

Patient Information

Patient's Name _____ Today's Date _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Phone number at which I may leave messages for you regarding medical information, appointment confirmations, etc.
(_____) circle one: home mobile office other

Other Phone numbers

(_____) circle one: home mobile office other

(_____) circle one: home mobile office other

Email _____

Birth Date _____ Age _____ Gender _____ Soc. Sec. # _____

single married divorced widowed domestic partnership other _____

Referred by _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone # Cell (_____) Home or Office (_____)

Physician's Name _____ Phone (_____)

Physician's Address _____ Date of last visit _____

Employment Please check all that apply

full-time part-time self-employed student unemployed retired

Occupation _____ Number of hours of work/study per week _____

Employer's Name _____ Phone (_____)

Employer's Address _____

Spouse / Domestic Partner Name _____

Spouse / Partner Employer _____ Phone (_____)

Spouse / Partner Employer Address _____

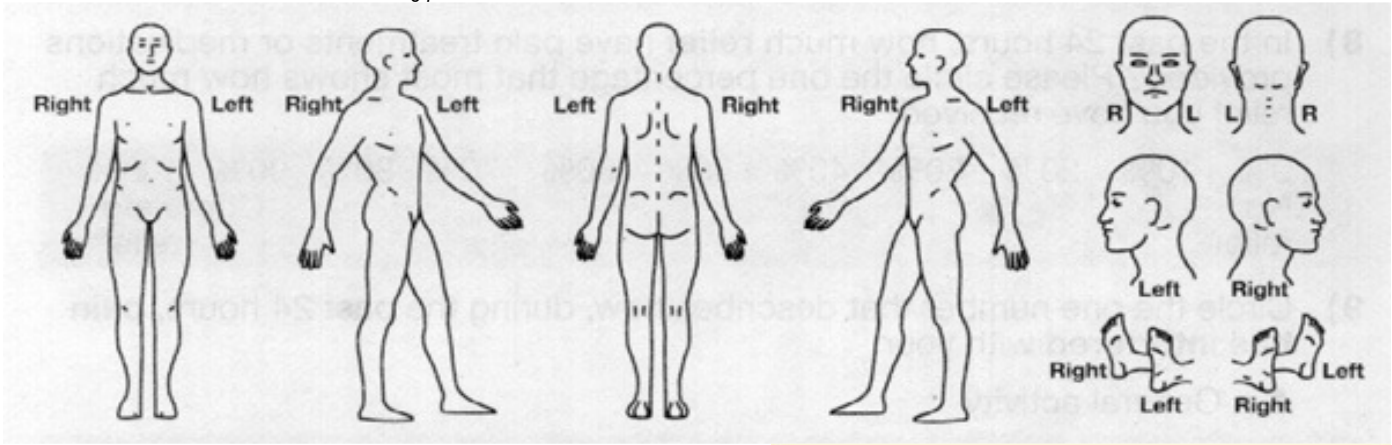
Initial Health History

Name _____ Age _____ Gender _____ Date _____

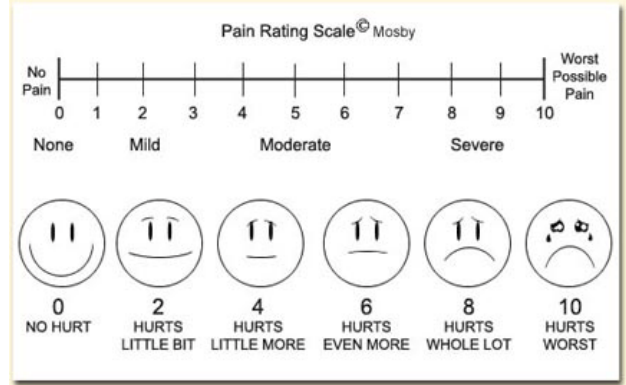
If any of your top 3 health concerns are pain, complete this page as appropriate. If not, skip to the next page.

Circle the area(s) where you feel pain. Inside each circle rank the priority of this condition for treatment today.

