Bai Shen Acupuncture
Classical Chinese Medicine

684 PARK STREET ◊ BELMONT, NC 28012 ◊ (704) 825-1584 ◊ info@baishen.org

Acupuncture Health History Questionnaire

Name: _____ Today's Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Phone Home: _____ Work: _____ Cell: _____

Birth Date: _____ Age: _____ Ht: _____ Wt: _____ Sex: M/F

Marital Status: _____ # of Children: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Practitioner: _____

Is this your first time getting acupuncture? Y / N How did you hear about us? _____

Goals: What would you most like to achieve with acupuncture treatments?

_____

_____

_____

Major Symptoms: Please list in order of importance what symptoms are of concern to you. List most concerning to least concerning along with duration of symptoms:

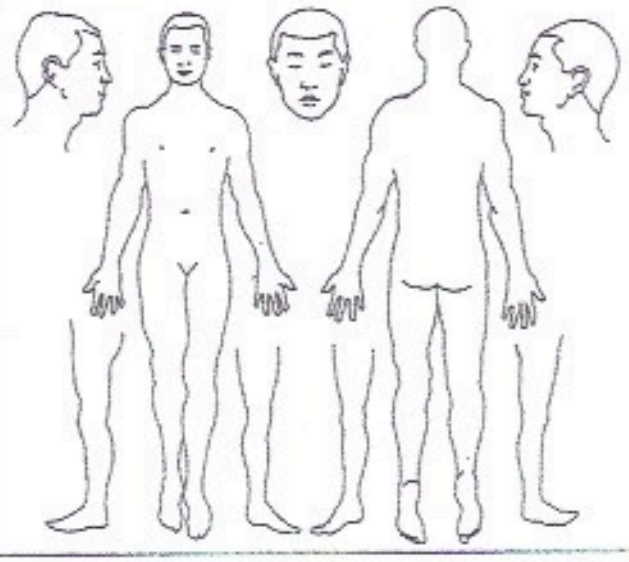
_____

_____

Are you experiencing pain/discomfort in any area of your body? Y / N

Use the illustration at the right to indicate painful or distressed areas. Indicate the location of the discomfort by using the symbol that best describes the feeling:

XXX = Sharp/ Stabbing
PPP = Pins & Needles
DDD = Dull/Aching
NNN = Numbness
TTT = Tightness/Spasms



Medical History

Do you have, or have you ever had, any of the following conditions? If yes, please indicate the date of your diagnosis.

	Date Diagnosed		Date Diagnosed
Cancer: Type_____		HIV	
Diabetes		Mental Illness	
Heart Disease		Seizures	
Hepatitis		Stroke	
High Blood Pressure		Hypothyroid	
High Cholesterol		Hyperthyroid	
Heart Attack		Other: _____	

Please list surgeries or major illnesses with date: _____

_____

_____

_____

Please list any medications or supplements you have taken in the past 2 months: _____

_____

_____

_____

Do you have a pacemaker or any metal devices in your body: Y / N

Family History

Please indicate close family members with any of the following:

	Family Members		Family Members
Cancer: Type_____		Heart Attack	
Diabetes		High Cholesterol	
Heart Disease		Stroke	
High Blood Pressure		Other: _____	

Lifestyle Habits

Do you have an exercise routine? Please describe: _____

_____

How many hours per night do you sleep on average? _____ Do you wake rested? Y / N

Nicotine Use: _____ Alcohol Use (# of drinks/wk & type): _____

Caffeine Use (# of drinks/day and type): _____

Water Intake (how much/day): _____

Dietary habits (# of meals/day and type of food): _____

_____

_____

_____

Please check all that apply:

Energy and Immunity

___ Chronic Fatigue Syndrome
___ Fatigue
___ Allergies (Specify) _____
___ Anemia
___ Thyroid Problems
___ Tendency to Catch Colds

Head, Eye, Ear, Nose and Throat

___ Eye Dryness
___ Eye Strain
___ Eye Pain
___ Color Blindness
___ Cataracts
___ Blurry Vision
___ Spots In Front of Eyes
___ Poor Night Vision
___ Facial Pain
___ Ear Ringing
___ Hearing Difficulties
___ Earaches
___ Headaches / Migraines
___ Teeth Grinding / TMJ
___ Sore Throat
___ Sinus Problems
___ Chronic Sinus Congestion
___ Nose Bleeds
___ Dry Mouth
___ Bad Breath
___ Mouth Sores / Bleeding Gums
___ Dental / Gum Problems
___ Increase in Thirst

Emotions / Sleep

___ Mood Swings
___ Anxious / Worried
___ Depressed
___ Stressed
___ Irritable
___ Difficulty Making Decisions
___ Insomnia
___ Nightmares
___ Difficulty Falling or Staying Asleep

Neuropsychological

___ Vertigo / Dizziness
___ Numbness / Tingling
___ Seizures
___ Lack of Coordination
___ Easily Stressed
___ Nervousness
___ Depression
___ Anxiety / Panic Attacks
___ Bad Temper / Irritable
___ Considered / Attempted Suicide
___ Seeing a Therapist
___ Seasonal Affective Disorder
___ Difficulty Concentrating
___ Poor Memory
___ ADD / ADHD

