

Transforming Touch Acupuncture
Earl Hinds, L.Ac.
Jill Janoff, CMT

Health History Questionnaire

Date_____

Thank you for taking the time to fill out this questionnaire thoroughly. This information is held in strict confidentiality. If you have any questions, please ask. If there is anything you wish to bring to our attention that isn't asked on the form, please note it in the Comments section. Please print this form (double-sided if possible) and complete it by hand, or complete it on your computer and then print it.

For the privacy and protection of your personal health information, please do not email this form to us.

Please complete the form in advance and bring it to your first appointment.

Name_____ Date of Birth_____ Age_____

Phone # (H)_____ (W)_____ (C)_____

Address_____

Height_____ Weight_____

Employer_____ Occupation_____

Referred By _____

E-mail Address_____

Spouse / Partner's Name_____ phone_____

Emergency Contact [if other than spouse/partner] _____

phone_____

Primary Care Physician_____ Phone _____

Physician's Address _____

Have you ever received acupuncture before? (Y) (N) If yes for what reason(s)?

What is the chief condition or health challenge you are seeking to change?

How long have you had this condition? _____

To what extent does it interfere with your daily life? _____

Have you been given a Western medical diagnosis for the problem? (Y) (N)

If yes, what? _____

List treatments/medications used for relief of this issue _____

Please note the degree of severity of your chief complaint today:

No Problem _____ Worst Imaginable
1 2 3 4 5 6 7 8 9 10

Please note the greatest degree of severity of your chief complaint to date:

