ACUPUNCTURE CASE HISTORY

Hanna Lee, L.Ac., Dipl. OM

Patient's Name ____ Birth Date ___________________
Last First Middle

Address ____
Street City State Zip

Home Phone ___________________ Work Phone ____________________ Cell Phone ____________________

Email: _________________________________Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partnered

Number of Children _____ If patient is a minor, give parent's/guardian's name __________________________________

How did you hear about our office? ____

MAJOR COMPLAINT, INJURY OR ILLNESS

Please List your Top 4 Chief Complaints, Injury, and/or Illness:

1. ___________________________________ 3. ___________________________________

2. ___________________________________ 4. ___________________________________

Date began: ____________________ Describe what caused it or how it started:______________________________
____
____

Have you ever had this condition or similar condition before? ☐ Yes ☐ No
Have you ever received treatment for this condition? If yes, when? By whom?
____
____
____

What was the diagnosis? What were the results of the treatment?
____
____

Has the condition gotten: ☐Better ☐Worse ☐About the same
What makes it better? ____
What makes it worse? ____

FAMILY MEDICAL HISTORY

Age parents died: Mother ______ Father ______

☐ Arthritis	☐ Drug Addition	☐ Liver Disease
☐ Allergies	☐ Epilepsy	☐ Mental Disorders
☐ Asthma	☐ Eye Disease	☐ Sinus Problems
☐ Alcoholism	☐ Heart Trouble	☐ Spinal Problems
☐ Cancer	☐ High/Low Blood Pressure	☐ TB
☐ Diabetes	☐ Kidney Disease	☐ Ulcers

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PERSONAL MEDICAL HISTORY

1. Major Surgeries, Illnesses, Diseases, Accidents (include dates) *(Please attach a sheet if more space is required)*:
____
____
____
____

2. Contagious Diseases: (Check if you have ever had any of the following.)
☐ HIV ☐ AIDS ☐ Hepatitis ☐ Venereal Disease ☐ Herpes
☐ Other:____

3. Allergies: (Drugs, chemicals, food, animals, seasonal, etc.)
____
____
____

4. Medications/ Supplements presently taking:
____
____
____

LIFESTYLE

Diet (Typical Foods)

- ☐ Beef
- ☐ Eggs
- ☐ Cheese
- ☐ Tofu
- ☐ Pork
- ☐ Bread
- ☐ Margarine
- ☐ Yogurt
- ☐ Poultry
- ☐ Milk
- ☐ Ice Cream
- ☐ Sweets
- ☐ Fish
- ☐ Butter
- ☐ Vegetables
- ☐ Salads
- ☐ Hot Spicy Foods

Habits

- ☐ Cigarettes
- ☐ Soft Drinks
- ☐ Salt
- ☐ Coffee
- ☐ Alcohol
- ☐ Black Tea
- ☐ Sugar
- ☐ Stress
- ☐ Recreational Drugs

Meals

Do you eat 3 meals per day?
☐ Yes ☐ No

Do you eat regular hours?
☐ Yes ☐ No

Appetite

- ☐ Up and down
- ☐ Poor
- ☐ Good
- ☐ Hungry frequently
- ☐ Loss of taste

Exercises

- ☐ Never
- ☐ Little
- ☐ Moderate
- ☐ Heavy

Emotions

- ☐ Happy
- ☐ Stressed
- ☐ Easily Irritable
- ☐ Angry
- ☐ Cry Easily
- ☐ Depression
- ☐ Restless
- ☐ Hurry to do things
- ☐ Difficulty making decisions

Energy

- ☐ Up and down
- ☐ Low
- ☐ Normal
- ☐ Excess
- ☐ Low after eating
- ☐ Tired in the afternoon

Weight

- ☐ Normal
- ☐ Underweight
- ☐ Overweight
- ☐ Recent gain
- Recent loss

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General Symptoms

Body Temperature:

[ ] Warm natured [ ] Flushed face [ ] Feel Warmer late afternoon and night [ ] Warm soles
[ ] Warm palms [ ] Alternate chills and fever [ ] Cold hands and feet [ ] Cold natured
[ ] Normal [ ] Other: ____

Perspiration:

[ ] Very little [ ] Easily [ ] Night sweats [ ] Profuse [ ] Palms [ ] Without exertion
[ ] Bad smell [ ] Normal [ ] Other: ____

Digestion:

[ ] Normal [ ] Nervous stomach [ ] Bloating [ ] Heartburn [ ] Nausea [ ] Vomiting
[ ] Full feeling or distention [ ] Belch/ burp [ ] Gallstones [ ] Stomach noises [ ] Weight Problems
[ ] Abdominal pain or cramps [ ] Gas [ ] Bad Breath [ ] Difficulty digesting fatty or oily foods
[ ] Bitter taste in mouth [ ] Indigestion [ ] Other: ____

Bowels:

[ ] Normal [ ] Loose stool [ ] Blood in stool [ ] Undigested food in stool
[ ] Diarrhea [ ] Hemorrhoids [ ] Pain or cramps [ ] Colon problems
[ ] Constipation [ ] Anus itch [ ] Stool with bad smell [ ] Mucous in stool [ ] Use laxatives
[ ] Burning anus [ ] Black stool [ ] Small amount of stool [ ] Intestinal worms [ ] Hard stool
[ ] Other: ____________________________