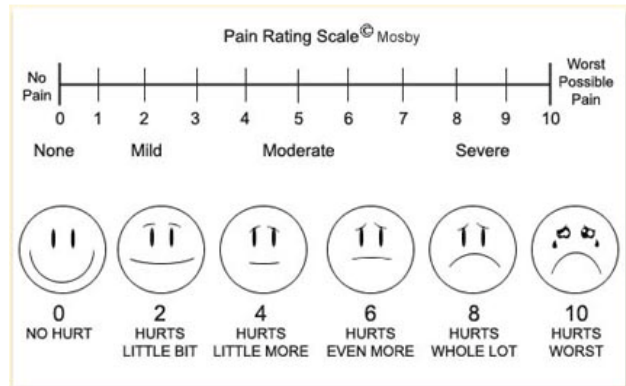
1 = the most important condition you would like treated, 2 = the second most important condition you would like treated, 3 = the third most important condition you would like treated. Use arrows to show radiating pain.



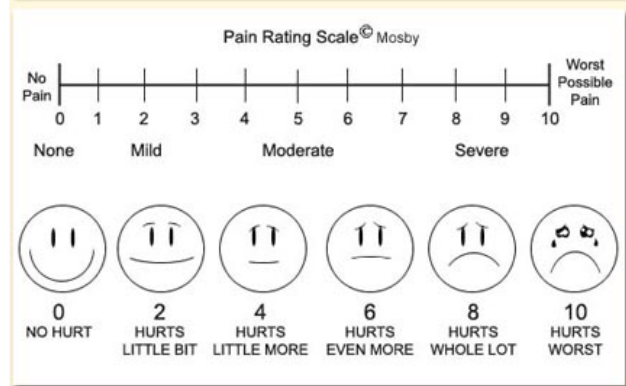
1 If your **primary** health concern is pain please circle your pain range



2 If your **secondary** health concern is pain please circle your pain range



3 If your **third** health concern is pain please circle your pain range



San Francisco Bay Area Musicians' Acupuncture Project p.3

Name _____ Age _____ Gender _____ Date _____

Please write in your top 3 health concerns in order of importance to you and answer the questions about each

1 _____ When did this begin? _____ ago

Diagnosis from MD or other specialist _____ Date of diagnosis _____

Circumstances of onset / unusual life events that occurred prior to onset (car accident, death of a loved one, excessive stress, gradual onset, cause unknown, etc.)

Severity Mark on the scale the severity of the condition. 1= minimal, 10 = worst imaginable | _____ |
1 2 3 4 5 6 7 8 9 10

How has this condition decreased your range of motion or limited your activities? _____

<p>Frequency</p> <input type="checkbox"/> constant <input type="checkbox"/> frequent <input type="checkbox"/> sometimes <input type="checkbox"/> occasional <input type="checkbox"/> rare <input type="checkbox"/> random times <input type="checkbox"/> only when I _____ <input type="checkbox"/> each episode lasts for _____ <input type="checkbox"/> only during the day / night (circle one) <input type="checkbox"/> wakes me at night Other _____	<p>This condition feels better</p> <input type="checkbox"/> when I press / massage _____ <input type="checkbox"/> when I'm tired <input type="checkbox"/> when I wake up / get out of bed <input type="checkbox"/> after moving around for a while <input type="checkbox"/> with vigorous exercise <input type="checkbox"/> in hot weather or after a hot shower <input type="checkbox"/> in cold weather or when I apply ice <input type="checkbox"/> in damp or foggy weather <input type="checkbox"/> _____ am / pm <input type="checkbox"/> before / during / after my period (circle all that apply) Other _____	<p>This condition feels worse</p> <input type="checkbox"/> when I press / massage _____ <input type="checkbox"/> when I'm tired <input type="checkbox"/> when I wake up / get out of bed <input type="checkbox"/> after moving around for a while <input type="checkbox"/> with vigorous exercise <input type="checkbox"/> in hot weather or after a hot shower <input type="checkbox"/> in cold weather or when I apply ice <input type="checkbox"/> in damp or foggy weather <input type="checkbox"/> _____ am / pm <input type="checkbox"/> before / during / after my period (circle all that apply) Other _____
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Accompanying symptoms _____

Treatments tried / Anything else I should know about this condition _____

For Pain Only Describe the quality of this pain by checking all that apply
 dull sharp throbbing numb pins & needles tight band sensation heavy
 aching stabbing burning tingling hollow sensation swollen / enlarged sensation other _____

2 _____ When did this begin? _____ ago

Diagnosis from MD or other specialist _____ Date of diagnosis _____

Circumstances of onset / unusual life events that occurred prior to onset (car accident, death of a loved one, excessive stress, gradual onset, cause unknown, etc.)

