GOLDEN TAMARACK ACUPUNCTURE LLC
Patient Health History

Name: _____ Today's Date: _____/_____/_____
(first) (middle) (last)

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone:_____ Work Phone: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Marital: M S D W

Occupation: _____ Employer: _____

Email Address: _____ May we contact you via Email? Y N

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? _____

_____

2. Please identify the health concerns that have brought you to Golden Tamarack Acupuncture 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? _____

d. _____ _____

How does this condition affect you? _____

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

_____

_____

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

_____

_____

_____

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

If so, how far along are you? _____

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

7. **Family History:** Check those applicable:	Father	Mother	Brothers	Sisters	Spouse	Children
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	_____	_____	_____	_____	_____	_____

8. **Height:** _____ **Weight:** Currently: _____

9. **Blood Pressure:** What is your most recent blood pressure reading? _____/_____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

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

Polio Tetanus Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: _____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

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

Mood Swings Nervousness Anxiety Mental Tension Depression Irritability

15. **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

16. **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

17. **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: _____		

18. **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

19. **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

20. **Urinary** (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	

21. **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	

22. **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: _____

23. **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

24. **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?): _____

25. **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

26. **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

27. **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? _____

28. **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? _____

j. Television habits: _____

k. Interests and hobbies: _____

How did you hear about Golden Tamarack Acupuncture?

_____

Voluntary Consent

I hereby request and consent to be treated with acupuncture, acupressure, or other techniques discussed and based on Traditional Chinese Medicine. I understand I may also be given recommendations on diet, nutrition or lifestyle and it is my decision as to whether or not to follow these recommendations.

The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-invasive techniques such as touch or palpation.

I have discussed the nature and purpose of my treatment with the acupuncturist, Coleen Fleming. I understand that there are no guarantees regarding cure or improvement of my condition. I understand there may be limitations to the care provider and that in my best interest I may be referred to another healthcare provider.

Possible Side Effects

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including temporary pain or discomfort, local bruising, slight bleeding, fainting. Unusual or rare risks associated with acupuncture include nerve damage, organ puncture, and infection.

Medical Referral

I understand treatment from this acupuncturist does not substitute for appropriate medical evaluation and treatment by a licensed physician. I have been advised to consult with a licensed physician if there is worsening of my ailment/condition, if it does not improve within and estimated timeframe or if a new ailment/condition arises. If I am presently under the care of a physician, I have been advised to continue all treatments and medications as prescribed.

Infectious Disease/Clean Needle Technique

I understand that universal precautions will be utilized during treatments to guard against the spread of infection, including the use of sterilized, prepackaged, one time use, disposable needles. Needles used in my treatment are used only on me and are disposed of as medical waste immediately after use.

I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content and by signing below I agree to all the terms stipulated by this document. I intend this form to cover the entire course of treatment for my condition and for any future condition(s) for which I seek treatment.

Right to obtain a copy of Privacy Practices notice: You have the right to request and receive a copy of the notice of privacy practices, as well as any revisions made to the notice at any time. I hereby acknowledge receipt and understanding of the Notice of Privacy Practices, as indicated by my signature below.

Print Patient Name: _____

Signature of Patient: _____

Date: _____

I hereby authorize release of my acupuncture treatment information in summary to my consulting Doctor. Please inform Dr. _____ of my progress.

Signature of Patient: _____