

Eric Aufdencamp, L.Ac., DOM

Patient History Form

Please fill out this CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. Thank you.

Personal Information

Name: _____ Age: _____ Birth Date: _____

Address: _____

City _____ State: _____ Zip: _____

Phone numbers: _____

E-mail address: _____

If under 18, person responsible for your account: _____

Career/Occupation: _____

Emergency Contact: Name: _____ Contact Phone: _____

Whom shall I thank for referring you? _____

Have you had acupuncture therapy before? Yes No

Have you received Chinese Herbal remedies before? Yes No

Please indicate if any of the following pertain to you:

Hepatitis HIV High Blood Pressure Seizures Pacemaker

Blood-Thinning Medication Pregnancy

Please indicate how frequently you consume the following:

Coffee: _____ Soda: _____ Water: _____

Alcohol: _____ Tobacco: _____

Please list any prescription or over-the-counter medications and supplements you are presently taking:

Medication / Supplement	Reason	For how long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Health History

Please indicate your top 3 health concerns for which you are seeking treatment and how long you have been experiencing them:

1. _____
2. _____
3. _____

What other forms of treatment have you sought?

What helps your condition?

What aggravates your condition?

What would you like to achieve with our acupuncture sessions?

As we will discuss, your health transformation is a process.

Please include your short-term health goals:

Please include your long-term health goals:

Please indicate your level of commitment to these goals. (How frequently will you be coming in? Will you carry out suggestions, including dietary modifications, that you may be recommended?)

Please list any surgeries or major health incidents (accidents, etc.) in your life and the date of occurrence:

If you experience any physical pain, please indicate where and since when: _____

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Symptoms Survey

How would you characterize your physical pain?

- dull/achy sharp/stabbing burning tingling /numbness electrical
 continuous comes and goes fixed location moves around radiating

Please indicate the symptoms or conditions you currently experience or have experienced in the past:

Earth	Currently	Past	Wood	Currently	Past
Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Loose stools / diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty ingesting	<input type="checkbox"/>	<input type="checkbox"/>
Gas or bloating	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>
Obsession	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux / heart burn	<input type="checkbox"/>	<input type="checkbox"/>
Worry thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Easily Frustrated/ angered	<input type="checkbox"/>	<input type="checkbox"/>
Lack of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>
Low energy after a meal	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Brittle hair or nails	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Fire	Currently	Past	Metal	Currently	Past
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell	<input type="checkbox"/>	<input type="checkbox"/>
Mentally restless	<input type="checkbox"/>	<input type="checkbox"/>	Colitis/diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Tightness in the chest	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Sadness/loneliness	<input type="checkbox"/>	<input type="checkbox"/>	Grief/ Nostalgia	<input type="checkbox"/>	<input type="checkbox"/>
Agitation/Fidgeting	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>

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Water	Currently	Past	Blood & Dampness	Currently	Past
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Knee pain/ problems	<input type="checkbox"/>	<input type="checkbox"/>	Sluggishness/Grogginess	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
High or low libido	<input type="checkbox"/>	<input type="checkbox"/>	Heavy feeling	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>
Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>

I usually experience : Hot Cold Thirst Dry mouth/throat

Lifestyle

How many hours of sleep do you get each night? _____

Do you experience: Difficulty falling asleep Staying asleep Interrupted sleep

Nightmares Vivid dreams Wake up not well-rested/groggy

How many bowel movements do you have in a day or week? _____

Are your bowel movements: Well-formed Loose Small pebbles Tan Almost black

Easy to pass Difficult to pass Sticky, like you have to wipe a lot

How would you rate your energy level on a scale of 1-10, with 10 being the highest: _____

How would you rate your stress level on a scale of 1-10, with 10 being the highest: _____

Please list your primary sources of stress: _____

How much do you think about them? _____

How much do they impact your life? _____

How many hours do you work per week? _____ Do you like your work? _____

What do you do in order to manage your stress and take care of yourself? _____

Is there anything else you think I should know or that you'd like to tell me? _____