Respiratory / Circulatory

___ Shortness of Breath
___ Asthma
___ Pneumonia
___ Cough / Wheezing
___ Coughing Blood
___ Chest Pain / Pressure
___ Bronchitis
___ Difficult Inhale / Exhale
___ Difficulty Breathing Laying Down
___ Production of Phlegm
___ Palpitations / Fluttering
___ Poor Circulations (Cold Hands / Feet)
___ Blood Clots
___ Irregular Heartbeat
___ Swelling of Hands / Feet
___ Phlebitis
___ Varicose / Spider Veins
___ Fainting
___ Chronic Cough
___ Night Sweats
___ Unusual Sweating
___ Hot/Cold Intolerance

Kidney / Urinary

___ Painful / Burning Urination
___ Frequent Urinary Tract Infections
___ Infections
___ Unable to Hold Urine
___ Scanty Urine Flow
___ Copious Urine Flow
___ Blood in Urine
___ Dribbling After Urination
___ Frequent / Urgent Urination
___ Night Urination--How Often? _____
What time? _____
___ Nocturnal Emission
___ Kidney Stones
___ Sores on Genitals
___ Herpes

Gastrointestinal

___ Ulcers
___ Changes in Appetite (Poor / Heavy)
___ Nausea / Vomiting
___ Bloating / Pain
___ Abdominal Pain / Cramps
___ Gas
___ Indigestion
___ Heartburn / Acid Reflux
___ Significant Thirst
___ Belching
___ Sudden Weight Change
___ Hemorrhoids
___ Blood in Stool
___ Mucous in Stool
___ Diarrhea
___ Black Stools
___ Loose Stools
___ Rectal Pain
___ Constipation
___ Chronic Laxative Use
___ IBS / Crohn's Disease
___ Hernia

Musculoskeletal

___ Neck / Shoulder Pain
___ Muscle Spasms / Cramps / Weakness
___ Sprains / Strains
___ Limited Range of Motion
___ Arm Pain
___ Hand / Wrist Pain
___ Finger Pain / Tingling / Numbness
___ Upper Back Pain
___ Mid Back Pain
___ Low Back Pain
___ Leg / Knee Pain
___ Foot / Ankle Pain
___ Hip / Pelvic Pain
___ Arthritis
___ Sciatica
___ Bursitis
___ Carpal Tunnel
___ Tendonitis
___ Rotator Cuff

Skin

___ Rashes / Eczema / Hives / Psoriasis
___ Dermatitis
___ Warts
___ Recent Moles
___ Dry Hair or Hair Loss
___ Changes in Skin Color
___ Easy Bruising
___ Acne
___ Fungal Infections
___ Dry / Itchy Skin

Male Health

___ Decreased Libido
___ Impotence
___ Premature Ejaculation
___ Prostate Enlargement
___ Prostatitis
___ Groin Pain
___ Pain in Testicles

Female Health

___ Hot Flashes
___ Vaginal Dryness
___ Vaginal Sores
___ Vaginal Discharge
___ Unusual Vaginal Discharge Odor
___ PMS
___ Age of First Menses _____
___ Date of Last Menses _____
___ Date of Last PAP/Pelvic _____
___ Irregular Cycle
___ Heavy Flow
___ Light Flow
___ Clots in Menstrual Blood
___ Menstrual Related Moodiness
___ Menstrual Related Breast Tenderness
___ Menstrual Related Bloating
___ Bleeding Between Cycles
___ Painful Periods (Pain before, during, or after your period?) _____
Number of Pregnancies _____
Number of Ectopic Pregnancies _____
Number of Live Births _____
Number of Miscarriages _____
Number of Abortions _____
___ Fibrocystic Breast Tissue
___ Breast Lumps / Cysts
___ Uterine Fibroids
___ Endometriosis
___ Ovarian Cysts
___ Polycystic Ovarian Syndrome
___ Frequent Yeast Infections
___ Decreased Libido
___ Difficult / Painful Intercourse
___ Infertility
___ Do You practice Birth Control? _____
What Type? _____

Please inform us of any other problems you would like to discuss.

Bai Shen Acupuncture

Classical Chinese Medicine

Consent Form for Classical Chinese Methods

I, the undersigned, hereby authorize Shari H. Miller, L.Ac., to perform the following specific procedures:

Acupuncture:	the insertion of special sterile, disposable needles through the skin into underlying tissues, at specific points on the body.
Herbs:	may be given in the form of pills or tinctures. Herbal formulas may include shell, mineral, plant and animal materials.
Moxa:	indirect or direct heat therapy on acupuncture point using moxa sticks to relieve symptoms.
Cupping:	a technique to relieve symptoms in which cups made of glass, bamboo or other materials are placed on the skin with a vacuum created by heat or other device.
Gua Sha:	rubbing on an area of the body with a round instrument.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: minor discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, fainting, or aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem, and strengthening the constitution.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Shari H. Miller, I .Ac., regarding cure or improvement of my condition.

I hereby release Shari H. Miller, L.Ac., from any and liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.

I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I declare that the medical history provided herein is accurate and complete, to the best of my recollection. If any other details come to mind at a later date, I will provide the information immediately. I will not hold Shari H. Miller, L.Ac, or Bai Shen Acupuncture, responsible for any misdiagnosis made as a result of my providing inaccurate or incomplete information.

Printed Patient's Name: _____

Signature: _____ **Date:** _____