Urination: (three to six times per day is normal):

[ ] Frequent [ ] Burning [ ] Bladder infections [ ] Urgency [ ] Nighttime
[ ] Blood [ ] Incontinence [ ] Kidney stones or infections [ ] Profuse [ ] Pus
[ ] Strong smell [ ] Cloudy [ ] Normal color [ ] Painful [ ] Scanty
[ ] Normal [ ] Other: ____

Thirst:

[ ] Less than normal [ ] Prefer Cold drinks [ ] Thirsty but do not drink [ ] Prefer hot drinks [ ] Excessive
[ ] Normal [ ] Other: ____

Sleep:

[ ] Difficulty falling asleep [ ] Lots of dreams [ ] Tired when get up in morning [ ] Awake easily
[ ] Nightmares [ ] Sleep too much [ ] Difficulty going back to sleep [ ] Restless
[ ] Normal [ ] Other: ____________________________________

Headaches – Dizziness:

[ ] Headaches [ ] Vertigo [ ] Poor balance [ ] Dizziness [ ] Faint easily [ ] Poor memory
[ ] Motion sickness [ ] Migraines [ ] Bend down/ stand up and get dizzy [ ] Other: ____________________________

Skin:

[ ] Dry [ ] Hives [ ] Cuts heal slowly [ ] Itchy [ ] Warts [ ] Yellow Skin [ ] Oily
[ ] Pimples [ ] Eczema [ ] Bruise easily [ ] Boils [ ] Rashes [ ] Moles [ ] Ulcers
[ ] Body odor [ ] Clammy [ ] Normal [ ] Other: _________________________________

Hair:

[ ] Dry [ ] Oily [ ] Falling out [ ] Dandruff [ ] Early grey [ ] Normal
[ ] Other: __________________________________

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Nails:

[ ] Soft [ ] Grow fast [ ] Grow slowly [ ] Purple [ ] Pale [ ] Ridges and lines
[ ] Spots [ ] Other: ______________________________

Eyes:

[ ] Wear glasses or contacts [ ] Eyelids swollen [ ] Cataracts [ ] Red [ ] Spots or lines in vision
[ ] Inflammation [ ] Glaucoma [ ] Blink [ ] Itch [ ] Pale under eyelids
[ ] Poor night vision [ ] Yellow sclera [ ] Twitch [ ] Pain [ ] Failing vision
[ ] Sensitive to light [ ] Sty history [ ] Strain [ ] Color Blindness [ ] Tear easily
[ ] Blurry vision [ ] Normal [ ] Other: ________________________________

Ears:

[ ] Poor hearing [ ] Ringing (high pitch) [ ] Discharges [ ] Earaches [ ] Ringing (low pitch)
[ ] Normal [ ] Other: ______________________________

Nose:

[ ] Stuffy nose [ ] Hayfever [ ] Sneeze a lot [ ] Environmental sensitivity [ ] Dry
[ ] Loss of smell [ ] Bleeding [ ] Mucous [ ] Blow nose a lot
[ ] Sinusitis [ ] Rhinitis [ ] Normal [ ] Other: __________________________________

Mouth & Throat:

[ ] Dry [ ] Gum problems [ ] Hoarseness [ ] Teeth problems [ ] Frequent sore throats
[ ] TMJ [ ] Thyroid problems [ ] Drool a lot [ ] Swollen glands [ ] Sores in mouth/tongue
[ ]Grind teeth [ ] Frequent colds [ ] Dry/cracked lips [ ] Difficulty swallowing [ ] Feel lump in throat
[ ] Hiccups [ ] Normal [ ] Other: _______________________________________

Respiratory:

[ ] Shortness of breath [ ] Difficulty inhaling [ ] Sigh a lot [ ] Chest pain [ ] Difficulty exhaling
[ ] Dry cough [ ] Difficulty breathing [ ] Asthma [ ] Bronchitis [ ] Cough with phlegm
[ ] Cough with blood [ ] Cough when lying down [ ] Cough a lot [ ] Tightness in chest
[ ] Normal [ ] Other: ________________________________

Cardiovascular – Circulation:

[ ] Normal [ ] High blood pressure [ ] Bleed easily [ ] Numbness in extremities
[ ] Diagnosed heart problems [ ] Low blood pressure [ ] Palpitations [ ] Purple palms and fingers
[ ] High cholesterol [ ] Murmur [ ] Varicose veins [ ] Ankle swelling
[ ] History of anemia [ ] Chest pain [ ] Facial swelling [ ] Slow beating of heart
[ ] Bruise easily [ ] Hand swelling [ ] Irregular heart beat
[ ] Broken blood vessels/ capillaries [ ] Other: __________________________________

Pain:

[ ] Neck [ ] Shoulder [ ] Elbow [ ] Hands/wrists [ ] Upper back [ ] Mid back
[ ] Low back [ ] Hips [ ] Sciatica [ ] Muscle weakness [ ] Muscle cramps [ ] Flank
[ ] Knees [ ] Spine [ ] Nerve [ ] Foot or ankle [ ] Damp weather [ ] Arthritis
[ ] Muscle twitching/spasm [ ] Other: ________________________________

Any Other Problems you would like to discuss?

