Acupuncture & Oriental Medicine of Sturbridge
48 Main Street, Sturbridge MA 01566
PHONE: 508.347.0055 **FAX**: 508.347.7576 **EMAIL**: aoms@charter.net

HEALTH HISTORY

Name		Today's Date	
DOB	Age	Height	Weight
Referred By		Have you tried Oriental Medicine Before?	
Address			
City	State	Zip Code	
Home Phone	Cell Phone	Work Phone	
Email		Occupation	
Primary Care Physician		Insurance plan	

MAIN COMPLAINT

- Please list the main issue that brings you in for Acupuncture & Oriental Medicine:
- When did this problem begin?
- Did anything occur that could have brought this on that you are aware of?
- Have you been given a diagnosis for this?
- Have you tried other treatments for this condition? If so, what & are you still?
- Please list any secondar y issues you would like to have addressed:

ACTIVITIES

Please refer to the section below & indicate with an"X" in the correct box the degree in which your condition interferes with the following activities -

ACTIVITY	NEVER DIFFICULT	SOMETIMES DIFFICULT	FREQUENTLY DIFFICULT	ALWAYS DIFFICULT
SLEEP	❍	❍	❍	❍
EATING	❍	❍	❍	❍
SPORTS	❍	❍	❍	❍
SCHOOLWORK	❍	❍	❍	❍
JOB	❍	❍	❍	❍
SOCIAL ACTIVITIES	❍	❍	❍	❍
HOUSE CHORES	❍	❍	❍	❍
DRIVING	❍	❍	❍	❍
WALKING	❍	❍	❍	❍
SEX	❍	❍	❍	❍
OTHER (PLEASE SPECIFY)	❍	❍	❍	❍

PAST MEDICAL HISTORY

- Surgeries & Dates:

- Siginificant Trauma & Dates (auto accidents, falls, etc.):

- Allergies (drugs, chemicals, foods,etc):

Please "X" any of the following that you currently exerpience -

Siginifcant Illnesses:

❒ Cancer	❒ Veneral Disease	❒ Impotence	❒ Heart Disease
❒ Diabetes	❒ Lyme Disease	❒ Raynaud's Disease	❒ Chronic Pain
❒ Seizures	❒ Asthma	❒ Emphysema	❒ Fibromyalgia
❒ Hepatitis	❒ Anemia	❒ Ulcer	❒ Food Allergies
❒ High Blood Pressure	❒ Stroke	❒ Chronic Fatigue	❒ Other:
❒ High Cholesterol	❒ Arthritis	❒ Polycystic Ovaries	❒
❒ Thyroid Imbalance	❒ Infertility	❒ Irritable Bowel	❒

Family History:

❒ Cancer	❒ Veneral Disease	❒ Impotence	❒ Heart Disease
❒ Diabetes	❒ Lyme Disease	❒ Raynaud's Disease	❒ Chronic Pain
❒ Seizures	❒ Asthma	❒ Emphysema	❒ Fibromyalgia
❒ Hepatitis	❒ Anemia	❒ Ulcer	❒ Food Allergies
❒ High Blood Pressure	❒ Stroke	❒ Chronic Fatigue	❒ Other:
❒ High Cholesterol	❒ Arthritis	❒ Polycystic Ovaries	❒
❒ Thyroid Imbalance	❒ Infertility	❒ Irritable Bowel	❒

LIFESTYLE

- Smoke (# per day) _____ Caffeinated drinks (per day) _____ Alcohol (per week) _____
- Meals (per day) _____ Fruit & vegetable servings (per day) _____ Daily water intake _____

- Do you follow a particular diet regimen? _____If so what?

- Please list your average daily meals:
  - Breakfast _____
  - Lunch _____
  - Dinner _____

- Do you have a regular exercise routine?
  - Days per week _____ Length of workout _____
  - Type(s) of activity(s) _____

- Please list any drug(s) you take for non-medical purposes

- Describe any occupational stress (chemical, physical, psychological, etc.)

