Medical History

Name (Last, First, Middle)	Date

Presenting Complaint / Health Problem

How long has this condition persisted? How did it start?	How sever is this condition?
	___ (5) Very severe ___ (4) severe ___ (3) Moderately Severe ___ (2) Mildly Severe ___ (1) Not severe
What kind of treatment have you tried in the past? Did it help?	

Have you had any allergies or an allergic reaction to anything?	Have you had any major illnesses or injuries in the past?

Indicate any significant illnesses that you or a close relative had. Use an "**X**" for you, "**P**" for Parent or "**S**" for Sibling.

___ ___ HIV / Aids
___ ___ Alcohol / Drug Addiction
___ ___ Eating Disorder
___ ___ Emphysema
___ ___ Arthritis
___ ___ Asthma
___ ___ Bladder Disease
___ ___ Polio / Meningitis
___ ___ Bursitis
___ ___ Colitis / Bowel Disorders
___ ___ Diabetes
___ ___ Mononucleosis
___ ___ Gall Stones
___ ___ Neuralgia
___ ___ Goiter

___ ___ Epilepsy / Seizures
___ ___ Chronic fatigue
___ ___ Obesity / Overweight
___ ___ Multiple Sclerosis
___ ___ Nephritis
___ ___ Stroke
___ ___ Hepatitis A - B - C
___ ___ Candida
___ ___ Cancer
___ ___ Thyroid Problems
___ ___ Ulcers
___ ___ Rheumatism
___ ___ Scarlet Fever
___ ___ Hernia
___ ___ Heart Disease

___ ___ Emotional Imbalance
___ ___ Psychosis
___ ___ STD
___ ___ Lyme Disease
___ ___ Autoimmune Disease Other
___ ___ Kidney Disorder
___ ___ Emotional / Physical Abuse
___ ___ Bowel / Digestive Issues
___ ___ Bleeding / Blood Disorder
___ ___ Other:

_____

_____

Chinese Medicine looks at the body from a holistic perspective. In order to provide the best care possible, be as complete as possible.

Please complete the following section by making a "X" next to any symptoms that you have experienced within the past month.

_____

Sleep / Energy
__ difficulty falling asleep
__ difficulty staying asleep
__ restless sleep
__ Lots of dreams
__ Wake up too early
__ Go to bed extra early
__ Need to take naps
__ Tired during the day
__ Mentally fatigued
__ Low sex drive

Food / Taste / Thirst / Digestion
__ Lack of appetite
__ Large appetite
__ Eat small portions
__ Eat large portions
__ Aversion to eating
__ Nausea / vomiting
__ Tired after eating
__ Bloating / full feeling
__ Frequent flatulence
__ Heartburn / Reflux
__ Difficulty digesting food
__ Frequent belching
__ Stomach discomfort
__ Frequent hiccups
__ Dry mouth
__ Increased saliva
__ Frequent thirst
__ Lack of thirst
__ Prefers cold water
__ Prefers warm water

Bowel Movements
__ Less then 1 / per day
__ More then 3 / per day
__ Mostly firm stools
__ Mostly loose stools
__ Diarrhea
__ Constipation
__ Difficult to pass BM
__ Pain, Before BM
__ Hemorrhoids
__ Black / bloody stools

Urine
__ Less then 3 / per day
__ More then 5 / per day
__ Urgency / incontinence
__ Wake up to urinate
__ Dark yellow or brown
__ Blood in urine
__ Cloudy urine
__ Pain or burning
__ Delayed urination
__ Strong odor

Body
__ Gaining weight
__ Loosing weight
__ Upper back pain / stiff
__ Lower back pain / ache
__ General body aches
__ Tend to feel warm / hot
__ Tend to feel cool / cold
__ Cramping in the limbs
__ Numbness in the limbs
__ Twitching in the limbs
__ Edema / swelling limbs
__ Heavy / weak limbs
__ Knee clicks or pops
__ Warmer in the evening
__ Shiver frequently
__ Sweat with little effort
__ Sweat at night
__ Sweat on palms / feet
__ Yellowish sweat
__ Oily sweat

Respiratory
__ Asthma / wheezing
__ Shortness of breath
__ Hay fever / allergies
__ Persistent cough
__ Coughing blood
__ Phlegm production
__ Frequent sighing
__ Frequent yawning

Chest
__ Chest pain
__ Heavy feeling in chest
__ Tightness in the chest
__ Irregular heart beat
__ Racing heart beat
__ Aware of heartbeat
__ Pain in the ribcage

Eyes / Ears / Nose / Throat / Mouth
__ Blurry vision
__ See floating spots
__ Dry eyes
__ Redness in the eyes
__ Watery eyes
__ Itchy eyes
__ Pressure in the eyes
__ Earaches
__ Discharge from ears
__ Excess ear wax
__ Bleeding from ears
__ Ringing sound
__ Difficulty hearing
__ Frequently sneeze
__ Congested sinuses
__ Frequent runny nose
__ Nose bleeds
__ Itchy nose
__ Dry nostrils
__ Toothaches
__ Loose teeth sensation
__ Teeth Grinding
__ Bleeding gums
__ Sore / tender tongue
__ Sores inside the mouth
__ Sores outside mouth
__ Dry / cracked lips
__ Soreness in the throat
__ Itchy throat
__ Swelling in the throat
__ Stuck feeling in throat
__ Difficulty swallowing