No Problem _____ Worst Imaginable
1 2 3 4 5 6 7 8 9 10

List any other health conditions you are seeking to change

List any other therapies you currently use and for what purpose

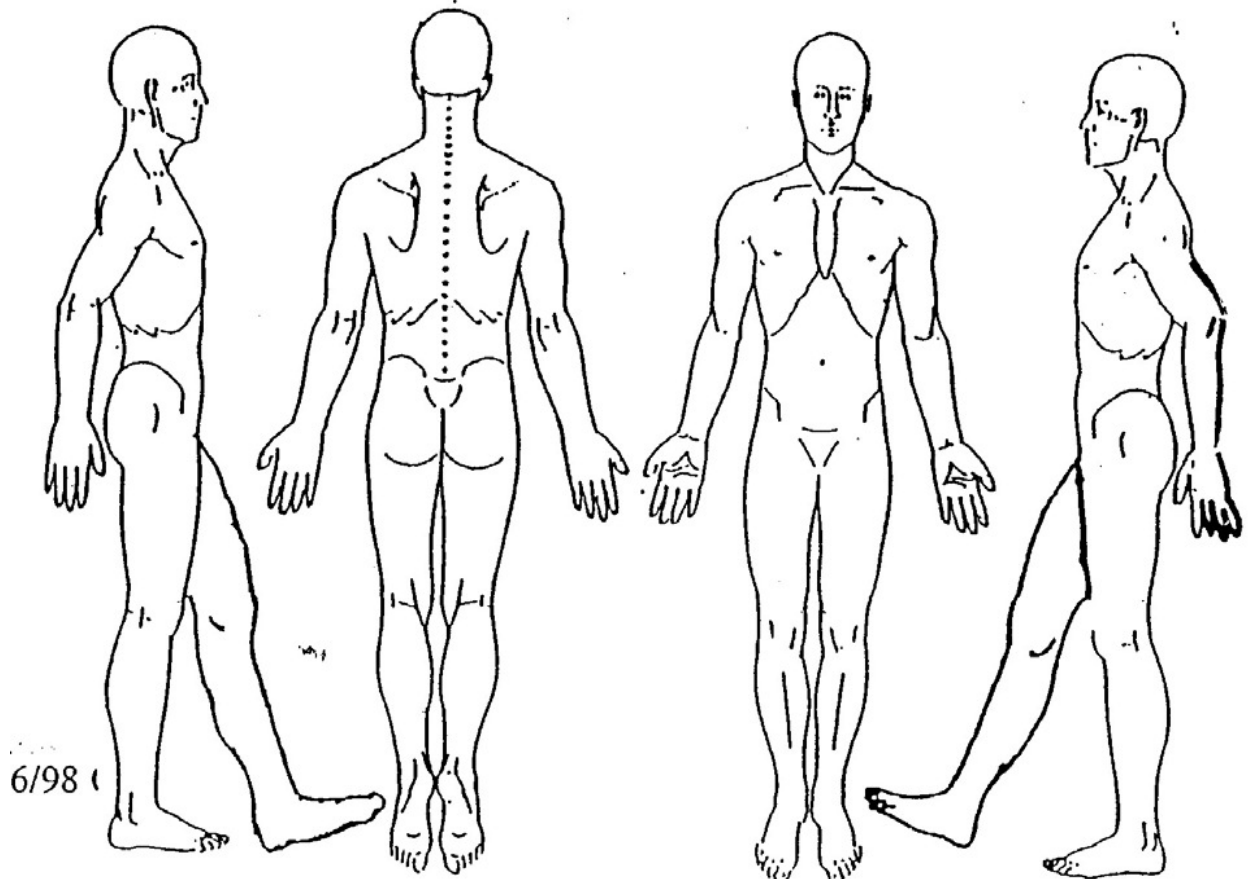
Comments: _____

On the Chart below please indicate any areas where you currently experience any pain, stiffness or loss of range of motion or decreased function.

Please note the quality of the pain-dull, aching, sharp, or burning

Please mark locations of old injuries or traumas and approximately when they occurred.

Use the space below the chart for any further explanation.



Past Medical History—please elaborate, as appropriate

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other |

Surgeries & Hospitalizations (type & dates) _____

Significant Traumas _____

Known allergies (drugs, chemicals, foods, etc.) _____

Occupational Stress (chemical, physical, psychological) _____

Birth History (prolonged labor, forceps, premature, etc.) _____

What medications / vitamins / supplements are you taking? _____

Have you undergone any courses of antibiotics recently? Many Moderate Few None

Family Medical History—please elaborate, as appropriate, and note which family member(s)

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other |

Habits & Lifestyle

Do you exercise regularly? Please describe: _____

Please describe the type of foods you eat daily:

Morning _____

Midday _____

Afternoon _____

Evening _____

Please check any of the habits below that apply to you, now or in the past, and indicate your usage per day or week:

- | | | |
|---|-------------------|----------------|
| <input type="checkbox"/> Tobacco _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Alcohol _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Coffee _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Marijuana _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Cocaine _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Heroin _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Amphetamines _____ per _____ | Age started _____ | Age quit _____ |
| <input type="checkbox"/> Other _____ per _____ | Age started _____ | Age quit _____ |

Have you experienced any of the following conditions?

Please check all the boxes that apply and add any information on the following page.

General

Past Current

- Catch cold easily
 Recurrent infections
 Night sweats
 Sweat easily
 Bleed or bruise easily
 Strong thirst(hot cold)
 Thirst
 No desire to drink
 Fatigue / low energy
 Sudden energy drops
 Time of day? _____

sudden weight change

- low body weight
 unable to gain weight
 unable to lose weight
 Food allergy
 perspire easily

Sleep

Past Current

- Difficult to fall asleep
 Wake up easily during the night

Times per night? _____

- Wake too early in morning

What time? _____

- Wake too early in morning; can't go back to sleep

What time? _____

- Nightmares

Bad dreams

Bad dreams

- Vivid dreams
 Grinding teeth
 Talking in sleep
 Sleepwalking
 Snoring
 Other _____

Skin / Hair

Past Current

- Dry skin / scalp / hair
 Rashes / hives
 Itching
 Eczema
 Warts
 Acne
 Change in moles
 Skin eruptions

Skin / Hair, cont.

