HEALTH HISTORY

Name First Last		**Today's Date** _____ / _____ / _____	
Street Address	**City**	**State**	**Zip code**
E-mail Address	**Date of Birth** _____/_____/_____	**Age**	**Sex** MALE FEMALE
Contact Phone # ( ) _____ - _____	**Emergency Contact** Name & Relationship	Phone # ( ) _____ - _____	
Occupation	**Marital Status**	**Have you ever had acupuncture before?** ☐ No ☐ Yes **When?** _____/_____/_____	
Primary Care Physician Name	Phone number ( ) _____ - _____	**How did you hear of our clinic?**	

MAIN REASONS FOR TREATMENT

Please write in your top 3 health concerns / complaints, in order of importance to you. **Circle** the items that make it better or worse and mark the severity of the condition on a scale of 1-10 (**1=no symptoms 10=worst ever**).

1 _____

When did it start? _____ago

Better with: ☐ Heat ☐ Cold ☐ Movement/Activity ☐ Rest ☐ Pressure/Massage _____

Worse with: ☐ Heat ☐ Cold ☐ Movement/Activity ☐ Weather change ☐ Stress ☐ Rest

Severity:

1 ——— **10**

2 _____

When did it start? _____ago

Better with: ☐ Heat ☐ Cold ☐ Movement/Activity ☐ Rest ☐ Pressure/Massage _____

Worse with: ☐ Heat ☐ Cold ☐ Movement/Activity ☐ Weather change ☐ Stress ☐ Rest

Severity:

1 ——— **10**

3 _____

When did it start? _____ago

Better with: ☐ Heat ☐ Cold ☐ Movement/Activity ☐ Rest ☐ Pressure/Massage _____

Worse with: ☐ Heat ☐ Cold ☐ Movement/Activity ☐ Weather change ☐ Stress ☐ Rest

Severity:

1 ——— **10**

HEALTH HISTORY

Please check all that apply:

	Self Past	Self Current	Family Member	Year(s)
☐ AIDS/HIV				
☐ Allergies				
☐ Appendicitis				
☐ Asthma				
☐ Cancer				
☐ Depression				
☐ Diabetes				
☐ Emphysema				
☐ Epilepsy				
☐ Heart Disease				
☐ Hemophilia				
☐ Hepatitis				
☐ High blood pressure				
☐ Stroke				
☐ Thyroid Disease				

List any conditions you have that are not listed above:

_____

_____

_____

MEDICATIONS & SUPPLEMENTS

Please list medications, supplements, and/or herbs you take on a regular basis:

Medication/Supplements	**Dose**	**Reason**

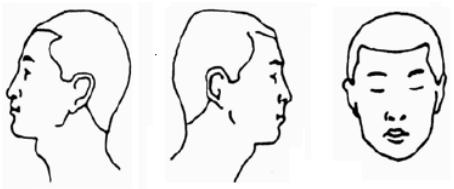
INJURIES, SURGERIES & HOSPITALIZATIONS

Injury/Surgery/Hospitalization	**Date**

HABITS	EXERCISE	DIET
Amount/Day If Quit, year ☐ Coffee _____ ☐ Soda _____ ☐ Alcohol _____ ☐ Drugs _____ ☐ Tobacco _____	Do you exercise regularly? ☐ Yes ☐ No If yes, what kind and how often? _____ _____ _____ _____	Are you following any special diet? ☐ Vegetarian ☐ Vegan ☐ Raw foods ☐ Other (please describe) _____ _____ _____

AREAS OF PAIN

☐ Headaches – please mark location(s):



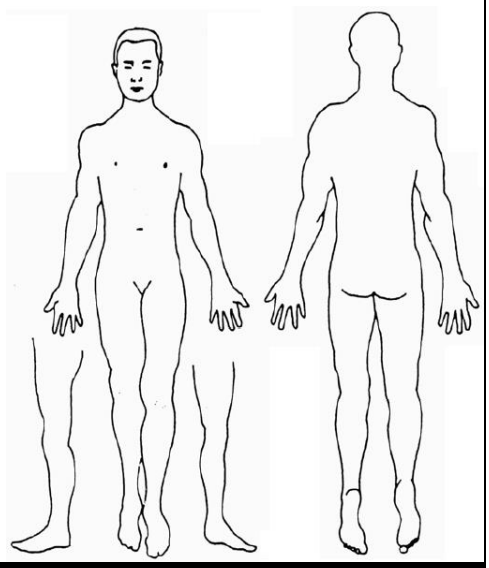
Left side Right side

	Right	Left
☐ Neck pain / tension		
☐ Shoulder pain / tension		
☐ Carpal Tunnel Syndrome		
☐ Stiffness / Arthritis in hands		
☐ Knee pain or weakness		
☐ Lower back pain / weakness		
☐ Back pain shooting down leg(s)		
☐ Heel pain		

