Partners In Health, LLC

Acupuncture and Oriental Medicine

Confidential Patient Information Form

Today's Date _____

BP _____ BPM _____

Name: _____ Please address me as: _____ Gender: ___

Address: _____ City: _____ State: ____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ Cell: _____

May we leave a message at this number? **Daytime:** yes/no **Evening:** yes/no **Cell:** yes/no

E-mail: _____ Marital Status: _____ Age: ___ Date of Birth: _____

Employer: _____ Hrs/Wk: _____

Type of work: _____ Type of repetitive actions: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

2nd Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Date of last physical exam: _____ Which Physician?: _____

Chiropractor: _____ Massage Therapist: _____

How did you hear about *Partners In Health*? _____

Have you ever tried: Acupuncture?_____ Chinese Herbs? _____ Other Herbs? ____ Massage? _____

May we send postcards or promotional materials to the address listed above? Yes _____ No _____

Reason for today's visit: _____

_____

How long have you had this condition? _____

Is it getting worse? _____ Does it interfere with: Work ____ Sleep ____ Other _____

What makes it feel better? _____ Worse? _____

Have you seen a physician about this? _____ When? _____

Diagnosis, if any: _____

What tests were performed and what were the results? (include x-rays, scans, blood work, etc.) _____

_____

Who else did you see about this condition? _____

What did s/he recommend? _____

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Do you have or have you ever been treated/diagnosed with any of the following? Circle all that apply and list year symptoms began or when condition was diagnosed):

	Year Diagnosed		Year Diagnosed		Year Diagnosed
AIDS/HIV		Fused bones		Pneumonia	
Allergies		Goiter		Polio	
Alcohol/Drug abuse		Severe Headaches		Rheumatic Fever	
Appendicitis		Heart Disease		Scarlet Fever	
Anxiety/Depression		Hemophilia		Seizures	
Arthritis/Bursitis		Hepatitis: Type?		Stomach Disorders	
Asthma/Emphysema		Herpes Simplex I		Stroke	
Back Problems		Herpes Simplex II		Thyroid Disorder	
Birth Trauma (yours)		Herpes Zoster (shingles)		Tumors	
Blood Clots		High/Low Blood Pressure		Tuberculosis	
Cancer		High Cholesterol		Ulcerative Colitis	
Cardiac Arrhythmia		Implantable Defibrillator		Ulcers	
Carpal Tunnel		Irritable Bowel		Other:	
Chronic Fatigue Synd.		Kidney Disease			
Crohn's Disease		Leukemia			
Diabetes: Type I or II		Multiple Sclerosis			
Edema		Neck Problems			
Epilepsy		Pacemaker			
Fibromyalgia		Pins/Plates/Rods in Bones			

Please list the procedure and year for any of the following that apply to you:

Surgeries: _____

_____

Major Traumas: _____

_____

Motor Vehicle Accidents (indicate on which side your vehicle was hit and rate of speed): _____

_____

Other hospitalizations: _____

_____

List all known allergies, including food and drugs (include type of reaction experienced): _____

_____

_____

_____

List your current medications:

Prescription Meds	**Dose/# times daily**	**Started**	**Last taken**	***Reason for taking***
Over the Counter Meds	**Dose/# times daily**	**Started**	**Last taken**	***Reason for taking***
Supplements	**Dose/# times daily**	**Started**	**Last taken**	***Reason for taking***

Your Family History

Parents:	Alive?	Health (circle one)	Deceased?
Mother	Age _____	Good/Fair/Poor	Age _____ of _____
Father	Age _____	Good/Fair/Poor	Age _____ of _____

Siblings (Blood relations only):

Sister	Age _____	Good/Fair/Poor	Age _____ of _____
Sister	Age _____	Good/Fair/Poor	Age _____ of _____
Sister	Age _____	Good/Fair/Poor	Age _____ of _____
Brother	Age _____	Good/Fair/Poor	Age _____ of _____
Brother	Age _____	Good/Fair/Poor	Age _____ of _____
Brother	Age _____	Good/Fair/Poor	Age _____ of _____

Children? Age/Name: _____
_____

Do you have a family history of:

	Who?		Who?		Who?
Asthma	_____	Drug/Alcohol Abuse	_____	Obesity	_____
Cancer	_____	Heart Disease	_____	Seizures	_____
Depression	_____	High Blood Pressure	_____	Stroke	_____
Diabetes	_____	High Cholesterol	_____		

*For the following questions, please circle all that apply to **you**:*

General

Poor Appetite	Heavy Appetite	Dizziness/Vertigo	Sweat Easily
Recent Weight Loss	Recent Weight Gain	Fatigue	Night Sweats
Prefer Hot Drinks	Prefer Cold Drinks	Lack of Energy	**Taste in mouth:**
Poor Circulation	Body Heaviness	Muscle Cramps	Bitter/Sweet/Bland
Chills	Fever	Bleed/Bruise Easily	or _____

Cravings for: _____

Overall, you generally feel: Too hot ____ Too cold ____ Just right ____
(That is, are you the first one to get cold or hot in a room with regard to other people)

Head, Ears, Eyes, Nose, and Throat

Headaches	Gum Problems	Glasses	Poor Night Vision	Excess Sputum
Migraines	Gum/Lip/Tongue Sores	Eye Strain	Cataracts	Swollen Glands
Concussion	Ringing in Ears	Eye Pain	Floaters	Enlarged Thyroid
TMJ	Poor Hearing	Dry Eyes	See Halos	Facial Pain
Teeth Grinding	Ear Aches	Red Eyes	Frequent Nose Bleeds	Other: _____
Teeth Problems	Sinus Problems	Glaucoma	Dry Mouth	_____