- Hair loss
 Thinning hair
 Graying of hair
 Other _____

Head

Eyes/Ears/Nose/Throat

Past Current

- Headaches
 Where? _____
 When? _____
 Migraines
 Dizziness / vertigo
 Earache
 Ear Discharge
 Hearing Change
 Ringing in ears
 High pitch? _____
 Low pitch? _____

- Blurry vision
 Night blindness
 Color blindness
 Spots before eyes
 Sore eyes
 Eye pain
 Excessive tearing
 Dry eyes
 Glasses / contacts
 Facial pain
 Facial paralysis
 Nosebleeds
 Nasal discharge
 Blocked nose
 Sinus congestion
 TMJ
 Teeth / gum problems
 Recurrent sore throat
 Hoarseness
 Loss of voice
 Tonsillitis
 Swollen glands
 Lips / mouth / gums
 Sores _____

Other _____

Respiratory

Past Current

- Pain with breathing
 Difficulty breathing
 Shallow breathing
 Shortness of breath
 Production of phlegm

Respiratory, cont.

- Recurrent / chronic cough
 Coughing blood
 Asthma / wheezing
 Bronchitis
 Emphysema
 Pneumonia

Cardiovascular

Past Current

- Pacemaker
 High blood pressure
 Low blood pressure
 Chest discomfort
 Chest pain
 Heart palpitations
 Tachycardia
 Cold hands or feet
 Swelling of hands or feet

- Blood clots
 Spider veins
 Fainting
 Anemia
 Other _____

Genito-urinary

Past Current

- Pain on urination
 Urgent urination
 Frequent urination
 Decreased urination
 Blood in urine
 Cloudy urine
 Change in urinary flow
 Urinary incontinence
 Incontinence at night
 Dribbling urination
 Do you wake to urinate?

How many times? _____

- Recurrent bladder infections
 Recurrent yeast infections

- Kidney stones
 Prostate problems
 PSA Level? _____
 Sexual drive Change
 Impotence
 Rashes / itching
 Other _____

Gynecological

- Past Current
 Irregular periods
 Painful periods
 Premenstrual syndrome

Age of first menses _____
days between menses _____

menses duration _____
1st day of last menses _____

- Menstrual cramping
Usual days of flow _____
flow type

Light Medium Heavy

- Clots
 Discharge between cycles
 Endometriosis
 Menopausal syndrome
 Abnormal PAP smear
 Abnormal bleeding
 Postcoital bleeding
 Postcoital pain
 Fibroids
 Infertility

Hysterectomy surgery date _____

- Vaginal dryness
 Vaginal discharge
 Vaginal sores
 Vaginal pain/infections
 Genital herpes
 Sexual dysfunction
 Breast pain
 Breast lumps
 Nipple discharge

Last mammogram date: _____

Other _____

Are you now pregnant?

yes ___ no ___

Do you practice birth control?

yes ___ no ___

what type & how long?

of pregnancies _____

births _____

miscarriages _____

premature births _____

abortions _____

Cesareans _____

D&C's _____

Gynecological, cont.

Age of menopause _____
Date of last PAP _____
other female concerns not addressed _____

Digestive

- Past Current
 Little appetite
 Strong appetite
 Hunger, no desire to eat
 Bad breath
 Belching
 Nausea
 Vomiting
 Heartburn
 Indigestion
 Bloating
 Abdominal pain
 Weight gain
 Weight loss
 Loose stools
 Diarrhea
 Dysentery
 Strong smelling stools
 Bloody stools
 Pale stools
 Green stools
 Black, tarry stools
 Constipation
 Dry stools
 not daily
 with difficulty
 Pain with passing stools
 Gas / flatulence
 Rectal pain
 Hemorrhoids
 Gall bladder problems
 Appendicitis
 Hernia
 Anorexia nervosa
 Bulimia
Other _____

Musculoskeletal

- Past Current
 Neck pain
 Shoulder pain
 Back pain
 Hand / wrist pain
 Knee pain
 Foot / ankle pain
 Joint / bone problems
 Muscle pain

Musculoskeletal, cont.

