Legal Name (First Last)	Preferred Name (if different)	Date of Birth

Ongoing Concerns (prioritized)

Concern	Started when?	How often?	How severe?
Headaches	*June 2010*	*4 per week*	*mild/mod/severe*

You may list more later on the Health Systems Check-list

Tell us about your prior medical history

Hospitalizations or Surgeries and Dates	Allergies to Medications	Type of Reaction

Illness	Past	Now	Family	Who?	Other Important Information?
Asthma	O	O	O		
Cancer	O	O	O		
Diabetes	O	O	O		
Digestive Concerns	O	O	O		
Heart Disease	O	O	O		
Hepatitis	O	O	O		
High Blood Pressure	O	O	O		
Lung Disease	O	O	O		
Seizures	O	O	O		
Thyroid Condition	O	O	O		
?	O	O	O		
?	O	O	O		

Preventative Care	Date of Last	Results?
PAP		
Mammogram		
Colonoscopy		
Annual Screening		
DEXA Scan (Bone Density)		
PSA (Prostate-specific antigen)		

Birth: Anything significant about your birth?

_____

_____

Vaccination History: Any reaction that you remember? Any unusual vaccination?

_____

_____

Allergies:

_____

_____

Childhood Illnesses: Any surgery, trauma, or major illnesses? (chronological order)

_____

_____

_____

Adolescent Illnesses:

_____

_____

_____

Adulthood Illnesses:

_____

_____

_____

What medications are you currently taking? (Both prescriptions and OTC)

Medication and Dose	Reason	Started?	Prescribed By
Prozac 20mg 2x/day	*Feeling Down*	*11/2008*	*Alan James, MD*

If you would like, we can provide you with a longer medication and supplement form

Supplement, Brand and Dose	Reason	Started?	Recommended By
Super Vitamin C (Thorne) 500mg / day	*Immune Support*	*11/2008*	*Self*

Preferred Pharmacy?

_____

Name Address Phone

Alcohol? YES NO What kind?_____ Drinks per day _____

Per week_____

Recreational Drug Use? YES NO What kind?_____ Times per week_____

Tell us about how you eat

Sodas, oz/day
Coffee, oz/day
Water, oz/day

Food Cravings
Snack Foods

Typical Breakfast

Typical Lunch

Typical Dinner

Food Sensitivity
Food Restrictions
Food Ethics ☐ Vegan ☐Vegetarian ☐Kosher ☐Other:

Do you eat?
☐ In the car ☐ Watching TV ☐ Standing
☐ With others ☐ On the go ☐ In a hurry
☐ After 11pm ☐ In your sleep ☐ On waking

How often do you eat out? Where?

Tell us about your home life

With whom do you live? (including family, pets, roommates)?

Name	Age	Relationship	Name	Age	Relationship

What is your occupation?

What are the major stressors in your life? (work, financial, emotional health, romance/love, physical health, family, spiritual, other)

How is your sleep? When do you go to sleep and wake up?

What do you do to relax? What are your hobbies?

What types of physical activity do you do?

Do you have religious or spiritual beliefs that may affect your healthcare?

Initial Health Systems Check-list

As a New Patient, please check any items that have concerned you in the last **YEAR**.
We will use this sheet to track progress over future visits.

