氣 Contemporary Acupuncture

PATIENT HEALTH HISTORY

Name: ____ Date: _____/_____/_____
(Last) (First) (Middle Init.)

Date of Birth: ______/______/______ Age: ______ Gender: M / F Marital status: S M D W

Address:______________________________ City:______________ State:________ Zip:______________

Phone Number:______________________ Cell Phone Number:______________________

Referred By:______________________________ Email Address:_________________________________

Emergency Contact:____
(Name) (Relationship) (Phone #)

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1. When, where, and why did you last receive health care? ____
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2. Please identify the health concerns that have brought you to "Contemporary Acupuncture Clinic" in order of importance below:

   Condition
   a. __________________________ ____
   b. __________________________ ____
   c. __________________________ ____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):
____
____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:
____
____

5. Do you have any reason to believe you may be pregnant? Y / N If so, how far along are you?
____

6. Do you have any infectious diseases? Y / N If yes, please Identify: ______________________________________

7. **Family History:**

Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=good, P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____

8. **Height:** __________ **Weight:** __________

9. **Blood Pressure:** Most recent reading? _______/_______ Pulse Rate:_________ Body Temperature:_______

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever *Diphtheria* *Rheumatic Fever* *Mumps* *Measles* *German Measles* *Chicken Pox*

11. **Hospitalizations and Surgeries:**

<u>Reason</u> <u>Date</u>

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12. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

<u>Reason</u> <u>Date</u>

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13. **Emotional** (please circle any you experience now; underline any you experienced in the past):

Mood Swings *Nervousness* *Mental Tension*

14. **Energy and Immunity** (please circle any you experience now; underline any you experienced in the past):

Fatigue *Slow Wound Healing* *Chronic Infections* *Chronic Fatigue Syndrome*

15. **Head, Eye, Ear, Nose, and Throat** (please circle any you experience now; underline any you experienced in the past):

Impaired Vision	*Eye Pain/Strain*	*Glaucoma*	*Glasses/Contacts*	*Tearing/Dryness*
Impaired Hearing	*Ear Ringing*	*Earaches*	*Headaches*	*Sinus Problems*
Nose Bleeds	*Sore Throats*	*Teeth Grinding*	*TMJ/Jaw Problems*	

16. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	*Frequent Common Colds*	*Difficulty Breathing*	*Emphysema*
Persistent Cough	*Pleurisy*	*Asthma/Hay Fever*	*Tuberculosis*
Shortness of Breath	*Other Respiratory Problems*	__________________	

17. **Cardiovascular** (please circle any you experience now; underline any you have experienced in the past):

Heart Disease	*Chest Pain*	*Palpitations/Fluttering*	*Swelling of Ankles*
High Blood Pressure	*Stroke*	*Heart Murmurs*	*Varicose Veins*

18. **Gastrointestinal** (please circle any you experience now; underline any you have experienced in the past):

Ulcers	*Changes in Appetite*	*Nausea/Vomiting*	*Epigastric Pain*
Passing Gas	*Heartburn*	*Belching*	*Gall Bladder Disease*
Liver Disease	*Hepatitis B or C*	*Hemorrhoids*	*Abdominal Pain*

19. **Genito-Urinary Tract** (please circle any you experience now; underline any you have experienced in the past):

Kidney Disease	*Painful Urination*	*Frequent UTI*	*Frequent Urination*
Heavy Flow	*Kidney Stones*	*Impaired Urination*	*Blood in Urine*

20. **Female Reproductive/Breasts** (please circle any you experience now; underline any you have experienced in the past):

Irregular Cycles	*Breast Lumps/Tenderness*	*Nipple Discharge*	*Heavy Flow*
Vaginal Discharge	*Premenstrual Problems*	*Clotting*	*Bleeding Between Cycles*
Menopausal Symptoms	*Difficulty Conceiving*	*Painful Periods*	

21. **Menstrual/Birthing History:**

Birth Control Type: ________	*Number of Abortions:* ________	*Number of Days of Menses:* _______
Number of Pregnancies: ________	*Number of Live Births:* ________	*Length of Cycle:* _______
Number of Miscarriages: ________		

22. **Male Reproductive** (please circle any you experience now; underline any you have experienced in the past):
Sexual Difficulties *Prostrate Problems* *Testicular Pain/Swelling* *Penile Discharge*

23. **Musculoskeletal** (please circle any you experience now; underline any you have experienced in the past):
Neck/Shoulder Pain *Muscle Spasms/Cramps* *Arm Pain* *Upper Back Pain*
Mid Back Pain *Low Back Pain* *Leg Pain* *Joint Pain*

24. **Neurologic** (please circle any you experience now; underline any you have experienced in the past):
Vertigo/Dizziness *Paralysis* *Numbness/Tingling* *Loss of Balance*
Seizures/Epilepsy

25. **Endocrine** (please circle any you experience now; underline any you have experienced in the past):
Hypothyroid *Hypoglycemia* *Hyperthyroid* *Diabetes Mellitus*
Night Sweats *Feeling Hot or Cold*

26. **Other** (please circle any you experience now; underline any you have experienced in the past):
Anemia *Cancer* *Rashes* *Cold Hands/Feet*

27. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? _________
b. Do you take supplements? Y / N If so, what brand:_____________________________________
c. Exercise routine: ____
d. How many hours per night do you sleep? ____________ Do you wake rested? Y / N
e. Occupation: ____ Hours/Week: ________
f. Nicotine/Alcohol/Caffeine Use: ____
g. Have you experienced any major traumas? Y / N Please explain below:
____
____
h. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day?_________________

HOW DID YOU HEAR ABOUT US?____

WOULD YOU LIKE TO RECEIVE OUR NEWSLETTER? ___________________________________

Contemporary Acupuncture
34930 N. Hwy 45, Suite 108
Lake Villa, IL 60046

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME:____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Please provide the following information regarding your Attending Physician:

Name:______________________________________

Address:____________________________________

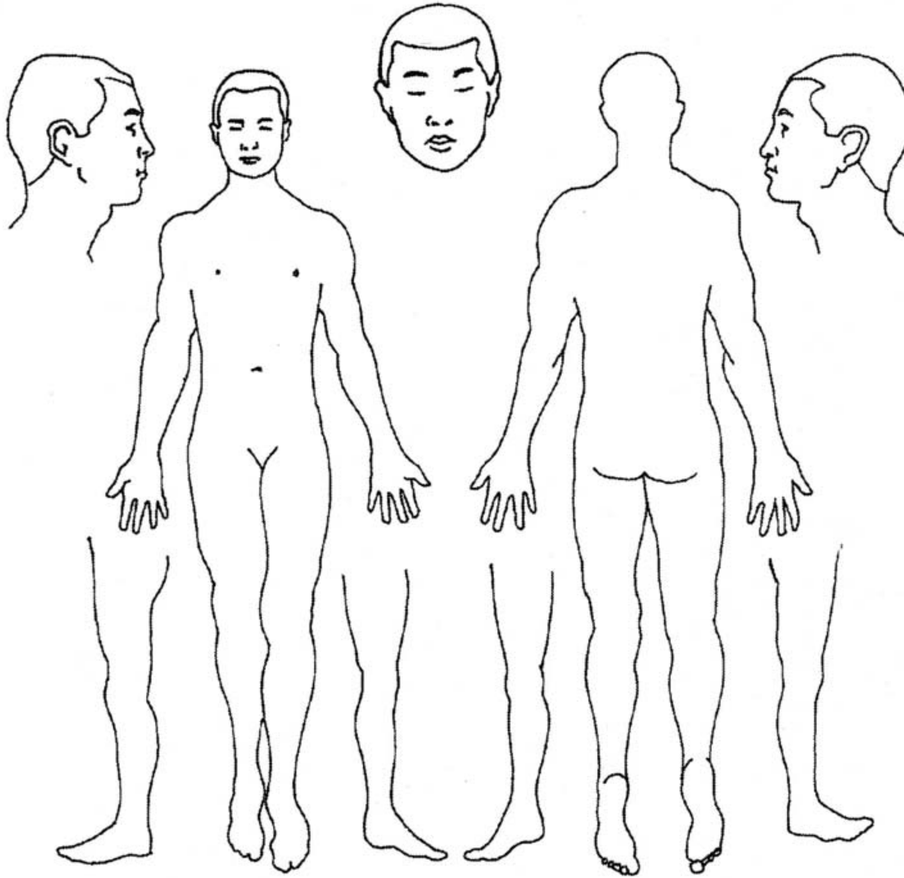
City, State, zip:______________________________

Telephone:__________________________________

Patient Signature:___________________________ Date:___________

PAIN CHART

Please indicate all areas of pain by filling in the area and placing a number 1-10 to indicate the level of pain as indicated at the bottom of the page.



0	**2**	**4**	**6**	**8**	**10**
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

ACUPUNCTURE CONSENT FORM

Acupuncture is performed by the insertion of PRE-STERILIZED, DISPOSABLE acupuncture needles through the skin, and / or the application of heat or electrical stimulation to the skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture and Oriental Medical treatment have been explained to me. Although rare, certain side effects may result from Acupuncture, I understand that each procedure or treatment has specific risks and benefits.

I have been informed of the risk and benefits of the procedures and products listed below that apply to my treatment:

- Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points.
- Use of mechanical, magnetic or electrical stimulation of acupuncture points, particularly in instances where stimulation is applied across the midline of the trunk or patients with a history of heart trouble.
- Herbs
- Homeopathy
- Nutritional Supplements

I have been informed and understand the risk and side effects listed below:

- Minor bruising
- Needle sickness
- Broken needles
- Some pain at the site of needle insertion
- Infection and the risks from needling in the vicinity of an infection

AUTHORIZATION

- I understand that I am responsible for my bill and that a 24 hour notice of cancellation is required or all applicable fees apply (full payment of services for scheduled appointment).
- If payment option involves the use of my credit card, I authorize payment directly to:
  Ricky J. Colmer Ph.D., L.Ac.
- I authorize the use of this form to be included in my medical history.

____

Patient's Signature: Date:

CONSENT TO TREAT A MINOR CHILD

I authorize Ricky J. Colmer Ph.D., L.Ac. to administer acupuncture, homeopathic, and/or herbal care as deemed necessary to my child: ______________________________(child's name).

____

Parent or Guardian's Signature: Date: