CASE HISTORY INFORMATION

Name ____________________ Birth Date ____________ Age ______

Address ____________________ Social Security # ____________________

City ____________________ Occupation ____________________

State ____________ Zip ____________ Employer ____________________

Phone (day) ____________ (evening) ____________ Employer's Address ____________________

Your Doctor's Name ____________________ City ____________________

Specialty ____________________ State ____________ Zip ____________

Phone ____________________ Employer's Phone ____________________

Diagnosis by Your doctor: ____________________

Present Complaints ____________________

Referred by ____________________ Pain is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

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PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Do you have a tendency to faint? ☐ Yes ☐ No
2. Do you bruise or discolor easily? ☐ Yes ☐ No
3. Do you bleed easily? ☐ Yes ☐ No
4. Do you have or ever had hepatitis? ☐ Yes ☐ No
5. Do you have high blood pressure? ☐ Yes ☐ No
6. Do you have heart problems? ☐ Yes ☐ No
7. Do you have respiratory problems? ☐ Yes ☐ No
8. Do you have digestive problems? ☐ Yes ☐ No
9. Do you have bowel problems? ☐ Yes ☐ No
10. Do you have kidney or bladder trouble? ☐ Yes ☐ No
11. Do you sweat a lot? ☐ Yes ☐ No
12. Do you have headaches? ☐ Yes ☐ No
13. Do you have excessive thirst? ☐ Yes ☐ No
14. Are you taking any therapies at this time? ☐ Yes ☐ No
15. Are you taking any medications/drugs/herbs? ☐ Yes ☐ No
    (If so, list on the other side)
16. Have you had any surgeries or operations? ☐ Yes ☐ No
    (If so, list on the other side)
17. Are you hungry at the present time? ☐ Yes ☐ No
18. Are you exhausted at the present time? ☐ Yes ☐ No
19. Are you nervous at the present time? ☐ Yes ☐ No
20. Are you allergic to anything? ☐ Yes ☐ No
21. (Females) Are you pregnant at this time? ☐ Yes ☐ No
    Last monthly period? ____________

Please indicate your payment method:
Cash ☐ Check ☐ Visa ☐ Master Charge ☐ Health Insurance ☐ Worker's Compensation ☐ Personal Injury Case ☐

SAMPLE

CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, the undersigned, do hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures. The methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There may be some bruising after cupping. The herbs and nutritional supplements which may be recommended are traditionally considered safe in the practice of Chinese Medicine.

I wish to rely on the acupuncturist to exercise judgement during the course of the treatment, which the acupuncturist feels at the time, is in my best interests.

By signing below I agree to the above named procedures. I intend this consent to cover the entire course of treatment for my present condition(s).

Patient's Signature ____________________ Date ____________

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