- Muscle weakness
 Osteopenia
 Osteoporosis
 Herniated disc level _____
 Sciatica
Other _____

Neurological / Mental

- Past Current
 Seizures
 Paralysis
 Tremors
 Stroke
 Concussion
 Nerve damage
 Numbness / tingling
 Dizziness / vertigo
 Lack of coordination
 Loss of balance
 Poor memory
 Difficulty concentrating
Other _____

Psychological / Behavioral

- Past Current
 Depression
 Manic Behavior
 Anxiety / nervousness
 Panic attacks
 Often stressed
 Easily angered
 Aggressive behavior
 Lose control of emotions
 Substance abuse
Other _____

Have you ever been treated for emotional problems?
yes ___ no ___

Have you ever considered or attempted suicide?
yes ___ no ___

Infection Screening

- Have you ever tested positive? When?
 HIV _____
 Tuberculosis _____
 Hepatitis _____
 Gonorrhea _____
 Syphilis _____
 Herpes (oral / genital) _____

Transforming Touch Acupuncture
701 Southampton Rd, Suite 207
Benicia, CA 94510
510 334 8705
www.transformingtouch.org

Mandatory Disclosure of Information

Please read this document carefully and sign where indicated

You are the most important person on your health-care team and as such, are entitled to receive clear and comprehensive information about the modalities and techniques of your therapy. Becoming informed and understanding what to expect from your treatment at the beginning will help make your experience more comfortable and more effective. If you have questions about your health, your treatment, or any aspect of acupuncture, therapeutic bodywork or traditional Chinese medicine, please feel free to contact me.

Before Your Treatment

To facilitate your treatment, please wear loose, comfortable clothing that can be pulled high enough to expose your elbows and knees. It's a good idea to have a light meal before acupuncture, but don't arrive uncomfortably full. Avoid consuming alcohol and caffeine before and immediately after your visit; likewise with strenuous exercise.

Please do not brush or scrape your tongue before coming in for treatment—the tongue's natural coating is one of our primary diagnostic tools and, once brushed off, is lost to us for the day. Coffee, cigarettes, and artificially colored foods, while not advisable under most circumstances, can also stain your tongue coat and are best avoided in the hours before a treatment.

After Your Treatment

Though most people feel extremely relaxed after acupuncture, some report feeling a bit lightheaded. If this happens to you, please rest awhile and go for a short walk. It will pass in short order. Some patients occasionally experience a worsening of their symptoms after an acupuncture treatment. This can be a part of the healing process and is usually soon followed by a marked improvement in overall wellbeing. Please contact our office if you have any concerns or feel any unpleasant effects after your visit. Supplements, herbal prescriptions and herbal patent medicines are intended solely for the person for whom they are dispensed. Please do not share your prescriptions with others.

Cancellation & Late Arrival

If you need to cancel or reschedule your appointment, **please give me at least twenty-four hours' notice**. Without such notice, and except in emergency situations, I reserve the right to charge for missed appointments. Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

Your Privacy

I believe absolutely in the right to privacy of my patients and will never disclose any of your personal information without your express consent, unless required to do so by law.

Please sign and date below to indicate that you have read and understood this information.

Signature of patient (or patient's representative, if the patient is a minor or is physically or legally incapacitated)

Date_____

Print name of patient (and representative, if applicable)

Masks: We wear masks and respectfully request our patients to wear masks while in our office, until further notice.

We treat many people with allergies and chemical sensitivities.

We value our patients and gratefully appreciate your assistance as we seek to provide a healthy environment for everyone.

For all of our comfort and health please refrain from wearing scented products, especially perfumes. Please also refrain from smoking prior to your appointment.

Please sign to acknowledge your agreement with these health safety policies.

Signature _____

Date _____

Informed Consent to Treatment

I, _____ the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of traditional Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by Earl Hinds, L.Ac. and/or other licensed acupuncturists who may treat me now or in the future while working with or associated with Earl Hinds, or who may serve as a substitute for Earl Hinds.

I understand the benefits and risks of acupuncture treatment, other traditional Chinese medicine methods of treatment and therapeutic bodywork.

I understand that some acupuncture points may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform Earl Hinds. Additionally, I will inform Earl Hinds if I have a severe bleeding disorder or if I am wearing a pacemaker or other electronic medical device.

I have had an opportunity to discuss with Earl Hinds and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that there is no implied or stated guarantee of the effectiveness of a specific treatment or series of treatments. I hereby release Earl Hinds from all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Please sign and date below to indicate that you have read and understood this form.

Signature of patient
(or patient's representative, if the patient is a
minor or is physically or legally incapacitated)

Date

Print name of patient (and representative, if applicable)

Street address of patient (and representative, if applicable)

City, state, ZIP code

Telephone number