# PERSONAL INFORMATION

Name:_____ Date:_____
Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Email:_____
Work Phone:_____ Occupation:_____
Emergency Contact:_____ Phone:_____
Whom should we thank for referring you to this office?_____
**Sex:** Male__ Female__ **Marital Status:** Married__ Single__ Divorced__ Widowed__

Have you received acupuncture therapy before? Yes/No

When?_____ With Whom?_____

**Please indicate any significant illnesses you or a blood relative (Grandparent, parent, sibling) have had:**

| **Illness** | **You** | **Your Relative** | **Approx. Date** | | **Illness** | **You** | **Your Relative** | **Approx. Date** |
|---|---|---|---|---|---|---|---|---|
| Cancer | | | | | Diabetes | | | |
| Hepatitis | | | | | Heart Disease | | | |
| High Blood Pressure | | | | | Seizures | | | |
| Rheumatic Fever | | | | | Emotional Disorders | | | |
| Infectious Diseases | | | | | Tuberculosis | | | |

**Sexually Trans. Diseases:** Gonorrhea__ Syphilis__ AIDS__ HPV__ Chlamydia__ Herpes__ DATE:_____

List any medications and supplements you are currently taking:

| **Medicine** | **Dosage** | **Reason** | **How Long** | **Prescribed By** | **Date of Last Checkup** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **Check if any of the following statements are true:** | | I have known allergies.____ | I have a pacemaker.____ |
|---|---|---|---|
| I am taking Coumadin/warfarin._____ | I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs)____ | | |

| **Please indicate the use and frequency of the following:** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Substance:** | **Yes** | **No** | **How much** | **Substance:** | **Yes** | **No** | **How Much** | **Substance:** | **Yes** | **No** | **How much** |
| Coffee/Black Tea | | | | Tobacco | | | | Water Intake | | | |
| Non Medical Drugs | | | | Alcohol | | | | Soda Pop | | | |

| What are the main health problems for which you are seeking treatment? _____<br>_____<br>_____<br>_____ | Practitioner's Use<br>**CLINICAL NOTES** |
|---|---|
| What other forms have you sought? _____<br>_____<br>_____<br>_____ | |
| List any other health problems you now have. _____<br>_____<br>_____<br>_____<br>_____ | |
| List any allergies, food sensitivities, or food cravings you now have. _____<br>_____<br>_____<br>_____ | |
| List any accidents, surgeries, or hospitalizations (include date). _____<br>_____<br>_____<br>_____ | |
| Lab results. _____<br>_____<br>_____<br>_____ | |

**How do you FEEL about the following areas of your life?** Please check the appropriate boxes and indicate any problems you may be experiencing.

| | **Great** | **Good** | **Fair** | **Poor** | **Bad** | **Your Comments** |
|---|---|---|---|---|---|---|
| Significant Other | | | | | | |
| Family | | | | | | |
| Diet | | | | | | |
| Sex | | | | | | |
| Work | | | | | | |
| Exercise | | | | | | |
| Spirituality | | | | | | |

# Measure Yourself Medical Outcome Profile (MYMOP)

Name:_____ Date: _____

Choose one or two symptoms (physical or mental) which bother you the most. Now consider how severe each symptoms has been over the past week and score it by circling the number that most accurately represents your pain.

SYMPTOM 1: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AS GOOD AS IT COULD BE | **0** | **1** | **2** | **3** | **4** | **5** | **6** | AS BAD AS IT COULD BE |

SYMPTOM 2: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AS GOOD AS IT COULD BE | **0** | **1** | **2** | **3** | **4** | **5** | **6** | AS BAD AS IT COULD BE |

Choose one activity (physical, social, or mental) that is important to you, and that your problem makes difficult or prevents you from doing. Score how badly this activity has been affected in the past week due to your problem.

ACTIVITY: _____

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AS GOOD AS IT COULD BE | **0** | **1** | **2** | **3** | **4** | **5** | **6** | AS BAD AS IT COULD BE |

How would you rate your general feeling of well-being during the past week?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AS GOOD AS IT COULD BE | **0** | **1** | **2** | **3** | **4** | **5** | **6** | AS GOOD AS IT COULD BE |

How long have you had Symptom 1, either all the time or on and off?

