Center for Acupuncture and Oriental Medicine, PLLC

Gary M. Rexford, L.Ac.

HEALTH HISTORY QUESTIONNAIRE

Welcome to the Center for Acupuncture and Oriental Medicine. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential with our Privacy Policy. If you have any questions, please ask us.

Name: ____

Street: ____ City: ____________________ State: ________ Zip: __________

Home Phone: _____________Work Phone: ____________Occupation: _____________________Marital Status: _______

Date of Birth: _____________________ Age: ________________ Height: ________________ Weight: _______________

Insurance Carrier: ______________________________________ SSN or Policy Number: __________________________

Email: ____ Referred by: _____________________________________

Emergency Contact (Name & Phone Number): ____

Family Physician: ________________Have you ever tried acupuncture or Chinese herbal medicine before?___________

MAIN ISSUE(S) YOU WOULD LIKE TO ADDRESS

Please explain your main issue: ____

____

How long has it been since you first noticed any symptoms: ____

Have you been given a diagnosis for this issue by a physician or chiropractor: ___________________________________

If so, what is it: ____

What kinds of treatment or therapy have you tried: ____

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

____

____

____

Please describe any use of drugs for non-medical purposes: ____

____

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES WHERE POSSIBLE)

- ☐ Allergies:
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor, forceps delivery, etc.)
- ☐ Other significant illness (describe): ______________
  ____
  ____

Accidents or significant trauma (describe): _______
____
____

OTHER RELAVENT MEDICAL HISTORY

____
____
____

FAMILY MEDICINE HISTORY

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Other

OCCUPATION

Your occupation: ____
Occupational stress factors (physical, psychological, chemical): ____
____

LIFESTYLE

Do you follow a regular exercise program? ______________ If so, please describe: ________________________________
____

Please describe your average daily diet: ____
____
____

Please check any of the following habits that apply. How much and how often do you use them?

- ☐ Cigarette smoking
- ☐ Coffee, tea or cola
- ☐ Alcoholic beverages

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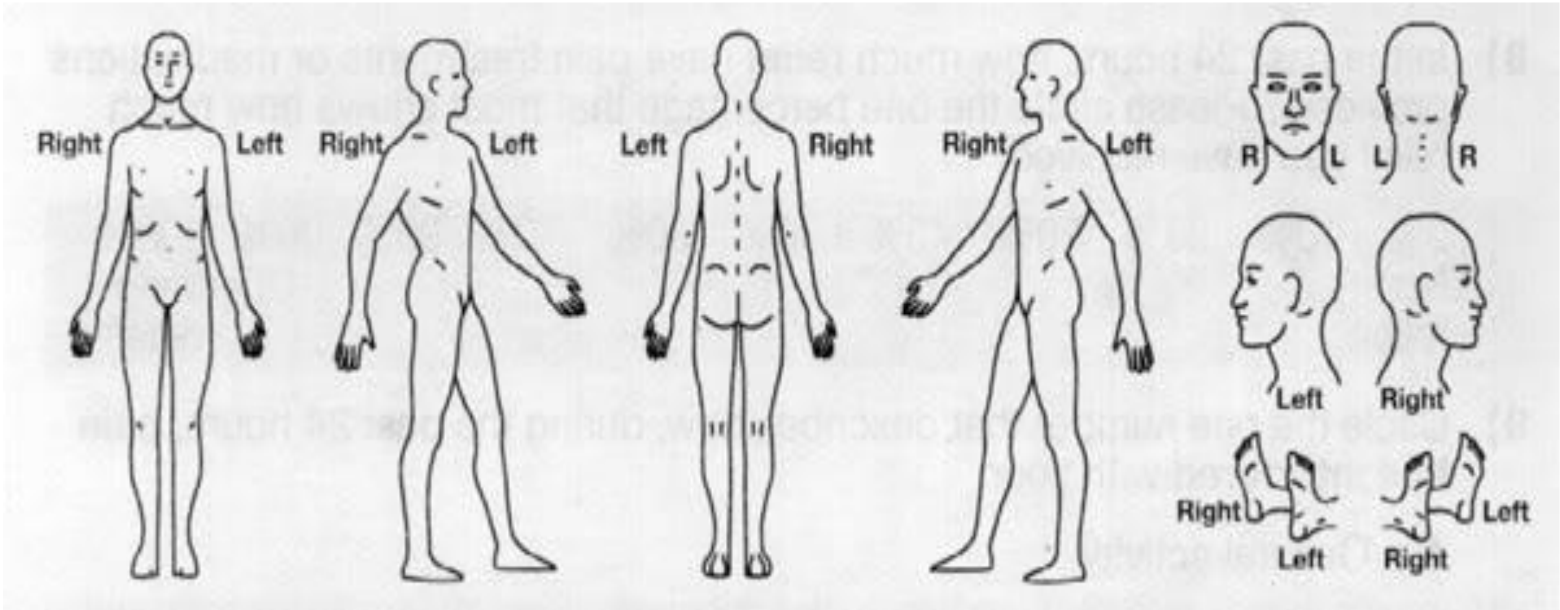
PLEASE MARK PAINFUL OR DISTRESSED AREAS BELOW



PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS AND INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health: ___________________________

____

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin issues: ____

____

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose Bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck issues: ____

____

CARDIOVASCULAR

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

Any other heart or blood vessel issues: ____

____

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung issues: ____

____

DIGESTIVE

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramp
- ☐ Chronic laxative use

Any other issues with stomach or intestines: ____

____

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate:__________ If yes, how often? ____

Any particular color to your urine: ____

Any other genital or urinary issues: ____

GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses: _____________ Age at menopause: _____________ Number of Pregnancies: _________________

Time between cycles: ____________ Duration of bleeding: ______________ First day of last menses: _______________

Do you practice birth control: ______________ If so, what type: _______________ For how long: __________________

Any other gynecologic issues: ____

____

MUSCULOSKELETAL

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

Any other joint or bone issues: ____ ________

____

NEUROPSYCHOLOGICAL

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

Have you ever been treated for emotional issues: ____

Have you ever considered or attempted suicide: ____

Any other neurological or psychological issues: ____

PLEASE LIST ANY OTHER ISSUES YOU WOULD LIKE TO DISCUSS

____

____

18 Middle Street Lancaster, New Hampshire 03584

(603) 631-0046

Center for Acupuncture and Oriental Medicine, PLLC

Gary M. Rexford, L.Ac.

I. <u>PATIENT ADVISORY TO CONSULT A PRIMARY HEALTH CARE PROVIDER</u>

Center for Acupuncture and Oriental Medicine – Gary M. Rexford, L.Ac., PLLC is committed to your health and well-being. I believe that while Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, I recommend that you consult your primary health care provider regarding any condition or conditions for which you are seeking acupuncture treatment.

We, the under-signed, do affirm that ____ (patient) has been advised by Center for Acupuncture and Oriental Medicine – Gary M. Rexford, L.Ac., PLLC to consult a primary health care provider regarding the condition or conditions for which such patient seeks acupuncture treatment.

Patient Signature: ____ Date: ____________________

Clinical Staff: ____ Date: ____________________

II. <u>INFORMED CONSENT TO ACUPUNCTURE TREATMENT</u>

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental Medicine provided by Center for Acupuncture and Oriental Medicine – Gary M. Rexford, L.Ac., PLLC. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, tui na (Chinese medical massage), and shiatsu.

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, and dizziness or fainting. 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 this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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), which may be recommended, are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some side effects include: diarrhea, rashes, hives and tingling of the tongue.

I will notify the clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my record may be used for teaching or research purposes, however my name and identifying information will not be disclosed. Otherwise all of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this 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 for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated).

Print name of Patient: ____

Signature of Patient or Representative: ____ Date: ________________

Print name of Patient's Representative (*if applicable*): ____

To be completed by the member of the Clinical Staff providing information and obtaining consent.

Print name of Clinical Staff: ____

Signature of Clinical Staff: ____ Date: ________________

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