Severity Mark on the scale the severity of the condition. 1= minimal, 10 = worst imaginable | _____ |
1 2 3 4 5 6 7 8 9 10

How has this condition decreased your range of motion or limited your activities? _____

<p>Frequency</p> <input type="checkbox"/> constant <input type="checkbox"/> frequent <input type="checkbox"/> sometimes <input type="checkbox"/> occasional <input type="checkbox"/> rare <input type="checkbox"/> random times <input type="checkbox"/> only when I _____ <input type="checkbox"/> each episode lasts for _____ <input type="checkbox"/> only during the day / night (circle one) <input type="checkbox"/> wakes me at night Other _____	<p>This condition feels better</p> <input type="checkbox"/> when I press / massage _____ <input type="checkbox"/> when I'm tired <input type="checkbox"/> when I wake up / get out of bed <input type="checkbox"/> after moving around for a while <input type="checkbox"/> with vigorous exercise <input type="checkbox"/> in hot weather or after a hot shower <input type="checkbox"/> in cold weather or when I apply ice <input type="checkbox"/> in damp or foggy weather <input type="checkbox"/> _____ am / pm <input type="checkbox"/> before / during / after my period (circle all that apply) Other _____	<p>This condition feels worse</p> <input type="checkbox"/> when I press / massage _____ <input type="checkbox"/> when I'm tired <input type="checkbox"/> when I wake up / get out of bed <input type="checkbox"/> after moving around for a while <input type="checkbox"/> with vigorous exercise <input type="checkbox"/> in hot weather or after a hot shower <input type="checkbox"/> in cold weather or when I apply ice <input type="checkbox"/> in damp or foggy weather <input type="checkbox"/> _____ am / pm <input type="checkbox"/> before / during / after my period (circle all that apply) Other _____
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Accompanying symptoms _____

Treatments tried / Anything else I should know about this condition _____

For Pain Only Describe the quality of this pain by checking all that apply
 dull sharp throbbing numb pins & needles tight band sensation heavy
 aching stabbing burning tingling hollow sensation swollen / enlarged sensation other _____

San Francisco Bay Area Musicians' Acupuncture Project p.4

Name _____ Age _____ Gender _____ Date _____

3 _____ When did this begin? _____ ago

Diagnosis from MD or other specialist _____ Date of diagnosis _____

Circumstances of onset / unusual life events that occurred prior to onset (car accident, death of a loved one, excessive stress, gradual onset, cause unknown, etc.) _____

Severity Mark on the scale the severity of the condition. 1= minimal, 10 = worst imaginable |-----|
 1 2 3 4 5 6 7 8 9 10

How has this condition decreased your range of motion or limited your activities? _____

Frequency	This condition feels better	This condition feels worse
<input type="checkbox"/> constant	<input type="checkbox"/> when I press / massage _____	<input type="checkbox"/> when I press / massage _____
<input type="checkbox"/> frequent	<input type="checkbox"/> when I'm tired	<input type="checkbox"/> when I'm tired
<input type="checkbox"/> sometimes	<input type="checkbox"/> when I wake up / get out of bed	<input type="checkbox"/> when I wake up / get out of bed
<input type="checkbox"/> occasional	<input type="checkbox"/> after moving around for a while	<input type="checkbox"/> after moving around for a while
<input type="checkbox"/> rare	<input type="checkbox"/> with vigorous exercise	<input type="checkbox"/> with vigorous exercise
<input type="checkbox"/> random times	<input type="checkbox"/> in hot weather or after a hot shower	<input type="checkbox"/> in hot weather or after a hot shower
<input type="checkbox"/> only when I _____	<input type="checkbox"/> in cold weather or when I apply ice	<input type="checkbox"/> in cold weather or when I apply ice
<input type="checkbox"/> each episode lasts for _____	<input type="checkbox"/> in damp or foggy weather	<input type="checkbox"/> in damp or foggy weather
<input type="checkbox"/> only during the day / night (circle one)	<input type="checkbox"/> _____ am / pm	<input type="checkbox"/> _____ am / pm
<input type="checkbox"/> wakes me at night	<input type="checkbox"/> before / during / after my period (circle all that apply)	<input type="checkbox"/> before / during / after my period (circle all that apply)
Other _____	Other _____	Other _____

