Great Wall Acupuncture & Chinese Medicine Clinic

Phone: 630 364 8523
or 317 529 2140
greatwallacupuncture@gmail.com
wangzhanxiang@gmail.com

Health History Questionnaire

In order for us to best service you, please fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If there is anything, please use the "comments" section. Thank you.

Name _____ Sex _____ Date of birth _____ Marital status_____

Address: Street/apt _____

City State ZIP

Home Phone_____ Work phone _____

Emergency Contact_____ Alternative Emergency Contact _____

Main concern(s) you would like us to help with:

When did this problem begin?

To what extent does this problem interfere with your daily life?

Have you been given a diagnosis for this problem? (If so, what ?)

What kind(s) of treatment you have tried?

Have you been treated with acupuncture before?

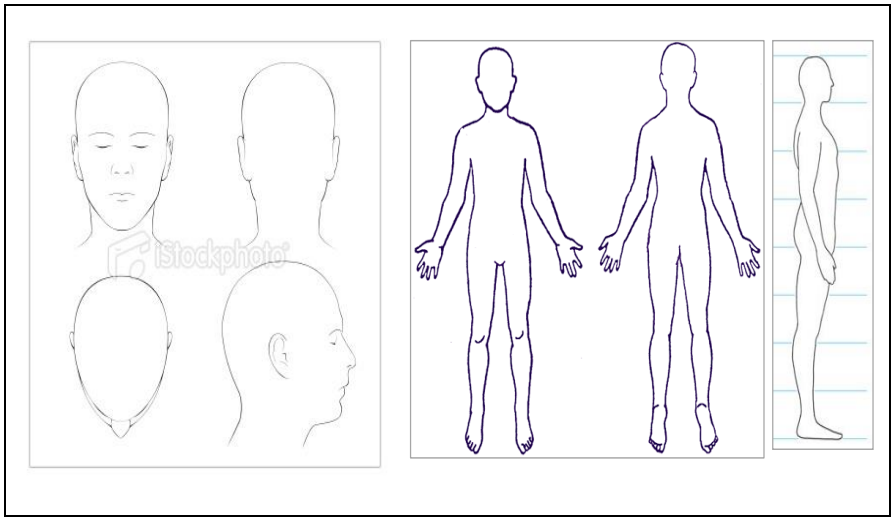
Medical History (please mark all that apply)

__**Bleeding disorder** __Hepatitis A B C __Cancer __Diabetes __Rheumatic fever
__**Heart disease** __Hypertension __Seizures __Stroke __Thyroid diseases
__Surgeries __Trauma (accidents, fall) __Smoking __Venereal diseases
__History of other diseases:

Allergies (chemicals, drugs, foods): _____

Medications taken in the past 2 months (Vitamins, herbs, Drugs, etc)
Have you been on a restricted diet? What kind?
If yes, how long and how much?
Any use of drugs for non-medical purpose?

Indicate to the right any painful or distressed areas:



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Please check if you have had (in the past 3 months)

General

□ Chills □ Fever
□ Sweat easily □ Night sweats
□ Cravings □ Poor sleeping
□ Weight loss □ Weight gain
□ Fatigue □ Change in appetite
□ Bleed or bruise easily
□ Strong thirsty (hot or cold drinks)
□ Peculiar tastes or smells

Head, eyes, ears, nose and throat

□ Headaches □ Migraines □ Dizziness
□ Concussions □ Facial Pain □ Eye pain
□ Glasses □ Eye strain □ Poor vision
□ Night blindness □ Spots in front of eyes
□ Color Blindness □ Cataracts □ Blurry vision
□ Ears Ringing □ Earaches □ Poor hearing
□ Sinus problems □ Nose Bleeds □ Teeth loose
□ Grinding teeth □ Sore in lips or tongue
□ Jaw clicks □ Recurrent sore throats

Respiratory

□ Asthma □ Bronchitis □ Cough
□ Coughing with blood
□ Phlegm and color (white, yellow pink)
□ Pain with deep breath
□ Difficulty in breathing when lying down
□ Other lung problems

Genito-Urinary

□ Pain upon urination □ Frequencies Urination
□ Blood in Urine □ Special in Urination color
□ Unable to hold urine □ Decrease in urine flow
□ Urgency to Urine □ Wake up to Urination
□ Kidney stone □ Impotence
□ Sores in genitals
□ Other problems in genitals or Urinary system

Neuro-psychological

□ Seizure □ Lack of coordination
□ Loss of balance □ Area of numbness
□ Depression □ Susceptible to stress
□ Bad temper □ Poor memory
□ Concussion □ tremors □ Anxiety
□ History of emotional problems
□ Other neurological psychological problems

Skin & Hair

□ Rashes □ Ulceration
□ Hives □ Fevers
□ Itching □ Eczema
□ Pimples □ Dandruff
□ Loss of hair □ Recent Moles
□ Change in hair or skin texture
□ Other hair or skin problems

