

PATIENT HEALTH HISTORY FORM

IDENTIFICATION DATA

Name _____ Today's Date _____
 Address _____ Date of Birth _____ Age _____
 City/Zip _____ Place of Birth _____
 Home Phone () _____ Business Phone () _____
 Mobile Phone () _____ Email Address _____
 Gender _____ Partner Status _____ Ethnicity _____
 Education _____ Occupation _____

FAMILY HISTORY

	<u>Father</u>	<u>Mother</u>	<u>Sibling</u>	<u>Children</u>	<u>Other</u>
Allergies:	_____	_____	_____	_____	_____
Blood Disorder:	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____
Cancer/Tumors:	_____	_____	_____	_____	_____
Seizures:	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Kidney/Bladder:	_____	_____	_____	_____	_____
Stomach/Intestinal:	_____	_____	_____	_____	_____
Drug Abuse:	_____	_____	_____	_____	_____
Tuberculosis:	_____	_____	_____	_____	_____
Heart Disorder	_____	_____	_____	_____	_____
Stroke:	_____	_____	_____	_____	_____
Other:	_____	_____	_____	_____	_____
Age of Death:	_____	_____	_____	_____	_____

PERSONAL HEALTH HISTORY

Allergies	(Food / Drug)	Asthma	Cancer	Hepatitis	Diabetes	Thyroid
Digestive	Tuberculosis	Seizures	Stroke	High Blood Pressure		Other

Hospitalizations:

Date: _____ Illness: _____ Hospital/Clinic _____

Pregnancy History / Number of Children:

Reason for seeking treatment today:

Referred by:

Please list all medications/supplements you are currently taking:

<u>Habits:</u>	<u>Current</u>	<u>Past</u>	<u>Frequency</u>
Cigarettes			
Marijuana			
Rec. Drugs			
Alcohol			
Caffeine			
<u>Diet:</u>	<u>(List foods eaten on a typical day)</u>		
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Restrictions			
Cravings			

Date of Last Physical Exam:

Name of Doctor:

Address/Phone:

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, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

I/We, the undersigned, do affirm that (patient) _____
has been advised by Susan Eng, L.Ac. to consult a physician regarding the condition(s)
for which above named patient seeks acupuncture and/or herbal medicine treatment.

(patient's signature)

(date)

(L.Ac.'s signature)

(date)

Susan Eng, L.Ac.

119 West 23rd Street, Suite 701
New York, NY 10011
212-868-5850

Name: _____ Date: _____

Please place a "C" next to any conditions you currently experience and a "P" next to any condition you have experienced in the past.

GENERAL

- Insomnia
- Frequent Dreams / Nightmares
- Fatigue
- Aversion to Cold
- Aversion to Heat
- Frequent Urination
- Thirst
- Depression
- Irritability
- Agitation
- History of Psychiatric Treatment
- Other

MUSCLES & JOINTS

- Joint Disorder
- Muscle Soreness
- Muscle Weakness
- Difficulty Walking
- Spinal Curvature
- Backache
- Back Pain
- Other

HEAD & NECK

- Headaches / Migraines
- Neck Stiffness
- Enlarged Lymph Glands
- Other

EYES

- Blurred Vision
- Visual Changer
- Poor Night Vision
- Spots / Floaters
- Eye Inflammation
- Other

EARS, NOSE & THROAT

- Infection
- Ringing
- Diminished Hearing
- Bleeding
- Sinus Infection
- Sorethroat
- Hoarseness
- Difficulty Swallowing
- Changes in Taste
- Changes in Smell
- Oral Ulcer

SKIN

- Hives
- Acne
- Eczema
- Psoriasis
- Dryness
- Bruise Easily
- Night Sweating
- Excess Sweating
- Changes in Moles or Lumps
- Other

RESPIRATORY

- Chronic Cough
- Difficulty Breathing
- Wheezing / Asthma
- Frequent Colds
- Coughing Up Blood
- Coughing Up Phlegm
- Other

CARDIOVASCULAR

- Palpitations
- Rapid Heart Beat
- Chest Pain or Tightness
- Heart Murmur
- Poor Circulation
- Cold Hands
- Cold Feet
- Ankle Swelling
- Phlebitis
- Other

GASTROINTESTINAL

- Nausea / Vomiting
- Reflux
- Indigestion
- Stomach Pain
- Diarrhea
- Constipation
- Poor Appetite
- Excessive Hunger
- Food Cravings
- Hemorrhoids
- Bloody or Black Stools
- Other

NEUROLOGICAL

- Seizures
- Tremors
- Dizziness
- Fainting
- Numbness
- Tingling
- Pain
- Paralysis
- Other

MALE REPRODUCTIVE

- Pain / Itching of Genitalia
- Genital Lesions
- Discharge
- Impotence
- Weak Urinary Stream
- Lumps in Testicles
- Prostate Disorder
- Other

FEMALE REPRODUCTIVE

- Urinary Tract Infections
- Vaginal Infections
- Pain / Itching of Genitalia
- Genital Lesions
- Discharge
- Pelvic Inflammatory Disease
- Abnormal Pap Smear
- Irregular Menstrual Periods
- Painful Menstrual Periods
- Premenstrual Syndrome
- Abnormal Bleeding
- Menopausal Symptoms
- Breast Disorder
- Other

INFECTION SCREENING

- HIV Risks: Self or Partner
- TB: Self or Partner
- Hepatitis: Self or Partner
- Parasitic Organisms
- Herpes
- Other

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Informed Consent to Acupuncture & Herbal Medicine Treatment

I consent to acupuncture and herbal treatments and other procedures associated with Chinese medicine by the acupuncturist named below. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of well being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. Burns on the skin are a potential risk of moxibustion; again, this rarely happens. I understand that while this document describes the major risks of treatment, other side effects may occur.

I will notify the acupuncturist if I am or become pregnant, since this will affect the treatment.

I do not expect the acupuncturist to be able to anticipate and explain all of the possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which, based upon the facts then known, the acupuncturist believes is in my best interests.

I understand that all my records will be kept confidential and will not be released 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.

Name of patient, please print

Signature of patient or legal guardian

Date

Signature of practitioner

Date