



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

ACUPUNCTURE HEALTH HISTORY

PATIENT INFORMATION	CONTACT INFORMATION
<p>Date _____</p> <p>Name _____</p> <p>Address _____</p> <p>City State Zip _____</p> <p>Age _____ Birth Date _____</p> <p>Occupation _____</p> <p>Company name _____</p> <p>Primary physician _____</p> <p>Physician phone number _____</p> <p>How did you hear about us? _____</p> <p>_____</p>	<p>Home phone _____</p> <p>Work phone _____</p> <p>Other/cell phone _____</p> <p>Email _____</p> <p>Another person we may contact if needed:</p> <p>Name _____</p> <p>Relationship _____</p> <p>Home phone _____</p> <p>Work phone _____</p>
HEALTH HISTORY	
<p>What are your primary reasons for coming in for treatment?</p> <p>1 _____</p> <p>2 _____</p> <p>3 _____</p> <p>How is your sleep? _____</p> <p>_____</p> <p>How is your digestion? _____</p> <p>_____</p> <p>List medications or food supplements you are taking.</p> <p>_____</p> <p>_____</p> <p>List serious illnesses, accidents or surgeries.</p> <p>_____</p> <p>_____</p> <p>Check illnesses that have occurred in blood relatives.</p> <p>___ Diabetes ___ High blood pressure ___ Stroke</p> <p>___ Cancer ___ Heart disease ___ Kidney disease</p>	<p>Check symptoms you have or have had in the last year:</p> <ul style="list-style-type: none"><input type="checkbox"/> Depression<input type="checkbox"/> Difficulty in focusing<input type="checkbox"/> Dizziness<input type="checkbox"/> Easily startled<input type="checkbox"/> Excessive worry<input type="checkbox"/> Excessive anger<input type="checkbox"/> Excessive fear<input type="checkbox"/> Fatigue ___ Tiredness<input type="checkbox"/> Headaches<input type="checkbox"/> Loss of sleep ___ Poor sleep<input type="checkbox"/> Loss or gain of weight<input type="checkbox"/> Nervousness ___ Irritability<input type="checkbox"/> Overwhelmed by life <p>Check conditions you have or have had in the past:</p> <ul style="list-style-type: none"><input type="checkbox"/> AIDS<input type="checkbox"/> Allergies<input type="checkbox"/> Anemia<input type="checkbox"/> Arthritis<input type="checkbox"/> Bleeding disorders<input type="checkbox"/> Breast lump<input type="checkbox"/> Cancer<input type="checkbox"/> Diabetes<input type="checkbox"/> Digestive challenges <p>How long has it been since you have had a complete medical exam? _____</p>



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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



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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.

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 _____