Mark areas of pain on diagram:

☐ Tingling
☐ Numbness
☐ Neuropathy
☐ Tension/Tightness
☐ Limited Range of Motion
☐ Limited Use

Description or notes:
_____
_____
_____
_____
_____
_____



The following is a whole body review of systems according to Chinese Medicine. Mark an X on the scales and check off any symptoms you have had <u>in the past two months</u>

COLD - YANG DEFICIENCY - QI DEFICIENCY

Please mark **your typical energy level** on the scale

1 ——————————— 10

EXHAUSTED HYPER-ACTIVE

Please check all that apply:

☐ Tend to be cool or cold (more so than most others)
☐ Prefer warm or hot drinks (not just in cold weather)
☐ Cold hands and feet (if only hands or feet, circle one)
☐ Dislike of cold (drafts, cold environments)
☐ White / pale complexion
☐ Frequent urination with pale urine, large amounts
☐ Sweat easily with little or no effort/exertion
☐ Reluctance to speak (takes too much energy)
☐ Tend to thin, watery diarrhea, especially after meals
☐ Fatigue
☐ Shortness of breath with little or no exertion
☐ Feel heavy and slow
☐ Tired in the mornings / difficult to wake up
☐ Energy drop during the day – Time of day: _____

HEAT - YIN DEFICIENCY – BLOOD DEFICIENCY

Please check all that apply:

☐ Tend to be warm or hot (more so than most others)
☐ Often thirsty
☐ Prefer cool or cold drinks (not just in summer)
☐ Face often warm or hot
☐ Red eyes
☐ Hot flashes or sudden face flushes
☐ Heat in palms and/or soles and/or chest
☐ Night sweating (not due to weather or heating)
☐ Hot or warm at night (more so than during the day)
☐ Feeling heartbeat or heart flutter
☐ Dry skin / nails / hair
☐ Brittle nails
☐ Dry throat
☐ Dry mouth
☐ Dry eyes
☐ Dizziness
☐ Blurred vision
☐ Difficulty concentrating
☐ Urination bright or dark yellow (without vitamins)
☐ Dry stools

ORGAN SYSTEMS

********** IMPORTANT **********

Please be aware these symptoms pertain to the ENERGY of each organ according to Chinese Medicine, not necessarily the organ itself.

Please check all symptoms that you have had in the past 2-3 months.

SPLEEN / STOMACH /INTESTINES

☐ Bloating or abdominal distension, especially after eating
☐ Low appetite, lack of interest in food
☐ Loose stools or diarrhea (tendency to)
☐ Diarrhea first thing in the morning
☐ Diarrhea after meals
☐ Raw/cold foods/liquids cause digestive upset or diarrhea
☐ Tired after eating
☐ Bleed/Bruise easily
☐ Gain weight easily
☐ Sweet, sticky taste/feeling in mouth
☐ Pain in stomach area
  ☐ On empty stomach ☐ After eating ☐ Feels hollow
  ☐ Better with pressure ☐ Worse with pressure
☐ History of prolapsed organs (check):
  ☐ Uterus/Cervix ☐ Bladder ☐ Rectum ☐ Stomach
☐ Hernia(s) – Location(s): _____
☐ Nausea/Vomiting (tendency to)
☐ Bad breath
☐ Bleeding gums
☐ Mouth sores (inside lips, cheeks, roof of mouth)
☐ Dry, cracked lips
☐ Frequent belching/burping
☐ Heartburn
☐ Constant hunger, even soon after eating
☐ Constipation (tendency to)
☐ Hemorrhoids: ☐ Pain ☐ Bleeding
☐ Blood in the stool
☐ Alternating Constipation & Diarrhea (IBS)
☐ Food allergies/sensitivities:_____

Do you crave any of the following flavors?