Accompanying symptoms _____

Treatments tried / Anything else I should know about this condition _____

For Pain Only Describe the quality of this pain by checking all that apply
 dull sharp throbbing numb pins & needles tight band sensation heavy
 aching stabbing burning tingling hollow sensation swollen / enlarged sensation other _____

In the last month, I have frequently experienced (check all that apply)

SLEEP	BOWEL MOVEMENTS	TEMPERATURE	CRAVINGS
<input type="checkbox"/> falling asleep takes _____ hours	<input type="checkbox"/> ragged edges	<input type="checkbox"/> feel colder than others	<input type="checkbox"/> sweet foods
<input type="checkbox"/> waking _____ times per night	<input type="checkbox"/> loose	<input type="checkbox"/> cold hands / feet	<input type="checkbox"/> salty foods
@ _____ am/pm, for _____ hour(s)	<input type="checkbox"/> diarrhea	<input type="checkbox"/> chills	<input type="checkbox"/> sour flavors
<input type="checkbox"/> vivid dreams / nightmares	<input type="checkbox"/> constipation	<input type="checkbox"/> prefer warm food and drink	<input type="checkbox"/> spicy foods
<input type="checkbox"/> not rested on waking	<input type="checkbox"/> thin stools	<input type="checkbox"/> feel warmer than others	<input type="checkbox"/> bitter flavors
<input type="checkbox"/> Bedtime _____, # of hours / night _____	<input type="checkbox"/> stools broken into small pieces	<input type="checkbox"/> hot hands, feet, chest	<input type="checkbox"/> other _____
	<input type="checkbox"/> alternating between loose & difficult	<input type="checkbox"/> hot at night	
	<input type="checkbox"/> undigested food particles	<input type="checkbox"/> hot flashes	MISCELLANEOUS
ENERGY LEVEL	<input type="checkbox"/> accompanied by blood or mucus	<input type="checkbox"/> prefer cold food and drink	<input type="checkbox"/> red / itching eyes
<input type="checkbox"/> fatigue	<input type="checkbox"/> bowel incontinence		<input type="checkbox"/> spots in front of eyes
<input type="checkbox"/> energy drop after meals		SWEATING	<input type="checkbox"/> sinus congestion
<input type="checkbox"/> sudden energy drop at _____ am / pm	URINATION	<input type="checkbox"/> night sweats _____ times / week	<input type="checkbox"/> phlegm (color _____)
<input type="checkbox"/> dependence on caffeine	<input type="checkbox"/> frequent	<input type="checkbox"/> unusual sweating	<input type="checkbox"/> cough
<input type="checkbox"/> body or limbs feel weak / heavy	<input type="checkbox"/> urgent	@ _____ am / pm	<input type="checkbox"/> headaches _____ x / week
	<input type="checkbox"/> small quantity	which area(s) of body _____	<input type="checkbox"/> migraines _____ x / month
APPETITE / THIRST	<input type="checkbox"/> excessive quantity		<input type="checkbox"/> sore throat
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> dark yellow	EMOTIONS	<input type="checkbox"/> frequent colds
<input type="checkbox"/> low appetite	<input type="checkbox"/> no color / very pale yellow	<input type="checkbox"/> anger / irritability	<input type="checkbox"/> mouth sores
<input type="checkbox"/> excessive thirst	<input type="checkbox"/> wake to urinate _____ times per night	<input type="checkbox"/> frustration	<input type="checkbox"/> palpitations
<input type="checkbox"/> mouth / throat dry	<input type="checkbox"/> slow stream / dribbling	<input type="checkbox"/> anxiety / worry	<input type="checkbox"/> bleed / bruise easily
but no desire to drink	<input type="checkbox"/> difficulty starting / stopping	<input type="checkbox"/> obsessive thinking	<input type="checkbox"/> difficult to concentrate
	<input type="checkbox"/> pain on urinating	<input type="checkbox"/> sadness	<input type="checkbox"/> poor memory
GENERAL GI	<input type="checkbox"/> burning	<input type="checkbox"/> grief	<input type="checkbox"/> dizziness / lightheaded
<input type="checkbox"/> acid reflux	<input type="checkbox"/> blood in urine	<input type="checkbox"/> depression	<input type="checkbox"/> ear ringing – high / low pitch
<input type="checkbox"/> nausea / vomiting	<input type="checkbox"/> cloudy urine	<input type="checkbox"/> fear	<input type="checkbox"/> diminished hearing
<input type="checkbox"/> bad breath	<input type="checkbox"/> urinary incontinence	<input type="checkbox"/> indecision	<input type="checkbox"/> erectile dysfunction
<input type="checkbox"/> abdominal bloating		<input type="checkbox"/> other _____	<input type="checkbox"/> premature ejaculation
<input type="checkbox"/> excessive gas			<input type="checkbox"/> decrease in libido
<input type="checkbox"/> noises from the lower abdomen			