____
____
____

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FOR MALES ONLY *Please check or explain if applicable:*

[ ] Reduced sex drive [ ] Premature ejaculation [ ] Seminal emission [ ] Impotence
[ ] Discharges [ ] Genital pain [ ] Prostate problems [ ] Dribbling urine
[ ] Pain or burning upon urination
Explain: ____
____

FOR FEMALES ONLY

Are you or might you be pregnant [ ] Yes [ ] No [ ]Unsure If yes, approximate date of conception? ___________
Are you experiencing reduced sex drive? [ ] Yes [ ] No
Do you have regular pap tests? [ ] Yes [ ] No How regular? ____________________________
Do you have regular breast exams? [ ] Yes [ ] No How regular? ____________________________
Do you have facial hair or excess body hair? [ ] Yes [ ] No
Other difficulties? [ ] Yes [ ] No Explain: ______________________________

Menstrual Cycle: *(Please check and explain as applicable)*
Age started: ______ Days of flow: ________ Age stopped: _______
How many days from the beginning of your period to the start of your next period? _________
[ ] Irregular [ ] Painful [ ] Heavy flow [ ] Scanty flow [ ] Dark color flow [ ] Light color flow
[ ] Clotting [ ] Backache [ ] Constipation [ ] Diarrhea [ ] Water Retention [ ] Abdominal bloating
[ ] Breast lumps [ ] Painful/tender breasts [ ] Spotting between period [ ] Emotional changes
[ ] Sigh a lot [ ] Lump in throat feeling [ ] Tightness in chest [ ] Hormonal problems
[ ] Other: ______________________________

Vaginal Discharges: [ ] Yellow [ ] Thick [ ] Bad odor [ ] White [ ] Clear
Other:____

Ovulation Symptoms: ____
____
____
____

Menopause problems: ____
____
____
____

Pregnancies: Total number _____ Number of miscarriages ____ Number of children_____ Number of abortions____

Pregnancy or childbirth complications: ____
____
____
____

Gynecological history and operations:
[ ] Ovaries: ______________________________ [ ] Uterus: ______________________________
[ ] Vagina: ______________________________ [ ] Fallopian tubes: ______________________________
[ ] Breasts: ______________________________ [ ] Other: ______________________________

What method of birth control do you now use? ____

What method of birth control have you used in the past? ______________________________________

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CONSENT TO TREAT & FINANCIAL RESPONSIBILITY

1. I authorize Hanna Lee, L.Ac. to perform all recommended treatment mutually agreed upon by me and to use the appropriate Chinese herbal medicine, supplements, and therapy indicated for such treatments.
2. I hereby voluntarily consent to be treated with acupuncture by Hanna Lee L.Ac. I understand that I may be treated with the application of insertion of sterile acupuncture needles *and/or* intradermal needles *and/or* acupuncture stimulator *and/or* finger pressure *and/or* the application of heat to the skin *and/or* cupping/gua sha *and/or* Chinese dietary therapy. I understand that the practice of Acupuncture and Chinese medicine is not an exact science and there are no guarantees that have been made to me as a result of treatment.
3. I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made.

Please initial (acknowledgement of above): _______

STATEMENT OF UNDERSTANDING

Massage (Tui Na), acupressure, acupuncture, cupping, gua sha, acupuncture stimulator, preventative or corrective exercise and nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for western medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury. We recommend that you consult your physician for any serious conditions and get at least two medical opinions. It is your right and responsibility for your own body.

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

I understand that complications may result from acupuncture treatment. Among these possible complications are: Areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, transient bruise, sensation of heat, cold, tingling or numbness and aggravation of present symptoms. Cupping and acupuncture stimulator may result in circular red or purple areas of skin that can last hours or days depending on the length of time the cups are in contact with the skin. Herbal remedies may result in Gastrointestinal disturbance.

Medical Referral

I understand that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by my practitioner or if a new ailment or condition arises, that I should consult a licensed physician. If you request that Hanna Lee L.Ac discuss your case with another healthcare provider we will gladly do so provided that you have signed a medical release form. This is a professional standard among all licensed healthcare providers.

Infectious Disease/ Clean Needle Procedure

I understand that infectious organisms can be carried through the air, through physical contact, and through body fluids. I understand that my acupuncture practitioner uses Universal Precautions to guard against the

spread of infection. I understand that Hanna Lee follows strict clean needle procedures. Only sterile, single-use disposable acupuncture needles are used and are discarded in a biohazard container.

Patient Responsibility
I understand that it is my responsibility as a patient to inform the Hanna Lee about all aspects of my health and that as treatment progresses, to inform my practitioner of any changes that occur. I have carefully read and understand the above information. I am aware of what I am signing and have felt free to ask questions.

Patient's Printed Name: ____

Patient's Signature: ____ **Date:** __________

Witness Signature: ____ **Date:** __________