Acu – Herbs Oriental Medicine Clinic, LLC.

450 NW Gilman Blvd. Ste. 305 Issaquah, WA 98027
Tel: 425 - 391 - 8198 / 425 - 442 - 7297 Fax. 425 - 391 - 6909
Web : www.acu-herbs.net

HEALTH HISTORY QUESTIONNAIRE

Date: _____

Name: _____ Phone: H- _____W- _____

Address: _____ City: _____State: _____ ZIP: _____

Age: _____ Date of Birth: _____Place of Birth: _____

Height: _____Weight: _____Marital Status: _____

Employer Name & Address: _____

Family Physician: _____ Referred by: _____

Insurance Company: _____ Policy #: _____

In Emergency, Notify: _____ Phone: _____

Have you been treated by acupuncture or oriental medicine before? Yes □ No □

Have you been treated by manipulation before? Yes □ No □

Main Problem(s) you would like us to help you with: _____

_____

How long ago did this problem begin (Be spedific)? _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____

_____

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

_____

What kind of treatments have you tried? _____

_____

_____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____

High Blood pressure _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____

Seizures _____ Venereal Disease _____ Other _____

_____

Surgeries (type of and date): _____

_____

Significant Trauma (auto accidents, falls etc.): _____

_____

Significant Dental Work (type and date): _____

Birth History (prolonged labor, forceps delivery, etc.):_____

_____

Allergies (drugs, chemicals, food/result): _____

_____

Family Medical History (check): Diabetes □ Cancer □ High Blood pressure □

Heart Disease □ Stroke □ Seizures □ Asthma □ Allergies □

Other □_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): _____

_____

_____

Occupational Stress (chemical, physical, psychological, etc.): _____

_____

Do you have a **regular exercise program**? Yes □ No □ Please describe. _____

_____

Have you ever been on **a restricted diet?** Yes □ No □ What kind? _____

_____

Please describe your **average daily diet:** _____

Morning - _____

Afternoon - _____

Evening -_____

How many packs of cigarettes do you smoke **per day?** _____

How much coffee, tea or cola do you drink **per week?** _____

How much **alcohol** do you drink **per week?** _____

Please describe any use of **drugs** for **non-medical purpose:** _____

_____

Please check any you have had in the last three months:

General:
- □ Poor appetite
- □ Fevers
- □ Sweat easily
- □ Localized weakness
- □ Bleed or bruise easily
- □ Peculiar tastes or smells
- □ Strong thirst (cold or hot)
- □ Thirst, no desire to drink
- □ Sudden energy drop - What time of day?_____
- □ Poor sleeping
- □ Chills
- □ Tremors
- □ Poor balance
- □ Fatigue
- □ Night sweats
- □ Cravings
- □ Change in appetite
- □ Weight gain
- □ Weight loss

SKIN AND HAIR:
- □ Rashes
- □ Itching
- □ Dandruff
- □ Change in hair or skin
- □ Ulcerations
- □ Eczema
- □ Loss of hair
- □ Hives
- □ Pimples
- □ Recent moles
- □ Other hair or skin problem:_ _____

HEAD,EYES, EARS, NOSE & THROAT:
- □ Dizziness
- □ Glasses
- □ Poor vision
- □ Cataracts
- □ Ringing in ears
- □ Sinus problems
- □ Grinding teeth
- □ Teeth problems
- □ Concussions
- □ Eye strain
- □ Night Blindness
- □ Blurry vision
- □ Poor hearing

- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw Clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Color blindness
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches. Where and When:_____

_____

☐ Other head or neck problem:__

_____

_____

CARDIOVASCULAR:

- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel Problems:_____

_____

RESPIRATORY:

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm _____ what color _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Other lung problems: _____

_____

GASTROINTESTINAL:

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal Problems: _____

_____

GENTO-URINARY:

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Impotency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Other genital or urinary system problems:_____

_____

Do you wake up to urinate?
☐Yes ☐No. How often? ___

Any particular color to your urine: _____

PREGANCY & GYNECOLOGY:

Number of pregnancies: ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Period between menses ____
Duration _____

First date of last menses

_____

- ☐ Unusual character (heavy or light)
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal sores _____
- ☐ Irregular periods
- ☐ Last Pap _____
- ☐ Breast lumps

Do you practice birth control?
☐Yes ☐No.

What type and for how long?

_____

MUSCULOSKELETAL:

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pain
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain

NEUROPSYCHOLOGICAL:

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Bad temper
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Depression
- ☐ Easily susceptible to stress
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Other neurological or psychological problems

_____

_____

CONSENT FORM FOR TRADITIONAL CHINESE METHODS & PRIVACY PRACTICES

I, the undersigned, hereby authorize the following Certified Acupuncturist: Li-Juan (Leah) Chen L. Ac. EAMP. OMD. To perform the following specific procedures:

Herbal Prescriptions: may be given in the form of pills, powders, tinctures, pastes, plasters, or in raw form to be cooked. Cooked herbs may be given to take internally or externally as a wash. Herbal formulas may include shell, mineral, and animal materials.

*** **If you do not want animal-based products used in your formula, please notify your practitioner at every visit when herbs are prescribed.** ***

Acupuncture: Insertions of special sterilized needles through the skin into the underlying tissues at specific points on the surfaces of the body.
Cupping: Cups made of glass, bamboo, or other materials are placed on the skin with a vacuum created by heat or other device. Mild bruising may result.
Moxa: Indirect burning on an acupoint using stick, string, or ball moxa to create a warming effect.

I recognize the potential risks and benefits of those procedures as described below:
Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruises, weakness, fainting, nausea, area of anesthesia and even aggravation of symptoms existing prior to the treatment.
Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energies, which may lead to the prevention or elimination of the presenting problem.

With this knowledge, I voluntarily consent to the above procedures, realizing that I have been given no guarantees by the practitioner, Li-Juan (Leah) Chen L. Ac. EAMP. OMD. regarding cure or improvement of my condition.

I also release Li-Juan (Leah) Chen L. Ac. EAMP. OMD. from any and all liability, which may occur in connection with the above-mentioned procedures, except for failing to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that, under the Health Insurance Portability & Accountability Act or 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my medical records may be used and disclosed only for the purposes of treatment, payment, and health care options. By signing below, I acknowledge that I have read and understand the **Notice of Privacy Practices** of Acu-Herbs Oriental Medicine Clinic, LLC. I am aware I may request a copy of my health record from this practitioner and may ask to correct this record. I may also request a copy of the Notice of Privacy Practices for my record.

I understand that if my insurance does not pay for the services and treatment performed by Li-Juan (Leah) Chen L. Ac. EAMP. OMD., I am responsible for payment of the charges incurred.

I am fully aware that the clinic allows a specific amount of time for treatment and that if I arrive late, my treatment will be adjusted to fit in that time schedule. I also understand that, except in emergencies, I must give 24 hours notice of intent to cancel or reschedule my appointment. Late arrivals and appointments missed without proper notice will be billed at current clinic rates.

_____ _____

Signature of Patient or witness or Person Authorized Date