Acupuncture:
Health History Questionnaire

LiveWell Integrated Health LLC

Name:_____Date:_____

Address:_____Zip:_____

Phone:_____Cell:_____

email:_____

Sex: □ M □ F Birthdate: _____/_____/_____

□ Single □ Married/Partnership □ Divorced □ Widowed □ Separated

Occupation:_____Employer:_____

Spouse/Partner Name:_____

Emergency Contact:_____Phone:_____

Have you had acupuncture before? □ Yes □ No

May we contact you via mail or email with newsletters/special offers? □ Yes □ No

Whom may we thank for referring you to our office? _____

Please describe condition(s) for which treatment is sought:

1._____

Date of onset: _____ Severity: □ mild □ moderate □ severe

What makes this condition better? _____

What makes this condition worse? _____

This condition impacts my ability to: □ work □ exercise □ sleep other:_____

2._____

Date of onset: _____ Severity: □ mild □ moderate □ severe

What makes this condition better? _____

What makes this condition worse? _____

This condition impacts my ability to: □ work □ exercise □ sleep other:_____

3._____

Date of onset: _____ Severity: □ mild □ moderate □ severe

What makes this condition better? _____

What makes this condition worse? _____

This condition impacts my ability to: □ work □ exercise □ sleep other:_____

Please indicate if any of the following apply to you:

Hemophiliac:	☐ Yes	☐ No	Epilepsy	☐Yes	☐No
Pacemaker:	☐ Yes	☐No	Vegetarian/Vegan	☐Yes	☐No
Heart condition	☐ Yes	☐No	Lung condition	☐Yes	☐No
Anticoagulant use	☐ Yes	☐No	Diabetes	☐Yes	☐No
Stroke/CVA	☐ Yes	☐No	Hepatitis	☐Yes	☐No
HIV/AIDS	☐ Yes	☐No	Cancer	☐Yes	☐No
Are you pregnant/is there a chance that you are pregnant?				**☐Yes**	**☐No**

Current medications:_____

Current herbs/supplements: _____

Lifestyle/Habits:

Please indicate as appropriate:

Exercise:

☐Mostly sedentary (little to no activity in career/home)

☐Mild exercise (housework, climb stairs, gardening etc)

☐Occasional vigorous exercise (moderate manual labor, exercise <4x/week for 30 min)

☐Regular vigorous exercise (hard manual labor, exercise >4x/week for 30 min)

☐Extreme exercise (professional/serious amateur athlete, exercise 6-7x/week for >45 min)

Diet:

Are you on a restrictive diet? ☐Yes ☐No Is your diet physician prescribed? ☐Yes ☐No
Condition diet is meant to treat: _____
Style/Type of Diet:_____
# of meals eaten in average day: _____
Estimated oz of water/day: _____

Do you consider your diet "healthy"? ☐Very ☐Somewhat ☐No

Caffeine Intake:

☐ None ☐Coffee ☐Tea ☐Cola/performance drinks
# of cups/cans per day:_____

Alcohol Consumption:

Do you consume alcohol? ☐Yes ☐No
Type of alcohol consumed:_____
# of drinks/week: _____

Tobacco Use:

Do you use tobacco? ☐Yes ☐No
Cigarettes: Packs/day_____ Chew: #/day_____ Pipe/cigar#/day_____
# of years used:_____

Recreational Drug Use:

Do you use recreational drugs? ☐Yes ☐No
Type of Drug:_____Frequency:_____

Family/Community:

How often do you see family/friends? ☐1x/week or less ☐2-4x/week ☐>4x/week

Does your spouse/partner discourage you from attending social events? ☐Yes ☐No

Do you feel safe in your home? ☐Yes ☐No

Other Symptoms/Systems:
Please indicate if you regularly experience any of the following.

