Confidential Patient Health History & Personal Information

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Date of Birth: ____/____/____ Age: _____ Marital status: -

Height: _____ Weight: _____ Is this your ideal weight:

Blood Pressure: What is your most recent blood pressure reading? _____/_____
Date taken? _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this confidential questionnaire as thoroughly as possible. Thank you.

Have you received acupuncture treatment before? When?

_____

For what reason? _____

_____

Did acupuncture help your condition? ☐ _____

Please identify the health concerns for which you are seeking treatment and the date of onset.

a. _____

b. _____

c. _____

_____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

_____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and dosage:

_____

_____

_____

Check the box if any of the following statements are true:

☐ I have sensitive skin/rashes ☐ I have metal implants ☐ I have Botox/fillers
☐ I have a pace maker ☐ I am taking Coumadin/Warafin ☐ I am taking lithium
☐ I have a breast implants ☐ I am taking an opioid (Codeine, Hydrododone, Meperidine)

Do you have any infectious diseases? Y ◯ N ◯
If yes, please identify: _____

Family History:

Illness	**You**	**Mother**	**Father**	**Sibling**	**Spouse**
Cancer	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Emotional Disorders	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Infection Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐	☐

Hospitalizations/Surgeries/Tests (XRays,CAT Scans, MRI, Special Studies):
Please include reason and date:

_____
_____
_____
_____
_____
_____

Please review the following symptoms and indicate any that you experience.

Symptoms of Qi Deficiency	**Occasional**	**Frequent**	**Symptoms of Yang Deficiency**	**Occasional**	**Frequent**
Always tired/low energy	☐	☐	Loose stool early in the morning	☐	☐
Spontaneous sweating	☐	☐	Urinary incontinence or urgency	☐	☐
Nasal congestion/runny nose	☐	☐	Nighttime urination	☐	☐
Catches cold easily	☐	☐	Always feels cold	☐	☐
Chronic sinus infections	☐	☐	Cold feet at night	☐	☐
Asthma or seasonal allergies	☐	☐	Heating pad helps pain/cramps	☐	☐
Food sensitivities	☐	☐	Excessive vaginal discharge	☐	☐
Shortness of breath	☐	☐	Uterine/vaginal prolapse	☐	☐
Bloating or fatigue after eating	☐	☐	Edema or ankle swelling	☐	☐
Craves sweets	☐	☐	**Symptoms of Qi and Blood Stag.**	**Occasional**	**Frequent**
Low appetite	☐	☐	Acid reflux/heartburn	☐	☐
Difficult concentrating	☐	☐	Difficulty digesting fatty foods	☐	☐
Loose stool or diarrhea	☐	☐	Bitter taste in mouth	☐	☐
Feels heavy/sluggish	☐	☐	Severe PMS mood symptoms	☐	☐
Bruises easily	☐	☐	Prone to anger/rage/irritability	☐	☐
Symptoms of Blood Deficiency	**Occasional**	**Frequent**	Difficulty in making decisions	☐	☐
Vivid dreams or nightmares	☐	☐	Numbness/tingling	☐	☐
Heart palpitations/anxiety	☐	☐	Heat and cold intolerance	☐	☐
Muscle spasms or twitching	☐	☐	Varicose/spider veins	☐	☐
Hair loss or brittle/weak nails	☐	☐	Chest tightness	☐	☐
Dizziness/fainting	☐	☐	Sighs frequently	☐	☐
Floaters in field of vision	☐	☐	Flatulence and/or belching	☐	☐
Diminished night vision	☐	☐	**Symptoms of heat**	**Occasional**	**Frequent**
Dry skin or chapped lips	☐	☐	Tongue or mouth sores	☐	☐
Difficulty relaxing/aggitation	☐	☐	Eczema or psoriasis or rashes	☐	☐
Cold hands and feet	☐	☐	Bleeding gums	☐	☐
Tendon tightness	☐	☐	Acne	☐	☐
Symptoms of K Deficiency	**Occasional**	**Frequent**	Constipation	☐	☐
Lower back or knee pain	☐	☐	Excessive appetite	☐	☐
Fearful or afraid	☐	☐	Blood in the stool	☐	☐
Low libido	☐	☐	Craves iced drinks	☐	☐
Long recovery from illnesses	☐	☐	**Other symptoms**	**Occasional**	**Frequent**
Craves salty foods	☐	☐	Headaches/Migraines	☐	☐
Adrenal fatigue	☐	☐	Neck/shoulder tension	☐	☐
Symptoms of Yin Deficiency	**Occasional**	**Frequent**	Hemorrhoids	☐	☐
Hot at night/night sweats	☐	☐	Cystic acne	☐	☐
Ringing in the ears	☐	☐	Oily skin	☐	☐
Difficulty falling/staying asleep	☐	☐	UTIs	☐	☐
Vaginal dryness	☐	☐	Yeast infections	☐	☐
Dry throat/mouth	☐	☐	Retains water easily	☐	☐

Women's Health:

Are you menstruating Y ◯ N ◯ Date of last period _____

Age menses began _____ Age of menopause

Numberof days in cycle _____ Number of days bleeding _____ Number of days spotting _____

Regular Cycle? Y ◯ N ◯

Please check any that apply to your menstrual cycle:

Color of blood	**Amount/type of blood**	**Cramps**
☐ pale/light red	☐ light	☐ Yes ☐ No
☐ red	☐ heavy	☐ before Period ☐ after ☐ during
☐ bright red	☐ even throughout	☐ mild pain ☐ moderate ☐ severe
☐ dark red	☐ clots	☐ stabbing pain ☐ achy Pain
☐ dark/brown/black	☐ thick	☐ constant pain ☐ comes and goes
	☐ thin/watery	Location of Pain: _____

Other

☐ Swollen breast	☐ Headaches	☐ Insomnia
☐ Weepy/Sad	☐ Irritable / Angry	☐ Change in bowel movements
☐ Increased appetite	☐ Decreased appetite	☐ Food cravings _____

☐ Excessive fatigue before or after period? _____

* Other Symptoms: _____

Do any of the following pertain to you?