Head / Hair
__ Foggy feeling in head
__ Buzzing noise in head
__ pressure in the head
__ Headaches / Migraines
__ Frequently dizzy
__ Faint fairly often
__ Itchy scalp
__ Dry brittle hair
__ Greasy Hair
__ Dandruff
__ Hair loss

Skin
__ Oily skin
__ Dry or flaking skin
__ Itchy skin
__ Rash / acne / eczema
__ Redness / discoloration
__ Growths or masses
__ Varicose veins
__ Bruise easily
__ Slow healing wounds
__ Easy bleeding
__ Warm to the touch
__ Cool to the touch

Mental / Emotional
__ Feel "stressed out"
__ Impatient / Irritable
__ Easy to anger
__ Nervous / anxious
__ Sadness / Depression
__ Lack drive / willpower
__ Forgetfulness
__ Mind not clear / Foggy
__ Worry / racing thoughts
__ Excess fear / fright
__ Frequently insecure
__ Poor memory
__ Lack emotional support
__ Family / Home Stress

Men Only
__ Genital pain
__ Impotence
__ Genital sores
__ Lump in testicles
__ Penis discharge
__ Nocturnal emission

Women Only
__ Has given birth to child
__ Past menopause
__ In menopause
__ Less than 25 day cycle
__ More than 35 day cycle
__ Irregular cycle
__ Periods under 3 days
__ Periods over 6 days
__ Heavy periods
__ Light periods
__ Periods contain clots
__ Pain before periods
__ Pain during periods
__ Pain after periods
__ Bleed between periods
__ Premenstrual tension
__ Breast pain / tender
__ Breast lumps / masses
__ Vaginal discharges
__ Uterine prolapse

Medication List

Name (Last, First, Middle)	Date
	/ /

Please List Any Prescription Medications - Over The Counter Medications - Supplements - Herbs

Name Of Medication:	Reason:	Dose Taken:	How Long:

Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at Practice Longevity / BridgePoint Health. I understand that Acupuncturists practicing in the state of Wisconsin are not considered to be primary care providers. Our practitioners at Practice Longevity / BridgePoint Health, advise you to consult a your primary care provider in addition to Acupuncture & Oriental treatment.

Acupuncture: I understand that acupuncture is performed by the insertion of single use sterile needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture is typically a safe method of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that are contraindicated in pregnancy. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Chinese Herbs & Vitamin Supplements: I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic or your primary care provider.

Acupressure / Tui-Na Massage: I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Special Situations: Please inform us if you have any allergies, severe bleeding disorders, diabetes, lymphedema, infectious disease-such as HIV / AIDS, hepatitis, tuberculosis, or if you are wearing a pacemaker or other electronic medical device.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgement during the course of treatment which the acupuncturist thinks is best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my primary care practitioner (i.e. M.D. or N.D.) for those services and for routine check-ups.

I request and consent to the performance of acupuncture and the Oriental Medicine procedures. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the risks and benefits of acupuncture and other treatments. I have had an opportunity to ask questions and understand that if at any time I have any questions about this information, I should ask my acupuncturist. I, hereby release Practice Longevity / BridgePoint Health from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Signature: _____ Date: _____ / _____ / _____

Printed Name: _____

Informed Patient Authorization

Patient Name:		Date of Birth: / /
Address:		SSN: For Insurance Only
City:	State:	Zip:
Home Phone:	Work Phone:	
Occupation: For Insurance Only	Employer: For Insurance Only	

Informed Consent:

The benefits and risks of receiving Acupuncture and Oriental Medicine Treatment have been explained to me. Although rare, certain side effects may result from Acupuncture & Herbal Formulas. I understand a licensed acupuncturist will be performing these treatments. I understand Practice Longevity may record medical and other information concerning my treatments in electronic or other physical form. Such information may be released by the clinic for the purposes outlined on this form. I understand that portions of my medical records may be disclosed to qualified non-clinician personnel for the purpose of conducting scientific or statistical research, management or financial audits without my consent. I understand that no guarantees have been made to me as a result of treatment or medical examination at Practice Longevity.

Records Release Authorization:

- I authorize the use of this form for all of my insurance submissions
- I authorize release of information to all of my insurance companies
- I permit a copy of this authorization to be used in place of an original
- I direct my previous, and current, health care providers to release medical records to this clinic
- I understand that I am fully responsible for my bill
- I authorize payment directly to Practice Longevity
- I authorize my clinician to act as my agent to obtain payment from my insurance company
- This authorization is not intended to allow the release of records regarding my treatments for services requiring a restricted release under State and Federal Law

Notice of Privacy Practices:

I have received a copy of the Practice Longevity notice of privacy paperwork. I understand the paperwork defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal privacy rights.

_____ Date: _____ / _____ / _____
Patient's Signature

_____ Date: _____ / _____ / _____
Witness Signature

Consent to Treat a Minor Child:

I authorize the licensed clinicians at Practice Longevity to administer Acupuncture and Oriental Medicine care as deemed necessary to

my _____(relationship).

_____ _____ Date: _____ / _____ / _____
Child's Name Adult Signature