PAST 3 MONTHS

Please check off all of the following that you have experienced in the past 3 months -

GENERAL

❒ Pooer appetite	❒ Poor sleeping	❒ Fatigue
❒ Fevers	❒ Chills	❒ Night sweats
❒ Sweat easily	❒ Tremors	❒ Cravings
❒ Localized weakness	❒ Poor balance	❒ Change in appetite
❒ Bleed or bruise easily	❒ Weight loss	❒ Weight gain
❒ Peculiar tates or smells	❒ Strong thirst (cold or hot drinks)	❒ Sudden energy drop -time of day?

SKIN & HAIR

❒ Rashes	❒ Ulcerations	❒ Hives
❒ Itching	❒ Eczema	❒ Pimples
❒ Dandruff	❒ Loss of hair	❒ Recent moles
❒ Change in hair or skin	❒ Any other hair / skin problems?	

HEAD, EYES, EARS, NOSE & THROAT

❒ Dizziness	❒ Concussion	❒ Migraines
❒ Glasses	❒ Eye strain	❒ Eye pain
❒ Poor Vision	❒ Night blindness	❒ Color blindness
❒ Cateracts	❒ Blurry vision	❒ Earaches
❒ Rining in ears	❒ Poor hearing	❒ Spots in front of eyes
❒ Sinus problems	❒ Nose bleeds	❒ Recurrent sore throats
❒ Grinding teeth	❒ Facial pain	❒ Sores on lips or tongue
❒ Teeth problems	❒ Jaw clicks	❒ Headaches -where & when?
❒ Any other head or neck problems?		

CARDIOVASCULAR

❒ High Blood Pressure	❒ Low blood pressure	❒ Chest pain
❒ Irregular heartbeat	❒ Dizziness	❒ Fainting
❒ Cold hands or feet	❒ Swelling of hands	❒ Swelling of feet
❒ Blood clots	❒ Phlebitis	❒ Difficulty breathing
❒ Any other heart or blood vessel problem?		

RESPIRATORY

❒ Cough	❒ Coughing blood	❒ Asthma
❒ Bronchitis	❒ Pneumonia	❒ Pain with deep breath
❒ Difficulty breathing when lying down		❒ Any other lung problems?
❒ Production of phlegm - color?		

GASTROINTESTINAL

❒ Nausea	❒ Vomiting	❒ Diarrhea
❒ Constipation	❒ Gas	❒ Belching
❒ Black stools	❒ Blood in stools	❒ Indigestion
❒ Bad breath	❒ Rectal pain	❒ Hemmerhoids
❒ Abdominal pain or cramps	❒ Chronic laxitive use	
❒ Any other problems with your stomach or intestines?		

GEITO-URINARY

❒ Pain on urination	❒ Frequent urination	❒ Blood in urine
❒ Urgency to urinate	❒ Unable to hold urine	❒ Kidney stones
❒ Decrease in flow	❒ Impotency	❒ Sores on genitals
❒ Wake up to urinate – how often?		❒ Particular color to urine?
❒ Any other problems with your gential or urinary system?		

PREGNANCY & GYNECOLOGY

❒ _____# of Pregnancies	❒ _____# of Births	❒ _____# of Premature births
❒ _____# of Miscarriages	❒ _____# Abortions	❒ _____Age at first menses
❒ _____Time between meses	❒ _____Duration of flow	❒ _____First date of last meses
❒ Unusal character – heavy or light		❒ Painful Periods
❒ Clots	❒ Irregular periods	❒ Vaginal discharge
❒ Vaginal sores	❒ Breast lumps	❒ _____Last PAP
❒ Changes in body/psyche prior to menstration		
❒ Do you practice birth control? _____ What type & for how long? _____		

MUSCULOSKELETAL

❒ Neck pain	❒ Muscle pain	❒ Knee pain
❒ Back pain	❒ Muscle weakness	❒ Foot / ankle pain
❒ Hand / wrist pain	❒ Shoulder pain	❒ Hip pain
❒ Any other joint or bone problem?		

