVE

Are you sexually active? ☐ Y ☐ N
- ☐ Change of sexual drive: ⇧ ⇩
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge

- ☐ Prostate disease
- ☐ Genital pain
- ☐ Jock itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

FOR WOMEN

MENSES

Age at first menses: _______
Length of full cycle: _______ days
Length of period: _______ days
Last period start date: _____ / _____
Number of pregnancies: _______
Number of births: _______
Are you pregnant now? ☐ Y ☐ N

MENOPAUSE

Age at last menses: _______
Year changes began: _____

- ☐ Hot flashes _____x / day
- ☐ Night sweats _____x / week
- ☐ Vaginal dryness
- ☐ Loss of sex drive

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)

- ☐ Cramps
  - ☐ Before bleeding
  - ☐ First day
  - ☐ During period
- ☐ Clots
- ☐ Breast tenderness

- ☐ Mood changes
- ☐ Fatigue w/menses
- ☐ Digestive changes w/menses
- ☐ Midcycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)

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Informed Consent for Acupuncture Treatment

Information for Patients

NATURE OF TREATMENT:
Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, dermal friction (Gua Sha), infra-red (heat lamp), Chinese herbs, therapeutic exercises and dietary counseling based on fundamentals of Chinese medicine.

PURPOSE OF TREATMENT:
The purpose of treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment based on these theories are used to promote health and treat organic or functional disorders.

POTENTIAL BENEFITS:
Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies. Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. We cannot guarantee the outcome of any course of treatment.

POTENTIAL RISKS:
Acupuncture and Oriental medicine have been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:

- Discomfort during and after the insertion of a needle
- "Needle sickness" (dizziness, fainting, nausea)
- Localized, minor bruising or swelling
- Minor burns with the use of Moxa
- Gastro-intestinal upset with the use of Chinese herbs (if this occurs, please consult with your practitioner so that your formula can be modified)
- Possible, temporary aggravation of symptoms that existed prior to treatment

Please notify your practitioner if you have any adverse effect from treatment.

USE OF DISPOSABLE NEEDLES:
To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused.

SPECIAL SITUATIONS:
Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify us if you might be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

CONSENT:
I request and consent to the performance of acupuncture and this Oriental Medicine procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I, hereby release Jeffry Batie, L.Ac. and 180° Acupuncture from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

____
Print Name

____
Signature of Client or Person Authorized to Consent

Date