Personal Information

1. Date:_____ / _____ / _____
mm dd yy

2. Name: _____ _____ 3. Gender: M F

4. Date of Birth: _____ /_____ /_____
mm dd yy

5. Marital Status: __ Single __ Married __ Divorce __ Widow

6. Do you have insurance? Y N

7. Patient's address:

Address:_____

City:_____ State:_____ Zip Code: _____

Home: ( ) - (C)( )

E-mail:_____

8. How did you hear about us?

__ Internet __ Phone Book __ referred by _____

9. Emergency Contact:

Name:_____

Relationship with patient: _____

Phone Number: ( ) -

10. Insurance information (fill out, if applicable)

Does your insurance cover acupuncture treatment? ___ Y ___ N

Carrier: _____

ID#: _____

Phone Number: ( ) -

Insured Information

Relationship to insured: __ Self __ Spouse __ Child __ other

Insured's Name:__ _____

Insured's Address _____

City:_____ State:_____ Zip Code: _____

Insured's Phone:_ _____ Insured's Gender: __ M __ F

1. Chief complaint:_____ _____

_____

_____

_____

2. Pain intensity(if applicable): 0 - no pain 10 - intense pain

0 1 2 3 4 5 6 7 8 9 10

3. Questionnaires (check if applicable)

a. Chills: __ Chills only __ Chills>Fever Fever>Chills

b. Fever: __ without aversion to cold __ occuring in the afternoon or at night

__ constant low grade fever __ alternating chills and fever

c. sweating: __ whole body __ only on the head __ only forehead

__ only on the hands __ only on 4 limbs __ only on 5 palms

__ Daytime __ Night time

d. Headache: __ Recent __ Gradual __ Daytime

__ Evening __ Whole head __ Forehead

__ Vertex __ Temples and side __ Nape and Neck

e. dizziness: __ Sudden onset __ Gradual onset

__ slight one accompanied by a feeling of heaviness

__ slight one aggravated when tired

__ severe one that everything seems to sway and loses balance

f. body pain: __ sudden onset + chills and fever

__ pain all over + feeling of tiredness

__ postpartum dull pain

__ postpartum sharp pain

__ pain in all arms and shoulders, experienced only when walking

__ pain in all muscles + hot sensation of the flesh

__ pain + feeling of heaviness

g. joint pain: __ wandering from joint to joint __ fixed and very painful

__ fixed, with swelling and numbness

h. backache: __ recent onset by sprain(sever, stiff)

__ continuous dull pain

__ severe pain, aggravated during cold and damp weather, alleviated by heat

__ boring pain with inability to turn the waist

__ pain in the back extending up to the shoulders

i. numbness: __ 4 limbs or only hands and feet on both sides

__ fingers, elbow and arm on one side only

j. chest pain: __ accompanied by cough with profuse yellow sputum

k. epigastric pain: __ food retention __ very dull and not very severe
__ alleviated by eating __ aggravated by eating
__ feeling of fullness in the epigastrium
l. hypogastric pain: __ pain in the hypogastric area
m. lower abdominal pain: __ relieved by bowel movement
__ aggravated by bowel movement
n. food: __ lack of appetite __ always hungry __ preference for hot food
__ fullness and distention after eating __ preference for cold food
o. taste: __ bitter __ salty __ sweet __ sour __ pungent __ lack of taste
p. vomit: __ sour vomiting __ bitter vomiting __ clear-watery vomiting
__ vomiting right after eating
q. constipation: __ acute constipation with thirst and dry yellow coating
__ small, bitty stools like goat's stools
__ the stools are not dry, but difficult in performing a bowel movement
__ with abdominal pain __ with dry stools, without thirst
__ alternation of constipation and diarrhea
r. diarrhea: __ presence of a foul smell __ absence of smell
__ chronic diarrhea __ daybreak diarrhea
__ with mucus and blood in the stools
__ loose stools with undigested food
__ a burning sensation in the anus while passing stools
__ black or very dark stools __ the blood comes first
__ the stools come first and then the blood
s. urination: __ enuresis or incontinence __ retention of urine
__ frequent and scanty urination __ difficulty in urination
__ very frequent and copious urination
__ pain before urination __ pain after urination
__ pain during urination
__ pale color __ dark color __ turbid or cloudy color
__ copious, clear and pale urination
__ large amount of urine __ scanty urination
t. insomnia: __ not being able to fall asleep, but sleeping well after falling asleep
__ waking up many times during the night
__ dream-disturbed sleep
__ restless sleep with dreams
__ waking up early in the morning and failing to fall asleep again
u. lethargy: __ feeling sleepy after eating
__ a general feeling of lethargy and heaviness of the body
__ lethargy with dizziness
__ extreme lethargy and lassitude with a feeling of cold

__ lethargic stupor with manifestations of heat

v. tinnitus: __ sudden onset __ gradual onset
__ aggravated by pressing with one's hand on the ears
__ alleviated by pressing with one's hand on the ears
__ high pitch __ low pitch

w. hearing loss: __ sudden onset __ gradual onset __ chronic cases

x. eyes: __ pain like a needle and with red eye associated with headache
__ pain, swelling and redness of the eyes
__ blurred vision and "floater" in the eyes
__ photophobia
__ a feeling of pressure or dryness in the eyes
__ dryness

y. thirst: __ thirst with desire to drink large amount of cold water
__ absence thirst
__ thirst but with no desire to drink
__ thirst with desire to sip liquids slowly, or to sip warm liquids

z. drink: __ desire to drink cold liquids __ desire to drink warm liquids

Menstruation (check if applicable)

a. cycle: __ always come early __ always come late
__ irregular __ regular

b. amount: __ heavy __ scanty

c. color: __ a dark red or brigh-red color __ pale blood
__ purple or blackish blood __ fresh-red blood

d. quality: __ congealed blood with clots __ watery blood
__ turbid blood

e. pain: __ before the periods __ after the periods __ during the periods

Leukorrhea (check if applicable)

a. color: __ white __ yellow __ greenish __ red and white
__ yellow + pus, blood

b. consistency: __ watery __ thick

c. smell: __ fishy __ leathery

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at the Smile Acupuncture. I understand that acupuncturists practicing in the state of Texas 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.

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 SMILE ACUPUNCTURE 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.

Printed Name: _____

Signature: _____ **Date:** _____/_____/_____

Parents or Guardian's signature (for under 18 ages) :_____

Patient Health History

Name: _____ Date: _____/_____/_____

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. Have you been evaluated by physician or chiropractor within 12 months? (Y or N
   a. Date: _____
   b. Physician Name and Speciality:_____

2. **Please identify the health concerns that have brought you to Smile Acupuncture Clinic in order of importance below:**

	Condition	**Past Treatment**
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

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

_____

_____

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

_____

_____

6. Do you have any infectious diseases? Y N

If yes, please identify: _____

7. Family History:

Cancer Diabetes Heart Disease Hypertension Kidney disease Others _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

10. Hospitalizations and Surgeries:

Reason	When	Reason	When

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

Reason	When	Reason	When