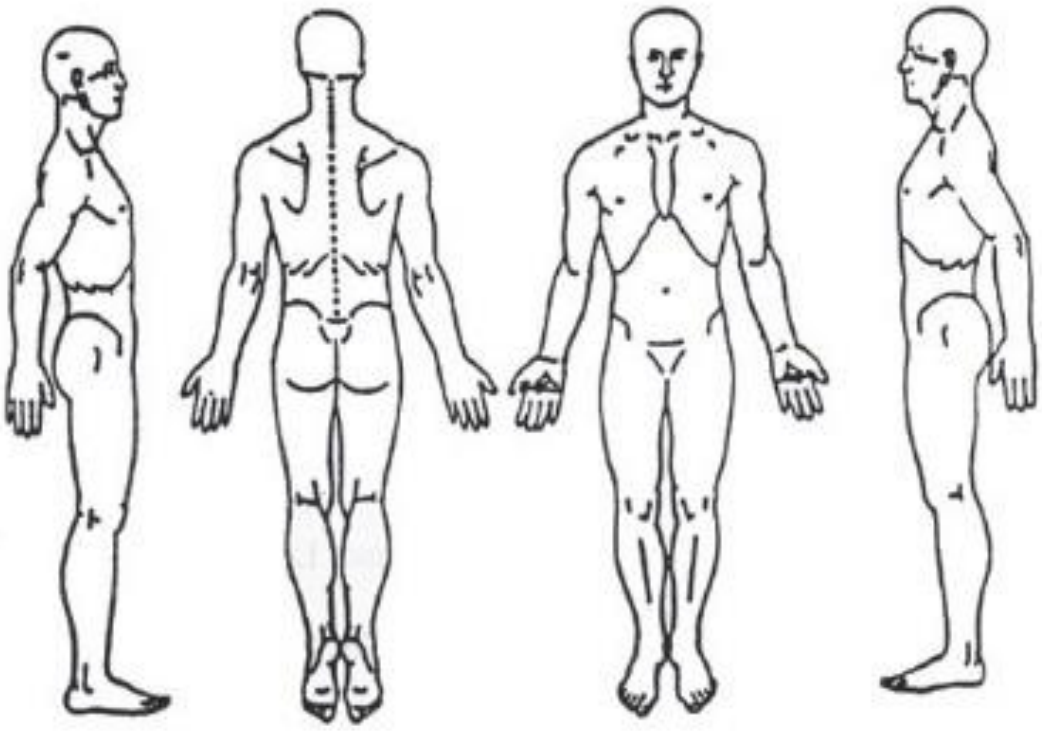
NEUROPSYCHOLOGICAL

❒ Seizures	❒ Dizziness	❒ Loss of balance
❒ Areas of numbness	❒ Lack of coordination	❒ Poor memeory
❒ Concussions	❒ Depression	❒ Anxiety
❒ Bad temper	❒ Easily succeptible to stress	
❒ Have you ever been treated for emotional problems?		
❒ Have you ever considered or attempted suicide?		
❒ Any other neurological or psychological problems?		

***ADDITIONAL COMMENTS –** Is there any other problem you would like to discuss?

PAIN ASSESSMENT

Please indicate where you experience pain on the diageram below.
Shade in the areas with the most severe pain darker.



Pain Scale

Rate the severity of your pain by checking 1 box on the following scale:

1 → Least Pain

10 → Extreme Pain

EXTREME

10

9

8

7

6

5

4

3

2

1

0

NO PAIN

- How did your pain begin?

- When do you have pain? ____All of the time _____On & Off

- Is you pain worse with any of the follwing:

  ❒ **Sitting** ❒ **Bending** ❒ **Walking** ❒ **Lifting** ❒ **Rest**

- Do you feel like your condition is _____Temporary? _____Permanent? _____ Don't know?