Head & Neck:

☐Dizziness ☐Fainting ☐Stiff neck ☐Enlarged lymph glands
☐Headache ☐Migraine
☐Other:_____

Eyes & Ears:

☐Blurred vision ☐Visual changes ☐Spots/floaters ☐Eye pain
☐Dry eyes ☐Poor night vision ☐Red/burning/itching eyes ☐Earache
☐ Reduced hearing ☐Ringing in ears ☐Chronic ear infection ☐ Vertigo
☐Other:_____

Respiratory/Nose:

☐Chronic Cough ☐Coughing up blood ☐Cough with phlegm ☐Difficulty breathing
☐Shortness of breath ☐Wheezing/Asthma ☐Frequent Colds ☐Chronic sinus infection
☐Nasal congestion ☐Bronchitis ☐Hay fever/allergies ☐Nosebleeds
☐Other:_____

Genital/Urinary:

☐Pain/itching of genitalia ☐Genital lesions/discharge ☐Painful/burning urination
☐Frequent urination ☐Excessive/scant urination ☐Blood in urine
☐Urgent urination ☐Unable to hold urine ☐Nighttime urination
☐Bedwetting ☐Increased libido ☐Decreased libido
☐Kidney Stone
☐Other:_____

Cardiovascular:

☐Heart palpitations ☐Chest pain/tightness ☐Poor circulation ☐Varicose veins
☐Irregular heart beat ☐Swelling feet/ankles
☐Other:_____

Mouth & Throat:

☐Bleeding gums ☐Recurrent sore throat ☐Bitter taste in mouth ☐Dry mouth
☐Tongue/Mouth sores/ulcers ☐Difficulty swallowing ☐Lump in throat

Muscles & Joints:

☐Joint pain ☐Body aches/stiffness ☐Generalized weakness ☐Numbness/tingling
☐ “Heaviness” of body/limbs ☐Joint swelling ☐Joint discoloration
☐Other:_____

Skin:

☐Hives/Rashes ☐Acne ☐Dry skin ☐Eczema/psoriasis ☐Bruise easily

☐Itchy skin ☐Spontaneous sweat ☐Brittle/weak nails ☐Night sweats

☐Changes in moles/lumps

☐Other:_____

Gastrointestinal:

☐Nausea ☐Vomiting ☐Gas ☐Rectal pain/itchiness

☐Hiccups ☐Bloating ☐Bad breath ☐Loose/soft stool

☐Constipation ☐Anal fissures ☐Hemorrhoids ☐Mucous in stool

☐Blood in stool ☐Black stool ☐Laxative use ☐Intestinal pain/cramps

☐Acid reflux/heartburn ☐Alternating diarrhea/constipation

☐Other:_____

Appetite/Thirst:

☐Exceedingly hungry☐ ☐Poor appetite ☐Hunger w/no desire to eat ☐Specific cravings

☐Excessive thirst ☐Thirst w/no desire to drink ☐No thirst

Temp of drinks most commonly desired: ☐Very cold ☐Tepid ☐Very Hot

☐Other:_____

Sleep:

☐Sound/restful ☐Trouble falling asleep ☐Trouble staying asleep

☐Wake easily/early ☐Dream disturbed ☐Vivid dreaming/nightmares

☐Difficulty waking up #of hours of sleep/night_____

☐Other:_____

Emotions:

☐Relaxed/calm ☐Sad/Grief/depressed ☐Fearful ☐Impatient

☐Angry/Frustrated ☐Forgetful/poor memory ☐Anxious ☐Stressed

☐Manic Other:_____

General:

☐Cold hands/feet ☐Always feel hot ☐Always feel cold ☐Fever& Chills

☐Recent unexplained weight changes ☐Fatigue

Menses:

Age at first Menses:_____ Number of days in cycle:_____

Number of pregnancies:_____ Number of live births: _____

First day of last period:_____ Approx date/year menopause:_____

☐Amenorrhea ☐Dysmenorrheal ☐Excessive flow ☐Scant flow

☐Mid-cycle spotting ☐Cramping ☐PMS ☐Oral Contraceptive use

Informed Consent to Acupuncture Treatment:

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental Medicine provided by the employees of LiveWell Integrated Health LLC (Licensed Acupuncturists/ Assistants/ Massage Therapists). 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, electrical stimulation, and bodywork therapies such as Medical Massage, Tui Na (Chinese 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. Rare and 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.

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 treatment.

I understand that members of the clinical staff of LiveWell Integrated Health LLC may discuss my case to provide thorough and accurate treatment of my condition. 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 and 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).

_____
Date Consent Completed

_____
Print Name of Patient

_____
Signature of Patient or Representative

_____
Print Name of Patient 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