CASE HISTORY INFORMATION

NAME:_____ BIRTH DATE:_____/_____/_____AGE:_____

ADDRESS:_____

_____ PHONE (day) _____-_____-_____

CITY:_____

STATE:_____ ZIP:_____ PHONE (evening) _____-_____-_____

YOUR DOCTOR'S NAME_____

SPECIALITY:_____ PHONE:_____-_____-_____

DIAGNOSIS BY YOUR DOCTOR:_____

_____

PRESENT COMPLAINTS:_____

_____

REFERRED BY:_____

PAIN IS: ☐Minimal ☐Slight ☐Moderate ☐Severe

PLEASE ANSWER THE FOLLOWING QUESTIONS

01	Do you have a tendency to faint?	Yes	No	13	Do you have excessive thirst?	Yes	No
02	Do you bruise or discolor easily?	Yes	No	14	Are you taking any therapies at this time?	Yes	No
03	Do you bleed easily?	Yes	No	15	Are you taking any medications/drugs/herbs? *(If so, list on other side)*	Yes	No
04	Do you have or ever had hepatitis?	Yes	No				
05	Do you have high blood pressure?	Yes	No	16	Have you had any surgeries or operations? *(if so, list on other side)*	Yes	No
06	Do you have heart problems?	Yes	No				
07	Do you have respiratory problems?	Yes	No	17	Are you hungry at the present time?	Yes	No
08	Do you have digestive problems?	Yes	No	18	Are you exhausted at the present time?	Yes	No
09	Do you have bowel problems?	Yes	No	19	Are you nervous at the present time?	Yes	No
10	Do you have kidney or bladder trouble?	Yes	No	20	Are you allergic to anything? (If so, list on other side)	Yes	No
11	Do you sweat a lot?	Yes	No				
12	Do you have headaches?	Yes	No	21	(FEMALES) Are you pregnant at this time? *Last monthly period?*_____	Yes	No

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, infrasonic AGM, 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 judgment 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 names procedures, I intend this consent to cover the entire course of treatment for my present condition(s).

Patient's Signature_____Date:_____/_____/_____

15) PLEASE LIST ANY MEDICATIONS, DRUGS, OR HERBS YOU ARE TAKING:

MEDICATION / DRUG / HERB NAME	REASON FOR TAKING	TAKING SINCE	PERSCRIBING PHYSICIAN

16) PLEASE LIST ANY SURGERIES OR OPERATIONS

SURGERY / OPERATION	DATE

20) PLEASE LIST ANY ALLERGIES