- Please list any additional comments:

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INFORMED CONSENT

I _____ authorize & understand the plan of care my acupuncturist is to administer to me. I agree to have any style of Oriental Medical performed as described below including but not limited to the following:

1- Insertion of sterile disposable needles into my body at various depths & locations

2- Heat treatments:
   a. Arthemesa vulgaris (moxabustion/moxa) is a Chinese herbal heat therapy in which the herb is either applied to the head of the needle, placed directly on the skin (with w water or cream barrier), or held over the skin in the form of a pole
   b. Heat lamp is placed over various areas of the body to warm the areas & promote circulation

3- Gwa Sha is a type of massage technique in which a redness/purple color of the skin is produced that remains usually from 3-5 days. Tenderness may also remain after the treatment for a few days in the local area.

4- Cupping is a technique in which glass cups are placed onto various parts of the body producing a suction effect to help promote blood & Qi flow in the meridians. A reddish/purple color may remain after the treatment in the local areas usually between 1-5 days.

5- Electrical Stimulation attacked to the needles may be used to enhance treatment. A tapping vibrating stimulation is produced on the needle that may also spread down the meridian. Ion pumping cord may also be used & attached to various points (needles, magnets, or skin) to also enhance the flow of Qi in the meridians.

6- Massage, pressure, magnets & gentle hands on manipulation may be applied to various acupoints & general body areas to reduce pain, increase relaxation & harmonize the free flow of Qi in the body. These techniques are commonly referred to as Tuina, Manual Meridian Balancing & Acupressure.

I understand that I have the right to refuse any form of treatment. I understand the purpose of the various forms of treatment & the possible consequences involved with these procedures & if unclear I will inquire from my acupuncturist. I also understand that there is always the possibility of unexpected complications & that there are no guarantees regarding the outcome of the treatments.

PATIENT:_____ **EVALUATING ACUPUNCTURIST:**_____

SIGNATURE:_____ **SIGNATURE:**_____

DATE:_____ **DATE:**_____

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NEW PATIENT INFORMATION

Changes in Appointments:

If we must cancel due to an emergency or inclement weather, we will do our best to inform you in a timely fashion. If possible, please provide us with the different phone numbers you can be reached at and the times you are most likely to be at those numbers.

Scheduling & Cancellations:

We advise you to plan ahead with your scheduling to keep consistency in your treatments. It is easier to cancel an appointment than to try to obtain your desired time slot within a short period of time. We do our best to get you in as soon as possible and keep an updated cancellation list. If you need to cancel an appointment, it is your responsibility to do so 24 hours in advance. If not, ***you will be charged the full amount of the missed visit***. Exceptions are made for emergency situations.

Payment & Insurance:

We ask that you make payments at the time of service is rendered. **Cash & check** are acceptable forms payment. Any checks returned will be charged $20 to your account. Although we do not contract with insurance companies, some insurance's will cover Acupuncture as an out of network benefit. If your insurance covers Acupuncture, we are happy to provide you with a receipt of service to be submitted by you if you choose.

Attire:

Please bring loose comfortable clothing with you for your treatment. If needed, a cover up will be provided, as it is necessary to have access to various parts of the body. Draping is provided to ensure comfort during the treatment.

Late for an Appointment:

If running late for an appointment, no more than 30 minutes, we will do our best to provide a full treatment. You will be charged the full amount. If you arrive more than 30 minutes late, we may be unable to treat you. You will be charged for treatment as a missed appointment.

I have read the above & agree to the policies listed.

Patient' Signature **Date**

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MEDICATIONS & SUPPLEMENTS

Medication:	**Medication**:
Indication:	Indication:
Dosage:	Dosage:
Time in Use:	Time in Use:
Medication:	**Medication**:
Indication:	Indication:
Dosage:	Dosage:
Time in Use:	Time in Use:
Medication:	**Medication**:
Indication:	Indication:
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