



Health History Questionnaire

Name:

Date:

Address:

City, State, Zip:

Preferred Phone:

Email:

DOB: Age:

Gender:

Occupation:

Employer:

Physician Phone:

Emergency Contact:

Phone:

Relationship to Patient:

How did you hear about Louisville Acupuncture?

Have you been treated by Acupuncture or Oriental Medicine before? ☐ Yes ☐ No

Primary reasons for this visit:

1.

2.

3.



Symptoms Form

Please check (circle specifics) if any of these symptoms have been a concern for you in the past year

General ☐ Chills/Excess heat ☐ Bleed/Bruise easy ☐ Muscle weakness/fatigue ☐ Poor sleep ☐ Night sweats ☐ Palpitations ☐ Fatigue ☐ Sweat easily ☐ Poor balance ☐ Poor memory ☐ Anxiety/Stress ☐ Cold hands/feet ☐ Edema ☐ Trouble w. weather changes	Head/Ears/Eyes/Nose ☐ Headaches ☐ Migraines ☐ Dizziness ☐ Tinnitus ☐ Hearing loss ☐ Earaches/Infections ☐ Eye pain ☐ Cataracts ☐ Poor vision/Eye strain ☐ Near/Far sighted ☐ Poor night vision ☐ Floaters ☐ Sinus problems ☐ Allergies/Hayfever ☐ Runny nose/Post-nasal drip ☐ Nose ☐ Grinding teeth ☐ TMJ ☐ Dental/Gum problems ☐ Cold Sores	Skin/Hair ☐ Rashes/Itching ☐ Eczema ☐ Psoriasis ☐ Dermatitis ☐ Ulcerations ☐ Changes in skin ☐ Skin growths (moles, tags) ☐ Brittle nails Urinary ☐ Painful urination ☐ Incontinence ☐ Frequent urination ☐ Urination at night ☐ Kidney stones ☐ Urinary tract infection ☐ Scanty urination ☐ Urgency ☐ Excessive urination ☐ Burning urination ☐ Bloody urine
Gastrointestinal ☐ Poor appetite ☐ Excessive appetite ☐ Cravings ☐ Weight Loss/Gain ☐ Strong thirst ☐ Nausea/Vomiting ☐ Gas/Belching ☐ Gallstones ☐ Trouble w. fatty foods ☐ Indigestion ☐ Heartburn/Reflux ☐ Bloating ☐ Bad breath ☐ Constipation ☐ Loose stool/Diarrhea ☐ Black/Pale stools ☐ Hemorrhoids ☐ Hernia ☐ Abdominal pain/cramp	Respiratory ☐ Difficulty swallowing ☐ Persistent sore throat ☐ Swollen glands ☐ Cough/Wheeze ☐ Frequent colds ☐ Pneumonia ☐ Coughing blood ☐ Tightness in chest ☐ Tuberculosis ☐ Emphysema ☐ Bronchitis	Other Any other health concerns or conditions you'd like us to know about?



Women / Men Health Form

For Women Only:

Are you currently pregnant? Planning to become Pregnant? Are you using birth control? What type?	# of pregnancies # of live births # of miscarriages # of abortions
What age did you have your first period?	When was the first day of your last period?
Average # of days in cycle:	Average number of days of flow:
Average number of pads/tampons used per day: Day 1: Day 2: Day 3: Day 4: Day 5:	Flow is: ☐ Light ☐ Normal ☐ Heavy
Color is: ☐ Pale ☐ Dark ☐ Bright Red ☐ Brown ☐ Purple	Blood clots? Size of clots: ☐ Yes ☐ No

Do you experience any of the following before or during your menstrual period?

☐ Water retention	☐ Pain/Cramping	☐ Nausea
☐ Breast tenderness/Swelling	☐ Migraines	☐ Hot flashes
☐ Depression	☐ Insomnia	☐ Night sweats
☐ Irritability	☐ Diarrhea/Constipation	

Vaginal Discharge? ☐ Yes ☐ No

If yes, is there a color or odor?

Is your libido: ☐ Low ☐ Normal ☐ High

Have you ever been diagnosed with any of the following:

☐ Endometriosis	☐ Cervical Dysplasia
☐ Polycystic Ovary Syndrome	☐ Uterine Fibroids
☐ Pelvic Inflammatory Disease	☐ Ovarian Cysts
	☐ Fertility Issues

Age of menopause onset?

Menopause Symptoms:

Hormone Replacement therapy? ☐ Yes ☐ No

Date of last PAP smear

Results:

Other gynecological issues:

For Men Only:

Date of last prostate checkup:

Results:

Have you ever experienced any of the following:

☐ Overactive libido	☐ Swelling in testicles	☐ Prostate problems
☐ Testicular pain	☐ Premature ejaculation	☐ Dribbling urination
☐ Nocturnal emissions	☐ Fertility Issues	☐ Painful urination
	☐ Impotence	☐ Difficult urination
		☐ Incontinence

Other Men's health issues?



Consent to Treat Form

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other incensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrol stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared, and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bums and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the 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 considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. 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 a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my patient records and lab reports, but 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 an opportunity to 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.

ACUPUNCTURIST NAME:

Marie Woollacott, LicAc, MAOM
2770 Dagny Way. Ste 210
Lafayette, CO 80026

PATIENT SIGNATURE:

DATE:

(or Patient Representative)

(indicate relationship if signing for patient)