Other recent health concerns _____

San Francisco Bay Area Musicians' Acupuncture Project p.5

Name _____ Age _____ Gender _____ Date _____

Check all that you have experienced to a significant degree, currently or in the past. If past, write approximate year next to checkbox.

- | | | |
|---|--|---|
| past current | past current | past current |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> fainting | <input type="checkbox"/> attempted / considered suicide |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> seizures | <input type="checkbox"/> emotional, physical / sexual abuse |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> paralysis | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> gallstones | <input type="checkbox"/> tuberculosis (TB) |
| <input type="checkbox"/> chest pain or pressure | <input type="checkbox"/> kidney stones | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> jaw/neck/shoulder/arm pain | <input type="checkbox"/> frequent urinary tract infections | <input type="checkbox"/> HIV |
| <input type="checkbox"/> nausea | <input type="checkbox"/> frequent vaginal infections | <input type="checkbox"/> sexually transmitted disease(s) |
| <input type="checkbox"/> swollen hands or feet | <input type="checkbox"/> frequent vaginal infections | _____ |
| <input type="checkbox"/> blood clotting disorders | <input type="checkbox"/> pelvic inflammatory disease | _____ |
| <input type="checkbox"/> phlebitis | <input type="checkbox"/> abnormal PAP smear | <input type="checkbox"/> genital warts |

tumors or lumps _____

other _____

Family History	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Tuberculosis							
Blood Disorder/ Anemia							
Diabetes							
Cancer / Tumors							
Seizures							
Stroke							
High Blood Pressure							
Heart Disease							
Kidney / Bladder Disorder							
Stomach / Intestinal Disorder							
Depression / Mental Illness							
Drug / Alcohol Use or Abuse							
Other							
Age at death							

Major Hospitalizations Surgeries – Please list any hospitalization or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medicines, Herbs, Supplements – Please check any that you are currently taking and list details below

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> aspirin | <input type="checkbox"/> antacids | <input type="checkbox"/> blood thinners | <input type="checkbox"/> sleeping pills |
| <input type="checkbox"/> ibuprofen | <input type="checkbox"/> fiber / laxatives | <input type="checkbox"/> blood pressure pills | <input type="checkbox"/> tranquilizers |
| <input type="checkbox"/> acetaminophen (Tylenol) | <input type="checkbox"/> diet pills | <input type="checkbox"/> insulin | <input type="checkbox"/> anti-depressants |
| <input type="checkbox"/> oral contraceptives | <input type="checkbox"/> allergy medication | | <input type="checkbox"/> other, please list |
-
- | | | |
|---------------|-------|--------------------------|
| Western Drugs | Herbs | Vitamins and Supplements |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medication Allergies _____

Food Allergies _____

Name _____ Age _____ Gender _____ Date _____

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Women Only

Have you had unprotected sex with a male partner since your last period? yes no

Date of first bleeding of most recent menstrual period _____ Total days of bleeding _____ Length of full cycle _____

Age at first menses _____ Please list all birth control methods used, past and present _____

Total Number of Pregnancies _____ Living _____ Ectopic _____ Miscarriages _____ Induced Abortions _____