GENERAL:	☐ NO COMPLAINTS	☐ WEIGHT LOSS	☐ FATIGUE	☐ COLD/FLU	☐ HARDER TIME EXERCISING
	☐ STRESS	☐ WEIGHT GAIN	☐ INSOMNIA	☐ CHANGES IN STRENGTH	☐ OTHER _____
HEAD/EAR:	☐ NO COMPLAINTS	☐ DIZZINESS	☐ HEADACHES	☐ HEAD TRAUMA	☐ MENTAL FOG
	☐ EARACHE	☐ CHANGES IN HEARING	☐ RINGING IN EARS	☐ CLOGGED EARS	☐ OTHER _____
EYES:	☐ NO COMPLAINTS	☐ CHANGES IN VISION	☐ BLURRING OF VISION	☐ EXCESSIVE TEARING	☐ OTHER _____
	☐ BLIND SPOTS	☐ EYE PAIN	☐ EYE IRRITATION	☐ DRY EYES	
NOSE/MOUTH:	☐ NO COMPLAINTS	☐ FREQUENT BLEEDING	☐ BLEEDING GUMS	☐ COLD/CANKER SORES	☐ TOOTH PAIN
	☐ BAD BREATH	☐ NASAL DISCHARGE	☐ NASAL CONGESTION	☐ DRY MOUTH/NOSE	☐ OTHER _____
NECK/THROAT:	☐ NO COMPLAINTS	☐ NECK PAIN/STIFFNESS	☐ LUMPS/BUMPS	☐ POSTNASAL DRIP	☐ OTHER _____
	☐ NECK STIFFNESS	☐ NECK TENDERNESS	☐ NECK TENSION	☐ SORE THROAT	☐ DIFFICULTY SWALLOWING
CHEST/LUNG /BREAST:	☐ NO COMPLAINTS	☐ BREAST TENDERNESS	☐ PAIN W/ BREATHING	☐ CHEST CONSTRICTION	☐ SHORT OF BREATH/WHEEZING
	☐ LUMPS/SWELLING	☐ NIPPLE DISCHARGE	☐ COUGH	☐ CHEST CONGESTION	☐ OTHER _____
CARDIOVASCULAR:	☐ NO COMPLAINTS	☐ PALPITATIONS	☐ CHEST PAIN	☐ HIGH BLOOD PRESSURE	☐ OTHER _____
		☐ IRREGULAR BEAT	☐ LEG SWELLING	☐ LOW BLOOD PRESSURE	☐ LOSS OF CONSCIOUSNESS
ABDOMEN/DIGESTION:	☐ NO COMPLAINTS	☐ ABDOMINAL PAIN	☐ DIARRHEA	☐ HEART BURN	☐ BLOATING/GAS
BOWEL MOVEMENTS PER DAY_____	☐ NAUSEA/VOMITING	☐ CHANGE IN APPETITE	☐ CONSTIPATION	☐ BLOOD IN STOOL	☐ OTHER _____
URINATION:	☐ NO COMPLAINTS	☐ FREQUENCY	☐ URGENCY	☐ FREQUENT INFECTIONS	
	☐ PAINFUL URINATION	☐ INCONTINENCE	☐ DRIBBLING	☐ INCOMPLETE EMPTYING	☐ OTHER _____
WOMENS HEALTH:	☐ NO COMPLAINTS	☐ PAIN WITH MENSES	☐ PELVIC PAIN	☐ DIFFICULTY CONCEIVING	☐ CYCLE LENGTH: _____DAYS
DAY #_____ IN CYCLE	☐ CHANGE IN MENSES	☐ VAGINAL DISCHARGE	☐ SPOTTING	☐ MENOPAUSE/NO PERIOD	☐ OTHER _____
MENS HEALTH:	☐ NO COMPLAINTS	☐ ERECTILE DYSFUNC.	☐ NIGHTIME URINATION	☐ OTHER _____	
	☐ DECREASED LIBIDO	☐ PROSTATE	☐ ____TIMES PER NIGHT		
MUSCULOSKELETAL:	☐ NO COMPLAINTS	☐ MUSCLE PAIN	☐ MUSCLE TENSION	☐ NUMBNESS/TINGLING	☐ RECENT INJURY
	☐ MUSCLE CRAMPS	☐ MUSCLE WEAKNESS	☐ JOINT PAIN	☐ RANGE OF MOTION	☐ OTHER _____
MENTAL/EMOTIONAL:	☐ NO COMPLAINTS	☐ SEIZURES	☐ MOOD CHANGES	☐ DEPRESSION	☐ LOSS OF COORDINATION
	☐ MEMORY CHANGES	☐ TREMOR	☐ MENTAL CHANGES	☐ COGNITIVE IMPAIRMENT	☐ OTHER _____
TEMPERATURE:	☐ NO COMPLAINTS	☐ RUNS COLD	☐ NIGHT SWEATING	☐ EXCESS SWEATING	☐ OTHER _____
	☐ COLD HAND/FEET	☐ RUNS HOT	☐ HOT FLASHES	☐ LACK OF SWEATING	☐ SPONTANEOUS SWEATING
SKIN/HAIR:	☐ NO COMPLAINTS	☐ EASY BRUISING	☐ RASH	☐ TEXTURE CHANGES	☐ CHANGES IN NAILS
	☐ DRYNESS	☐ SLOW HEALING	☐ COLOR CHANGES	☐ THINNING HAIR	☐ OTHER _____

Additional Health Systems Concerns:

Today Integrative Health + Wellness

Acupuncture & Chinese Medicine

INFORMED CONSENT

I hearby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at Today or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instruction provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PATIENT'S PRINTED NAME: _____

PATIENT SIGNATURE: _____DATE: _____
(Or Patient Representative, please indicate relationship if signing for patient)

ACUPUNCTURIST: _____