☐ Sweet ☐ Salty ☐ Sour ☐ Spicy
☐ Bitter (plain coffee, dark chocolate, etc)

LUNGS

☐ Cough: ☐ Dry ☐ Moist
☐ Phlegm when coughing
  ☐ Only feel the phlegm, no coughing up
  ☐ Easy to cough up ☐ Difficult to cough up
  ☐ Watery phlegm ☐ Thick, sticky phlegm
  ☐ White phlegm ☐ Yellow or Green Phlegm
☐ Wheezing / Asthma
☐ Labored breathing or shortness of breath
  ☐ More difficult to inhale ☐ More difficult to exhale
☐ Catching colds often/easily
☐ Chest tightness
☐ Allergies
  ☐ Runny nose ☐ Stuffy nose ☐ Scratchy throat
  ☐ Watery eyes ☐ Itchy eyes ☐ Cough
  ☐ Sneezing ☐ Other: _____

Allergic to: _____
_____

KIDNEYS

☐ Prematurely gray hair
☐ Dark circles under the eyes
☐ Frequent urination
☐ Night time urination (# of times:_____)
☐ Ringing in the ear(s) (tinnitus) – may be occasional
☐ Difficulty concentrating
☐ Infertility
☐ Loosening of teeth
☐ Bone spurs – Location: _____
☐ Urination – difficult or slow to start
☐ Urination – weak stream
☐ Urination – dribbling after finishing
☐ Urination – cloudy urine
☐ Kidney stones (past or current)
☐ Stress incontinence (when sneezing, coughing, and/or laughing)
☐ Tend to get UTI's (frequent, urgent, burning urination)
☐ Significant memory loss (senility, Alzheimer's)
☐ Severe fatigue after sex (men and women)
☐ Loss of sex drive (men and women)
☐ Impotence (men)
☐ Premature ejaculation
☐ Night-time semen loss

LIVER / GALLBLADDER

☐ Dark spots in visual field (floaters)
☐ White flashes in visual field
☐ Irritability
☐ Occasional high-pitched ringing in ear(s)
☐ Tendency to anger outbursts
☐ Pain or discomfort around the ribcage or at the rib-sides
☐ Feeling of a lump in the throat
☐ Depression
☐ Tendency to sigh
☐ Digestive disturbances caused by emotional upset
  ☐ Loose stool/diarrhea ☐ Nausea/Vomiting
☐ Bitter taste in mouth
☐ Sour taste in mouth
☐ Muscle twitches or spasms (eyelid, calf, etc)
☐ Pale nails
☐ Vaginal dryness
☐ Gallstones (current or past)

HEART

☐ Palpitations (heart flutter, pounding, **and/or** being aware of your heart beating in an uncomfortable way)
☐ Dull ache and tightness in chest
☐ Anxiety
☐ Poor memory
☐ Arrhythmia (irregular heart beat)
☐ Heart valve prolapse
☐ Tongue sores

SKIN & HAIR

☐ Allergic skin rashes / hives
☐ Eczema – location(s): _____
☐ Psoriasis – location(s): _____
☐ Acne – location(s): _____
☐ Frequent itching – locations: _____
☐ Hair on head falling out
☐ Dandruff
☐ Alopecia
☐ Skin sores that don't heal
☐ Herpes: ☐ Oral ☐ Genital
☐ Other _____

"DAMPNESS"

☐ Feel worse overall with weather changes
☐ Thirst but no desire to drink
☐ Abdominal distension & heaviness
☐ Feel phlegm in throat / constant clearing of throat
☐ Heaviness in legs and/or arms
☐ Mucus in stool
☐ Swollen ankles
☐ Puffy eyes / face
☐ Swollen hands / fingers
☐ Fogginess / clouded mind
☐ Reluctance to move body, feels too burdensome

EMOTIONS

Which of these emotions are you aware of frequently:

☐ Anger/Frustration
☐ Joy/Aliveness
☐ Worry/Obsessing
☐ Grief/Sorrow/Sadness
☐ Fear/Anxiety
☐ Easily startled
☐ Post-Traumatic Stress Syndrome
☐ Mental restlessness
☐ Panic attacks – How often? _____

SLEEP

Sleep # hours/night _____
☐ Difficulty falling sleep
☐ Difficulty staying asleep / waking throughout the night
☐ Wake _____ times/night
☐ Wake to urinate ____ times/night
☐ Disturbing dreams
☐ Lots of dreams
☐ Restless sleep / tossing and turning
☐ Wake in the early morning, unable to fall back asleep
☐ Snoring
☐ Other sleep issues: _____