*For the following questions, please circle all that apply to **you**:*

Respiratory and Cardiovascular

Short of Breath	Chest Pain/Tightness	Heart Murmur	Implantable Defibrillator
Can't lie flat	Palpitations	Pacemaker	Blood Clots
Wheezing	Irregular Heartbeat	Stent	Varicose Veins/Phlebitis

Cough: Dry/hacking/tickly/recurring/productive **Sputum color:** clear/white/yellow/green/brown/red/thick/thin

Gastrointestinal

Acid Reflux	Trouble Swallowing	Laxative Use	Bloody Stools
Bad Breath	Heartburn	Diarrhea	Gallstones
Bloating	Nausea	Constipation	Hemorrhoids
Gas	Vomiting	Black Tarry Stools	Rectal Pain
Hiccup	Intestinal Cramps	Mucus in Stools	Itchy/Burning Anus

 # Bowel movements per day ____ (or week ____) Texture: dry/hard/soft/formed/unformed/watery

Genitourinary

Burning Urination	Bloody Urination	Hernia	Premature Ejaculation
Painful Urination	Incomplete Urination	Impotence	Prostate Problems
Frequent Urination	Incontinence	Kidney Stones	Abnormal Penile Discharge
Urgent Urination	Clear/Bright/Dark Urine	Urinary Stones	Change in Libido/Sex Drive

Musculoskeletal Pain

Neck	Ribs	Elbow (R or L)	
Shoulder (R or L)	Hip (R or L)	Other Joint Pain (list): _____	
Upper/Lower Back	Knee (R or L)	Limited Range of Motion	Other: _____

Skin and Hair

Acne	Hives	Infections: _____
Dandruff	Itching	Rashes: _____
Eczema	Psoriasis	Ulcerations/Non-healing sores: _____

Neuropsychological

ADD/ADHD	Easily Stressed	Panic Disorder	Suicidal Thoughts
Anxiety	Irritable	Post-Traumatic Stress	Attempted Suicide
Bipolar	Moody	Schizophrenia	Abuse Survivor
Depression	Numbness	Seizures	Currently in Therapy

Is there anything else you would like to share? _____

Sleep

How many hours of sleep do you normally get per night? _____ Do you wake rested? _____
Is it hard for you to fall asleep? _____ Do you know why? _____
Do you have to get up at night to urinate? _____ How many times? _____
Is there a particular time you wake up in the middle of the night? _____
Once you fall asleep, do you stay asleep? _____ If not, why not? _____
Is it hard to fall asleep after returning to bed? _____
Rate your quality of sleep (0=poor, 10=excellent): _____ Do you nap during the day? _____
What time of day do you feel your best? _____ Worst? _____ Why? _____
_____

Lifestyle

Exercise (list):	Times per week:	Stress Level (0=low, 10=high):
_____	_____	at work _____
_____	_____	at home _____
_____	_____	other _____

Ounces of water drunk per day _____ Caffeinated beverages _____
Alcohol: (circle one) wine (4 oz.) beer (12 Oz.) liquor (1 ½ oz.)
____ drinks per day **OR** ____ drinks per week **OR** ____ drinks per month
Cigarettes/cigars/pipe/chewing tobacco (circle whichever applies) _____ per day **OR** ____ per week
Marijuana _____ per day **OR** ____ per week
Other recreational drugs and frequency _____
Job Hazards _____
____ I have a social network (friends/family/spiritual) I can rely on ____ I feel isolated
If you are in a relationship, do you ever feel afraid or threatened? _____

Females Only

Age periods began: _____	# Pregnancies: ____	Are you pregnant? _____
Date of last period: _____	# Live births: ____	Trying to conceive? _____
Age of menopause: _____	# Miscarriages: ___	Taking birth control? _____
Surgical menopause? _____	# Abortions: _____	Hormone replacement? _____

Date of last PAP smear: _____ Do you regularly examine your breasts? _____
Vaginal discharge is: none/white/yellow/foul-smelling Vaginal sores/lesions? _____
If still menstruating, periods are: regular/irregular/painful If painful: before/during/after period?
Color of blood is: pale red/bright red/dark red/purple Volume: Heavy/Light Clots are: small/large
Do you feel irritable or bloated prior to your period? _____ Tender/swollen breasts? _____

Other Concerns Not Previously Mentioned

_____

Everything I have written is true; I will update this office when there are significant changes.

_____ Date: _____
Signature

Partners In Health, LLC
Acupuncture and Oriental Medicine

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the *Partners In Health, LLC* Clinic. I understand that acupuncturists practicing in the state of Wisconsin are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: **local bruising, minor bleeding, fainting, pain or discomfort,** and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: **changes in bowel movement, abdominal pain or discomfort,** and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems which I associate with these substances, I should **stop taking them** and call the clinic as soon as possible.*

Acupressure/Tui-Na Massage, Cupping and GuaSha: I understand that I may also be given acupressure/tui-na massage, cupping, or guasha as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: **bruising, sore muscles or aches**, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: **electrical shock, pain or discomfort,** and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I give my permission and consent to treatment.

Cancellation Policy: *To avoid being billed for a missed appointment, Partners In Health requires 24-hours advance notice if you must change or cancel your appointment.*

Consent To The Use And Disclosure Of Health Information For Treatment, Payment, Or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.

I understand that I have the right:

- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____