0 – 4 WEEKS  4 – 12 WEEKS  3 MONTHS – 1 YEAR  1 – 5 YEARS  OVER 5 YEARS

Are you taking any medication FOR THIS PROBLEM? Please circle: **YES / NO**

**IF YES**, Please write name of medication and how often it is taken:

_____

How important to you is cutting down the medication?

NOT IMPORTANT  A BIT IMPORTANT  VERY IMPORTANT  NOT APPLICABLE

IF NO, How important to you is avoiding medication for this problem?

NOT IMPORTANT  A BIT IMPORTANT  VERY IMPORTANT  NOT APPLICABLE

## For Women

Age of 1st period (menarche) _____ Are you pregnant? Y / N Number of pregnancies: _____

Age of last period (menopause): _____ # of live births _____ # of abortions: _____ # of miscarriages: _____

Number of days between periods: ____ Date of last: Gynecologic Exam _____ Pap Smear: _____

Number of days of flow: _____ Mammogram: _____ Bone Density Scan: _____

Color of flow: _____ Results: _____

Clots? Y / N Color _____ _____

Average number of pads you use per day: 1st day_____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids__ Fibrocystic Breasts__ Ovarian Cysts__ PID__ **Other**_____

Location of pain: Lower abdomen__ Lower back__ Thighs__ Other _____

**Nature of Pain** (Please indicate before, during, or after menses)

**Other symptoms related to menses:**

| | | | | |
|---|---|---|---|---|
| Cramping _____ | Cramping_____ | Discharge__ | Vaginal Dryness__ | Headache__ |
| Burning_____ | Burning_____ | Nausea__ | Constipation__ | Diarrhea__ |
| Dull_____ | Dull_____ | Swollen breasts__ | Mood Swings__ | Ravenous Appetite__ |
| Consistent_____ | Consistent_____ | Poor appetite__ | Hot flashes__ | Night Sweats__ |
| Bearing down sensation_____ | | Increased Libido__ | Decreased libido__ | Insomnia__ |

## For Men

Date of last prostate checkup_____ PSA results_____ Manual prostate exam results_____

Lab results_____

Frequency of urination: Daytime____ Nighttime____ Color of urine: Clear__ Murky__ Odor:_____

**Symptoms relate to prostate:**

| | | | | |
|---|---|---|---|---|
| Prostate problems___ | Delayed stream___ | Dribbling___ | Incontinence___ | Retention of urine___ |
| Rectal dysfunction___ | Increased libido___ | Decreased libido___ | Premature ejaculation__ | Impotence___ |
| Back pain___ | Groin pain___ | Testicular pain___ | Other_____ | |

## SYMPTOM SURVEY (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

**No mark**( ) = never experience **Check mark** () = sometimes experience **Plus sign** (+) = frequently experience

___lack of appetite
___excessive appetite
___loose stool or diarrhea
___digestive problems, indigestion
___vomiting
___belching, burping
___heartburn/reflux
___feeling the retention of food in the stomach
___tendency to become obsessive in work, relationships, etc
___insomnia, difficulty sleeping
___heart palpitations
___cold hands and feet
___nightmares
___laughing for no apparent reason
___angina pains
___abdominal pain
___chest pain
___sciatic pain
___headaches
___pain or coldness in genital area
___cough
___shortness of breath
___decreased sense of smell
___nasal problems
___skin problems
___feeling of claustrophobia
___bronchitis
___colitis or diverticulitis
___constipation
___hemorrhoids
___recent use of antibiotics
___eye problems
___jaundice (yellowish eyes or skin
___difficulty digesting oily foods
___gall stones
___light colored stool
___soft or brittle nails
___easily angered/agitated
___difficulty in making plans or decisions
___spasms or twitching of muscles
___low back pain
___knee problems
___hearing impairment
___ear ringing
___kidney stones
___decreased sex drive
___hair loss
___urinary problems
___fatigue
___edema
___blood in stool
___black tarry stool
___easily bruised
___difficult to stop bleeding
___asthma
___tendency to catch colds
___intolerance to weather changes
___allergies
___hay fever
___dizziness
___tendency to faint easily
___high cholesterol levels
___sudden weight loss

# INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist.

I understand the methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), bleeding and Chinese herbal medicine.

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, with possible dizziness or fainting. Bruising is common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I understand that the risk of infection is negligible when all needles are sterile.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe, 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, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately inform the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the 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 condition(s) for which I seek treatment.

Patient Name _____

Patient/Guardian Signature _____ Date_____