Patient Health History

Name: Referred By:

Current Address:

Date of Birth: Height: Weight:

Place of birth:

E-mail address: Home Phone:

Cell Phone Work Phone:

Please indicate which phone I should contact you:

Contact person's name and phone number:

Method of payment (please circle or mark with X the one that applies): Check Cash Paypal

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.

Describe your principal complaint

What has been diagnosed by M.D?

Any problems during your birth?

Vaccination History: Any reactions that you remember? Any unusual vaccinations?

Childhood Illness: any surgeries or accidents?

Age:

Age

Adolescence Illness: any surgeries or accidents?

Age

Age:

Adulthood Illness: any surgeries or accidents?

Age

Age

Family History Check those applicable

	Mother	Father
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	_____	_____

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:

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

If so, how far along are you?

Do you have any infectious diseases? Y N If yes, please identify:

Blood Pressure: What is your most recent blood pressure reading? _____/_____ When?

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

Mood Swings Nervousness Mental Tension

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

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 Sinus Problems Nose Bleeds

Frequent Sore Throats Headaches Teeth Grinding TMJ/Jaw Problems Hay Fever

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:

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

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

Genito-Urinary Tract (please circle any that you experience now and underline any that you've 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

Female Reproductive/Breasts (circle any that you experience now and underline any that you've 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

Menstrual/Birthing History:

Age of First Menses: _____ Birth Control Type: _____ # of Live Births: _____

# of Days of Menses: _____ Length of Cycle: _____

# of Pregnancies: _____ # of terminated pregnancies: _____ # of Miscarriages: _____

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

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?):

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

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

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?

Lifestyle:

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

Exercise routine:

Spiritual practice:

How many hours per night do you sleep?: Do you wake rested? Y N

Patient Health History

Occupation: Hours/Week:

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

Nicotine/Alcohol/Caffeine Use:

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

Interests and hobbies:

Signature:

_____

Consent to receive Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Yamin Chehin, Licensed Acupuncturist.

Acupuncture/Moxibustion: 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 understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Yamin Chehin as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the

possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

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

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: _____

Printed Name: ___ _____

Thank you for your cooperation

~ Yamin Chehin, L.Ac, Dipl O.M.