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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Symptons 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	□	□	Eye Problems	□	□
Loose stools / diarrhea	□	□	Jaundice	□	□
Digestive problems	□	□	Difficulty ingesting	□	□
Gas or bloating	□	□	Belching	□	□
Obsession	□	□	Acid Reflux / heart burn	□	□
Worry thoughts	□	□	Easily Frustrated/ angered	□	□
Lack of appetite	□	□	Depression	□	□
Fatigue	□	□	Difficulty making decisions	□	□
Low energy after a meal	□	□	Gallstones	□	□
Sweet cravings	□	□	Ringing in the ears	□	□
Hemorrhoids	□	□	Brittle hair or nails	□	□
Low blood pressure	□	□	High cholesterol	□	□

Fire	Currently	Past	Metal	Currently	Past
Insomnia	□	□	Cough	□	□
Heart palpitations	□	□	Shortness of breath	□	□
Nightmares	□	□	Decreased sense of smell	□	□
Mentally restless	□	□	Colitis/diverticulitis	□	□
Chest pain	□	□	Tightness in the chest	□	□
Poor memory	□	□	Constipation	□	□
Sadness/loneliness	□	□	Grief/ Nostalgia	□	□
Agitation/Fidgeting	□	□	Claustrophobia	□	□

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

I usually experience : □ Hot □ Cold □ Thirst □ Dry mouth/throat

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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 Women

Age of first period:_____Date of last period:_____Number of days between periods: _____

Number of pregnancies:_____Miscarriages:_____Abortions:_____

Are you currently sexually active? □ Yes □ No Partners are: □ Men □ Women

Number of days of flow: _____

Please indicate color of blood and number of pads/tampons per day of flow below:

	Color: *Pale/light red	* Bright red	* Dark red/brown	Cramping: * Mild	*Moderate	*Severe	# of pads: *1-3	*4-7	*8+
Day 1,2	□	□	□	□	□	□	□	□	□
Day 3,4	□	□	□	□	□	□	□	□	□
Day 5+	□	□	□	□	□	□	□	□	□

Please indicate if you experience the any of these symptoms during your menses:

□ Lower back pain	□ Diarrhea	□ Constipation	□ Moodiness/Weepy	□ Breast pain/soreness
□ Blood clots	□ Increased appetite	□ Decreased appetite	□ Headache
□ Nausea	□ Insomnia	□ More tired	□ Hemorrhoids
□ Bloating	□ Down-bearing sensation	□ Scant or late menses	□ Irregular menses

Please indicate if you experience any of these other gynecological symptoms:

□ Vaginal dryness □ Profuse vaginal discharge □ Yeast infections □ Urinary tract infections

Please indicate if you have been diagnosed with any of the following:

□ Fibroids □ Fibrocystic breasts □ Endometriosis □ Ovarian Cysts □ Polycystic Ovary Syndrome

□ Pelvic Inflammatory Disorder

Please list any STDs you have: _____

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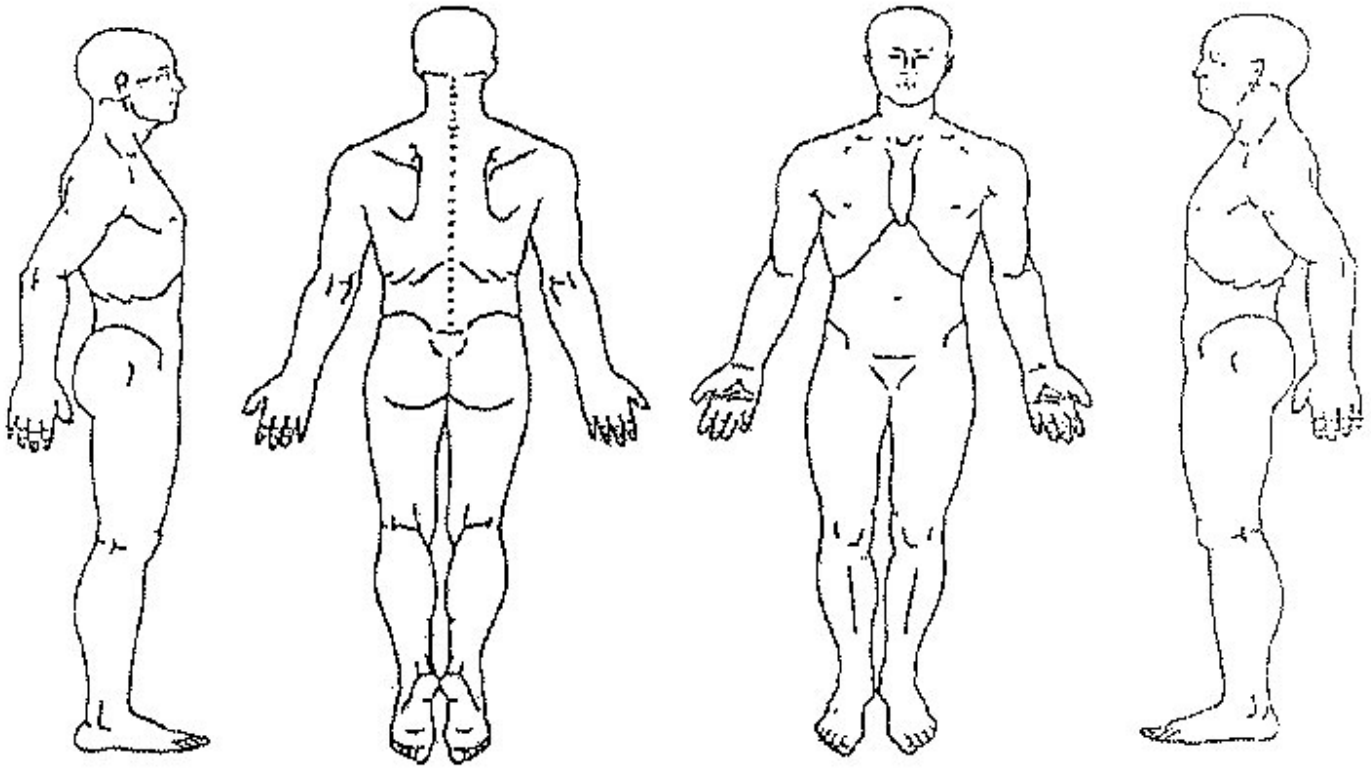
Please draw on the figures below to indicate areas of pain or concern:



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, cupping, 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. _____ (***initials***)

_____
Patient's Name

_____ _____
Patient's/Guardian's Signature If Guardian, Relationship to Patient

_____
Date Signed