1221 Connecticut Ave., N.W.
Suite 5B
Washington, D.C.
20036
202.300.8428

ACUPUNCTURE HEALTH HISTORY

Patient Information

Date____________________________________

Name____________________________________

Address__________________________________

City State Zip_____________________________

Age________ Birth Date_____________________

Occupation ______________________________

Company name ____________________________

Primary physician _________________________

Physician phone number____________________

How did you hear about us? ________________

____

Contact Information

Home phone ______________________________

Work phone ______________________________

Other/cell phone___________________________

Email ____________________________________

Another person we may contact if needed:

Name ____________________________________

Relationship_______________________________

Home phone ______________________________

Work phone_______________________________

Health History

What are your primary reasons for coming in for treatment?

1 ____

2 ____

3 ____

How is your sleep? _________________________

____

How is your digestion? ______________________

____

List medications or food supplements you are taking.

____

____

List serious illnesses, accidents or surgeries.

____

____

Check illnesses that have occurred in blood relatives.

___Diabetes ___ High blood pressure ___ Stroke
___ Cancer ___ Heart disease ___ Kidney disease

Check symptoms you have or have had in the last year:

- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry
- ☐ Excessive anger
- ☐ Excessive fear
- ☐ Fatigue ___ Tiredness
- ☐ Headaches
- ☐ Loss of sleep ___ Poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness ___ Irritability
- ☐ Overwhelmed by life

Check conditions you have or have had in the past:

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive challenges

How long has it been since you have had a complete medical exam? ______________________________

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Check symptoms you have had in the last year:

MUSCLE/JOINT/BONES
- ☐ Tremors or Cramps
- ☐ Swollen joints

Pain, tightness, weakness, or numbness in:
- ☐ Neck ___ Shoulders
- ☐ Upper back ___ Mid back ___ Lower back
- ☐ Arms ___ Elbows ___ Hands
- ☐ Hips
- ☐ Knees ___ Legs
- ☐ Ankles ___ Feet
- ☐ Other______________________________

EYES/EAR/NOSE/THROAT/RESPIRATORY
- ☐ Asthma ___ Wheezing ___ Frequent sighing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ Enlarged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing ___Ringing in the ears
- ☐ Persistent cough
- ☐ Sinus problems

SKIN
- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin___ Itchy skin ___Sensitive skin
- ☐ Rash(es)
- ☐ Sweats ___Night sweats

GENITO/URINARY
- ☐ Blood ___ Pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection ___ Stones
- ☐ Lowered libido

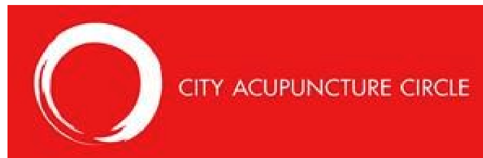
CARDIOVASCULAR
- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid ___ Irregular heart beat
- ☐ Swelling of ankles
- ☐ Cold hands ___ Feet

GASTROINTESTINAL
- ☐ Acid reflux ___ Heartburn
- ☐ Belching ___ Gas ___ Bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder problem
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Stomach pain
- ☐ Poor appetite
- ☐ Vomiting

IF APPLICABLE
- ☐ Erection difficulties
- ☐ Penal discharge
- ☐ Prostate problem
- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant? __________

SIGNATURE: DATE



INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture treatment and other Oriental medical procedures including cupping, guasha, acupressure, electro-acupuncture, seed pressing on me (or on the minor I am legally responsible for) by JoseLo Gutierrez, L.Ac., Seth Shamon, L.Ac., Geoff Edwards, L.Ac., Yilan Xiang, L.Ac., and Jamie Wick, L.Ac.

I understand and am informed that, in the practice of acupuncture there are some risks of treatment, including but not limited to: bruising, numbness or tingling near the needling sites that may last up to a few days, and that in rare occasions, light headedness, dizziness or fainting may occur.

I do not expect the above mentioned practitioner to be able to anticipate and explain all the risks and complications, and agree to rely on the acupuncturist to exercise judgment during the course of treatment of the procedure(s) that the acupuncturist feels at the time, based upon the facts then known, is in my best interest. I also understand the results are not guaranteed. I have read or the above information has been read to me. I have also had the opportunity to ask questions about this consent form to cover the entire course of treatment for my present condition and for any future condition for which I may seek treatment.

NOTICE OF ADVICE

I hereby acknowledge that the acupuncturist above mentioned has recommended I also speak to a primary care physician regarding the condition(s) for which I seek acupuncture treatment.

Print Name____

Signature_____________________________________Date________________

Acupuncturist_________________________________ Date_________________