Check all that apply to your menstrual periods in the last 3 months

- | <u>Cycle</u> | <u>PMS</u> | <u>PMS (continued)</u> | <u>During menses</u> | <u>Color of flow</u> |
|--|---|--|---|--|
| <input type="checkbox"/> late | <input type="checkbox"/> anger / irritability | <input type="checkbox"/> breast tenderness | <input type="checkbox"/> abdominal cramps on day(s) _____ | <input type="checkbox"/> pink |
| <input type="checkbox"/> early | <input type="checkbox"/> sadness / crying | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> low back pain on day(s) _____ | <input type="checkbox"/> light red |
| <input type="checkbox"/> irregular | <input type="checkbox"/> depression | <input type="checkbox"/> low back pain | <input type="checkbox"/> thigh / leg pain on day(s) _____ | <input type="checkbox"/> medium red |
| <input type="checkbox"/> no menses | <input type="checkbox"/> disturbed sleep | <input type="checkbox"/> thigh / leg pain | <input type="checkbox"/> clots, size _____ | <input type="checkbox"/> dark red |
| <input type="checkbox"/> mid-cycle spotting | <input type="checkbox"/> cravings for _____ | <input type="checkbox"/> other _____ | <input type="checkbox"/> overall heavy flow | <input type="checkbox"/> purple |
| <input type="checkbox"/> other abnormal bleeding | | | <input type="checkbox"/> overall light flow | <input type="checkbox"/> brown / black |

MENOPAUSE

Age menopause symptoms began _____ Age at last menses _____ Internal/Topical hormones used _____

hot flashes _____ x / day night sweats _____ x / night low back pain vaginal dryness decrease in libido other _____

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All Clients

Please check any habits which apply to you now or in the past

- | | | | | | |
|---------------|------------------------------|-----------------------------|---------------------|-------------------|----------------|
| Coffee | <input type="checkbox"/> yes | <input type="checkbox"/> no | # per day _____ | age started _____ | age quit _____ |
| Tobacco | <input type="checkbox"/> yes | <input type="checkbox"/> no | # per day _____ | age started _____ | age quit _____ |
| Marijuana | <input type="checkbox"/> yes | <input type="checkbox"/> no | # per day _____ | age started _____ | age quit _____ |
| Alcohol | <input type="checkbox"/> yes | <input type="checkbox"/> no | # per day _____ | age started _____ | age quit _____ |
| Crack/Cocaine | <input type="checkbox"/> yes | <input type="checkbox"/> no | times per day _____ | age started _____ | age quit _____ |
| Speed | <input type="checkbox"/> yes | <input type="checkbox"/> no | times per day _____ | age started _____ | age quit _____ |
| Heroin | <input type="checkbox"/> yes | <input type="checkbox"/> no | times per day _____ | age started _____ | age quit _____ |
| Other _____ | | | times per day _____ | age started _____ | age quit _____ |

Height _____ Current Weight _____

Please describe any restricted diet you follow(ed) now or in the past _____

Please describe your typical daily diet

Breakfast _____ Morning Snack _____

Lunch _____ Afternoon Snack _____

Dinner _____ Evening Snack _____

Please describe any regular program of exercise

What are the top priorities in your life?

What are your goals for your health?

Have you ever had acupuncture? If so, for what condition(s)?

Please provide any additional information about yourself or your condition(s) not covered by the above questions

Please bring relevant lab, X-ray, MRI, etc. reports to your appointment (No need to bring actual images, copies of X-rays, etc.)

INFORMED CONSENT FOR TRADITIONAL CHINESE MEDICINE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist(s) who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand that clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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

<p><i>To be completed by patient:</i></p> <p>PATIENT'S NAME _____ (please print)</p> <p>PATIENT'S SIGNATURE _____</p> <p>DATE SIGNED _____</p> <p>ARE YOU PREGNANT? ___YES ___NO</p>	<p><i>To be completed by the patient's representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:</i></p> <p>NAME OF PATIENT _____ (please print)</p> <p>PATIENT'S REPRESENTATIVE _____ (please print)</p> <p>REPRESENTATIVE'S SIGNATURE _____</p> <p>AS: _____ Relationship or Authority of Patient's Representative</p> <p>DATE SIGNED _____</p> <p>WITNESS _____</p>
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NAME(S) OF TREATING ACUPUNCTURIST(S) Amy Hanks, MS, L.Ac. or any other Licensed Acupuncturist
working for or affiliated with the San Francisco Bay Area Musicians' Acupuncture Project