

# Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first) (middle) (last)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender: M/F Marital status: S M D W P

Address \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

*Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.*

1. When and where did you last receive health care? \_\_\_\_\_

For what reason? \_\_\_\_\_

2. Have you had acupuncture before? Y N Have you used Chinese herbal medicine before? Y N

3. Please identify the health concerns that have brought you to our clinic in order of importance below:

**Condition**

**Past Treatment**

a. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

b. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

c. \_\_\_\_\_

How does this condition affect you? \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

6. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? \_\_\_\_\_

7. Do you have any infectious diseases? Y N If yes, please identify: \_\_\_\_\_

8. **Family History:**

Father                      Mother                      Brothers                      Sisters                      Spouse                      Children

Check those applicable:

Age (if living)	_____	_____	_____	_____	_____	_____
Health (G=Good, P=Poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma/Hay fever/Hives	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age (at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

9. **Height:** \_\_\_\_\_ **Weight:** Currently: \_\_\_\_\_ Past Maximum: \_\_\_\_\_ When? \_\_\_\_\_

10. **Blood Pressure:** What is your most recent blood pressure reading? \_\_\_\_\_ / \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

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

Scarlet Fever    Diphtheria                      Rheumatic Fever                      Mumps                      Measles                      German Measles                      Chicken Pox

12. **Immunizations** (please circle any that you have had):

Polio                      Tetanus                      Rubella/Mumps/Rubella                      Pertussis                      Diphtheria                      Hib                      Hepatitis B

Others: \_\_\_\_\_

13. **Hospitalizations and Surgeries:**

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

<u>Reason</u>	<u>When</u>	<u>Reason</u>	<u>When</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Mood Swings                      Nervousness                      Mental Tension

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

Fatigue                      Slow Wound Healing                      Chronic Infections                      Chronic Fatigue Syndrome

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

Impaired Vision                      Eye Pain/Strain                      Glaucoma                      Glasses/Contacts                      Tearing/Dryness

Impaired Hearing                      Ear Ringing                      Earaches                      Headaches                      Sinus Problems

Nose Bleeds                      Frequent Sore Throats                      Teeth Grinding                      TMJ/Jaw Problems                      Hay Fever

18. **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                      Tuberculosis

Shortness of Breath                      Other Respiratory Problems: \_\_\_\_\_

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

Heart Disease                      Chest Pain                      Swelling of Ankles                      High Blood Pressure

Palpitations/Fluttering                      Stroke                      Heart Murmurs                      Rheumatic Fever                      Varicose Veins

20. **Gastrointestinal** (please circle any that you experience now and underline any that 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

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

Kidney Disease                      Painful Urination                      Frequent UTI                      Frequent Urination                      Heavy Flow

Kidney Stones                      Impaired Urination                      Blood in Urine                      Frequent Urination at Night

22. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that 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

23. **Menstrual/Birthing History:**

1. Age of First Menses: \_\_\_\_\_                      4. Birth Control Type: \_\_\_\_\_                      7. # of Abortions: \_\_\_\_\_

2. # of Days of Menses: \_\_\_\_\_                      5. # of Pregnancies: \_\_\_\_\_                      8. # of Live Births: \_\_\_\_\_

3. Length of Cycle: \_\_\_\_\_                      6. # of Miscarriages: \_\_\_\_\_                      9. Menopause: \_\_\_\_\_

24. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties      Prostrate Problems      Testicular Pain/Swelling      Penile Discharge

25. **Musculoskeletal** (please circle any that you experience now and underline any that 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 (if so, where?): \_\_\_\_\_

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

Vertigo/Dizziness      Paralysis      Numbness/Tingling      Loss of Balance      Seizures/Epilepsy

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

Hypothyroid      Hypoglycemia      Hyperthyroid      Diabetes Mellitus      Night Sweats      Feeling Hot or Cold

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

Anemia      Cancer      Rashes      Eczema/Hives      Cold Hands/Feet

Is there anything else we should know? \_\_\_\_\_

29. **Lifestyle:**

a. Do you typically eat at least three meals per day?      Y      N      If no, how many? \_\_\_\_\_

b. Exercise routine: \_\_\_\_\_

c. Spiritual practice: \_\_\_\_\_

d. How many hours per night do you sleep? \_\_\_\_\_      Do you wake rested?      Y      N

e. Level of education completed:      High School      Bachelors      Masters      Doctorate      Other

f. Occupation: \_\_\_\_\_      Employer: \_\_\_\_\_      Hours/Week: \_\_\_\_\_

Do you enjoy work?      Y/N      Why/Why not \_\_\_\_\_

g. Nicotine/Alcohol/Caffeine Use: \_\_\_\_\_

h. Have you experienced any major traumas?      Y      N      Explain: \_\_\_\_\_

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? \_\_\_\_\_

How did you hear about my services? \_\_\_\_\_      Would you like to be on our e-mail list? \_\_\_\_\_

***\*Please note that all appointments require a 24 hour cancellation notice. If 24 hour cancellation notice is not given the full payment for the treatment scheduled is required.***

***\*I authorize Yasmin Spencer, LAc, DAOM, Dipl. OM to release and/or request information to/from insurance companies, and all medical providers. I authorize assignment of benefits to be paid directly to Yasmin Spencer, LAc, DAOM, Dipl. OM***

**Signed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Yasmin Spencer, LAc, DAOM, Dipl. OM

## Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture by the board certified acupuncturist Yasmin Spencer, LAc, DAOM. I understand that acupuncturists practicing in the state of Pennsylvania are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment.

I accept that no Guarantee is made concerning the results of my acupuncture treatment, and I have been informed that I may stop treatment at any time.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

### RELEASE OF INFORMATION

I consent to the use and disclosure of my protected health information for treatment, payment and/or clinical operations. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance on my prior consent.

### NOTICE OF PRIVACY PRACTICES AND PATIENTS RIGHTS

I acknowledge that I have received a copy of the Notice of Privacy Practices and Patient Rights and have had the opportunity to ask questions about it. All questions I have asked have been fully answered.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_ **Phone:** \_\_\_\_\_