MENSTRUAL & REPRODUCTIVE (WOMEN)

☐ I have gone through menopause in (year) _____ (complete this section about your periods before menopause)

☐ **I AM (or may be) PREGNANT** ☐ **I am trying to get pregnant** – How long? _____
☐ **I gave birth within the past year** ☐ **I am breastfeeding**

Age at first period: _____
Date last period began: ___/___/___
Length of full cycle (period to period) _____ days
Length of bleeding: _____ days

Number of pregnancies _____
Number of miscarriages _____
Number abortions _____
Number of births _____
Number of Premature births _____

☐ Birth control pill:
☐ Current
☐ Past (How long?
_____

Please check ALL that apply:

☐ **PMS** (Pre-Menstrual Syndrome)
- ☐ Mood changes (irritability, weeping, sensitive)
- ☐ Breast tenderness or distension
- ☐ Bloating
- ☐ Headaches or migraines before period
- ☐ Breast cysts/lumps that change with cycles
- ☐ Digestive changes with periods
  - ☐ Constipation ☐ Loose stools ☐ Cravings

☐ Menstrual Cramps
- ☐ Before period starts
- ☐ First day
- ☐ During period
- ☐ Dull, achy pain
- ☐ Sharp, stabbing pains

Pain is relieved with
- ☐ Heat (hot pack, etc)
- ☐ Cold
- ☐ Pressure/Massage

☐ Lower back pain related to periods
☐ Vaginal discharge (unrelated to period/ovulation)
☐ Clear/White ☐ Yellow ☐ Watery ☐ Thick

☐ NO periods (Amenorrhea) How long? _____
☐ Irregular periods
☐ Always early ☐ Always late ☐ Varies cycle to cycle

Color of flow:
☐ Dark red ☐ Bright red ☐ Pale red / pink
☐ Purple ☐ Almost black ☐ Brown

Consistency:
☐ Thick, heavy ☐ Watery ☐ Medium/Normal

Flow:
☐ Heavy (constant changing of pads/tampons)
☐ Light (change pads once or twice a day)
☐ Moderate
☐ Period starts and stops
☐ Clots in flow

Other symptoms:
☐ Fatigue with periods
☐ Midcycle spotting
☐ Other: _____
_____
_____
_____

Welcome to my practice

·Here is some important information for you:

Location

- Contact information 919-964-3949
- 5306 Six Forks Rd·, Suite 107 Raleigh, NC 27609
- Email touchpointewellness@gmail·com
  https://www·facebook·com/TouchpointeWellness

Preparation for Treatment:

- Please wear loose fitting clothes, as this allows access to most areas needed for treatment and generally eliminates the need to disrobe·
- Do not worry if you forget, you will be draped·
- Please have eaten a light meal prior to treatment·
- **Do not brush your tongue·**
- No alcohol prior to treatment·

Fees:

- **Initial Consultation & 1st Treatment: $120**
  90-120minutes

  We will go over your condition and health goals to determine the appropriate course of acupuncture treatment for your condition· A customized treatment plan will be discussed· Acupuncture may be performed on the same day depending on availability· Acupuncture's effects are cumulative· Acute conditions generally take a shorter course of treatment: 5 to 6 consecutive weekly treatments· Chronic conditions usually require more consecutive treatments over a longer period of time·

- **Acupuncture Treatments: (after initial consultation) $80·00**
  45-60 minutes·

Packages are available for cost savings· Your practitioner will go over your course of treatment and package options during your initial evaluation·

Cancellation Policy:

Out of respect for my time and the time of other patients, there is a 48-hour cancellation policy for new patients and 24-hour cancellation for existing patents. $80 cancelation fee will be assessed if cancelled less than 24 hours before the scheduled time if you are running late, please call or text to inform the clinic.

Payment: due at time of service.

- Cash, check, or Credit Card (Visa, MasterCard, Discover, and American Express). Health Savings and Flexible Spending Accounts also accepted.

Insurance:

- Superbills can be provided to submit for reimbursement from your health insurance provider if requested. Please contact your provider for the conditions that they cover and for specific codes that will enable them to process your claim. I am happy to work with you in this matter.

www.touchpointewellness.com