☐ live births # _____	☐ fibroids / cysts	☐ STD/PID _____
☐ miscarriage # _____	☐ endometriosis	☐ human papillomavirus (HPV)
☐ termination # _____	☐ vaginal discharge	☐ breast/ovarian/uterine cancer
☐ C-section # _____	☐ vaginal odor	☐ fibrocystic breast

☐ traumatic birth experience

☐ birth control, type used/ how long? _____

Are you pregnant now? - Are you trying to pregnant? - If yes, how long? _____

Have you been diagnosed with infertility? -

When? _____

Cause of infertility? _____

Have you/ Are you/ Do you plan on using IVF or other ART (Assisted Reproductive Technology)? Y ◯ N ◯

If you have used IVF or other ART was it successful? Y ◯ N ◯

Please detail your history or plan with any medicated Assisted Reproductive Technology:

_____

_____

_____

Lifestyle:

Do you exercise Y◯ N◯ If so, describe what you do and how often _____

_____

How many hours per night do you sleep? _____ Do you wake rested? Y◯ N◯
If you do not sleep well, explain the issue: _____

_____

Occupation: _____ How many work hours/week: _____
Do you like your work? _____
How stressful is your work on a scale from 1 (no stress) to 10 (high stress)? _____
Other stresses in your life? _____

_____

Please indicate the use of the following:

Coffee/Black tea: Y◯ N◯ How many/day: _____ Tobacco: Y◯ N◯ How much: _____

Water intake: Y◯ N◯ How many glasses/day: _____ Soda: Y◯ N◯ How many/week: _____ ___

Non-Medical Drugs: Y◯ N◯ How often: _____ Alcohol: Y◯ N◯ How many /week: _____ ___

Describe your typical diet:
breakfast

_____

lunch

_____

dinner

_____

snacks

_____

Other information you would like to report:

_____

_____

_____

_____

_____

Consent to Treatment Form

By signing below, I (*or the patient named below, for whom I am legally responsible*) do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by **Michelle Luiz, LAc** and **Jennifer Saferstein, LAc** at **The Womb Wellness Center**. I understand that Chinese Medical Practitioners practicing in the state of Ohio are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxa, gua- sha/cupping, Chinese herbal medicine and nutritional counseling.

Acupuncture and Moxa: I understand that acupuncture is performed by the insertion of needles through the skin and that moxa is the application of heat at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I have been informed that acupuncture and moxa are generally safe methods of treatment, but that it may have some side effects. Side effects may include: **bruising**, **numbness** or **tingling**, and **dizziness** or **fainting**. I understand that I should not move while the needles are being inserted or retained or while moxa is being performed and that doing so may cause pain or burning.
Unusual and rare risks of acupuncture include, but are not limited to, nerve damage, organ puncture and infection. **This clinic uses sterile disposable needles and maintains a clean and safe environment**.

Gua Sha/Cupping: I understand that if I receive Gua Sha or Cupping that there will be sub-cutaneous blemishing/discoloration that will last 3 or 4 days. I understand that I may refuse this therapy.

Chinese Herbs: I understand that I may refuse taking herbs. 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, although some may be toxic in large doses. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.
I understand that some herbs may be inappropriate during pregnancy and will notify the clinic if I become (or suspect I am) pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.
Should I experience any problems, which I associate with these substances, I should stop taking them and call The Womb Wellness Center as soon as possible.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

The Womb Wellness Center 24 Hour Cancelation Policy:
24-hour advance notice is required when canceling or rescheduling your appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours notice you will be responsible for paying the full amount of your appointment fee.
****Please initial your understanding of this policy _____

Signature: _____**Date:** _____

Printed Name: _____

How did you hear about us? Please check all that apply:

☐ Web ☐ Social media ☐ Friend or family ☐ Professional/provider

Who referred you? _____

May we thank them? ☐Yes ☐No

COVID19 Safety Form

Additional Health Questions:

- Have you had a fever in the last 24 hours of 100°F or above? Y/N
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, cough, or shortness of breath? Y/N
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Y/N

Modified Cancelation Policy

24-hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24-hours advance notice you will be charged the full amount of your appointment. *If you are experiencing respiratory or flu like symptoms including, fever, cough, or shortness of breath you must reschedule your appointment and you will not be charged the cancellation fee. Please give us as much notification as possible.*

I understand that if at anytime in the future I reply yes to any of the above health questions prior to my appointment in the studio I must call to reschedule my appointment. _____ initial

Consent

I understand that, because acupuncture and massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive acupuncture and/or massage from a practitioner at The Womb Wellness Center.

Client Name _____

Signature _____

Date_____