

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?
		<input type="checkbox"/> (5) Very severe <input type="checkbox"/> (4) severe <input type="checkbox"/> (3) Moderately Severe <input type="checkbox"/> (2) Mildly Severe <input type="checkbox"/> (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.		
<input type="checkbox"/> HIV / Aids <input type="checkbox"/> Alcohol / Drug Addiction <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Emphysema <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bladder Disease <input type="checkbox"/> Polio / Meningitis <input type="checkbox"/> Bursitis <input type="checkbox"/> Colitis / Bowel Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Gall Stones <input type="checkbox"/> Neuralgia <input type="checkbox"/> Goiter	<input type="checkbox"/> Epilepsy / Seizures <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Obesity / Overweight <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Nephritis <input type="checkbox"/> Stroke <input type="checkbox"/> Hepatitis A - B - C <input type="checkbox"/> Candida <input type="checkbox"/> Cancer <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Ulcers <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Hernia <input type="checkbox"/> Heart Disease	<input type="checkbox"/> Emotional Imbalance <input type="checkbox"/> Psychosis <input type="checkbox"/> STD <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Autoimmune Disease Other <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Emotional / Physical Abuse <input type="checkbox"/> Bowel / Digestive Issues <input type="checkbox"/> Bleeding / Blood Disorder <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____

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 than 1 / per day
- More than 3 / per day
- Mostly firm stools
- Mostly loose stools

- Diarrhea
- Constipation
- Difficult to pass BM
- Pain, Before BM
- Hemorrhoids
- Black / bloody stools

Urine

- Less than 3 / per day
- More than 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

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: _____