Musculoskeletal

□ Neck pain □ Muscle pain
□ Knee pain □ Back pain
□ Foot/ankle pains □ Hand/wrist pains
□ Shoulder pain □ Hip pain
□ Any joint pain □ Muscle weakness
□ Other bone/muscle joint problems

Cardiovascular

□ Hypertension □ Low blood pressure
□ Chest pain □ Irregular heartburn
□ Blood clots □ Swelling of hands
□ Fainting □ Swelling of leg/foot
□ Phlebitis □ Cold hand and feet
□ Difficulty in breathing
□ Other heart and blood vessel problems

Gastro-intestine

□ Nausea □ Vomiting □ Belching
□ Bad breath □ Indigestion □ Poor appetites
□ Constipation □ Diarrhea □ Black stool
□ Blood in stool □ Rectal pain □ Hemorrhoids
□ Gas □ Abdominal pain or cramps
□ Other problems in stomach or intestine

Reproductive and Gynecologic

□ Vaginal discharge □ Menstrual pain
□ Irregular periods □ Menstrual clots
□ Spotting or pain between periods
□ Unusual periods (heavy, light, or other)
□ Changes in body/psyche prior to period
( ) #of pregnancies ( ) #of miscarriages
( ) Age of 1st menses ( ) Age of Menopause
( ) Date of last period ( ) #Days periods last
( ) Days(#) between periods
□ Date of last pap and results
□ Birth control? What type for how long ?
□ Any chance you are pregnant now?

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Informed Consent

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below for whom I am legally responsible for) by the acupuncturist named 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 the clinic or office listed below or any other office of clinic, whether signatories to this form or not.

I understand that treatment methods may include (but are not limited to), acupuncture, electrical stimulation, moxa, cupping, *Tui-Na* (oriental massage), Chinese herbal medicine, and nutritional counseling, etc. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I have been informed that acupuncture is a generally safe method of treatment, but may have some side effects, including BRUISING, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk especially in immune deficiency case, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. Bruising is a common side effect of cupping. Broken needle as accident may happen although it is rare.

I have been informed that 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 Oriental Medicine, although some may be toxic in large doses.

I understand that herbs MAY CAUSE ALLERGY and side effects depending on individuals. I will immediately notify members of the clinical staff any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that herbs may need to be prepared and the tea consumed according to the instructions provided orally or in writing. The herbs may have special smell or taste. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that some herbs may be inappropriate during PREGNANCY. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications treatment, and I wish to reply 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 of my present condition and for any future condition(s) for which I seek treatment.

Patient Signature:_____ ***Date****:(MM/DD/YYYY)*_____

Office Signature:_____ ***Date:****(MM/DD/YYYY)*_____

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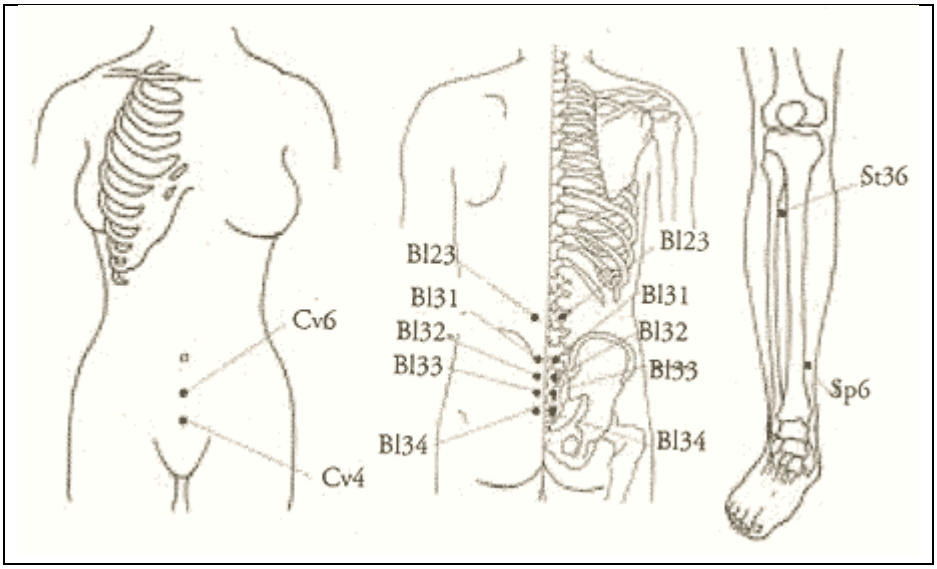
For fertility and menstruation related support in woman only:



_____(initial)

I have been informed that for women infertility and menstruation related diseases, needling/cupping the acu-points in lower abdominal and lower back may be required for better effects in combination with distal acu-points.

The practitioner may have to press along the meridian to pin point the tender point for a best needle result.