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For Men

Date of your last prostate exam: _____

Are you currently sexually active? Yes No

Partners are: Male Female

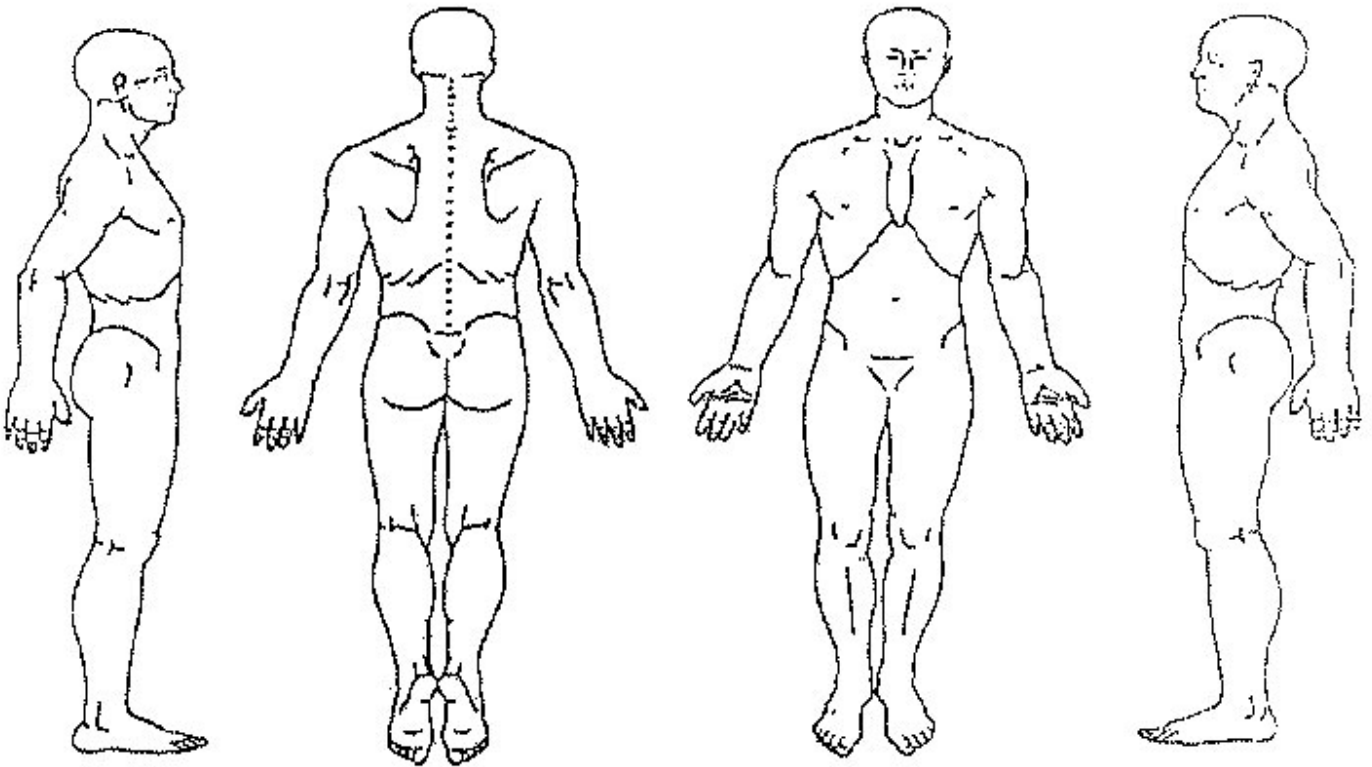
Please list any STDs you have: _____

Please explain any concerns you may have with your sexual function or libido:

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Please draw on the figures below to indicate areas of pain or concern:



Add any notes in the following area:

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CONSENT TO TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for whom I am legally responsible) by Acupuncturist and Doctor of Oriental Medicine Eric Aufdencamp

I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cuppling, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand that the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. I currently **(am / am not)** pregnant (*please circle*).

If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist immediately.

I have been informed that I have a right to refuse any form of treatment. I have read, or have read to me the above consent. I have also had an opportunity to ask questions about this consent, and by signing below I agree to the above named procedures. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent to cover the entire course of treatment for my present and any future conditions for which I seek treatment. _____ (*initials*)

I understand that it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss and emergency situation and/or to share appropriate medical information. My signature provides my practitioner permission to release my medical records for the reasons listed above. _____ (*initials*)

I agree to pay the full charge for any missed appointments without 24 hour notice of cancellation. _____ (*initials*)

I agree to pay all charges incurred for services rendered, over and above insurance coverage. _____ (*initials*)

Patient's Name

Patient's/Guardian's Signature

If Guardian, Relationship to Patient

Date Signed