Palmetto Acupuncture Clinic

Health History Questionnaire

CONFIDENTIAL

1825 Sumter Street Columbia, South Carolina 29201 ☯ www.palmettoacupuncture.com ☯ P 803.806.8889 F 803.806.8893

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	First Name	Last Name	Middle Initial
_____ / _____ / _____			

Gender **M F**	Date of Birth _____ / _____ / _____	Age	Eye Color:	Height:	Weight:

Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Phone (Nighttime) # – **Home Work Mobile** *Circle One* ( )	
Alternate Phone # – **Home Work Mobile** *Circle One* ( )	Place of Employment	Occupation
Name & Phone Numbers of Partner: Primary ( ) Alternate ( )	Name & Phone Numbers of Emergency Contact: Primary ( ) Alternate ( )	

E-Mail:

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How did you hear about us? *Please circle one and write the name*

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________ Other:____________

Have you received a Diagnosis for your condition(s)? Y / N If so what: By Whom:	Have you had Acupuncture before? Y / N Did you have a positive ☐ Experience ☐ Out come

	Severe	Moderate	Slight	Major Complaint(s), in order of **importance** to you:
1.	☐	☐	☐	________________
2.	☐	☐	☐	________________
3.	☐	☐	☐	________________
4.	☐	☐	☐	________________
5.	☐	☐	☐	________________

When/how did this condition occur? Give dates if possible. 1) ________________

2) ________________ 3) ________________

How do these conditions impair your daily activities? 1) ________________

2) ________________ 3) ________________

Treatment(s) you have received for this condition: 1) ________________

2) ________________ 3) ________________

What treatments helped the most? 1) _____

2) _____ 3) _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.	**OCCUPATIONAL CONCERNS** Check (√) if your work exposes you to the following:	**DIET & EXERCISE** Check (√) all that apply.
Year	**Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)**		☐ Stress	☐ Regular Exercise
			☐ Environmental ☐ Heavy Typing ☐ Heavy Lifting ☐ Others:	☐ Low-Fat ☐ Low-Carb ☐ Vegetarian
				☐ Other:
				☐ Drink Coffee: Cups/Day
			Occupation: _____	☐ Drink Soda oz/Day

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst). Leave blank if Not Applicable.

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater
_____ Bad Taste
_____ Bad Breath
_____ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Dropped Bladder
_____ Incontinence
_____ Lack of Bladder Control
_____ Weakness/ Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Cold Hands
_____ Cold Feet
_____ Low Sex Drive / Libido
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Fear
_____ Hot Flash/ Night Sweating
_____ Do you crave: Salty

Heart / Small Intestine

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life
_____ Do you crave: Bitter

LUNG / LARGE INTESTINE

_____ Bloody Cough
_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge / Circle Color - White Yellow Green
_____ Post Nasal Drip / Circle Color: White Yellow Green
_____ Sinus Infection/ Congestion
_____ Itchy, Red, or Painful Throat
_____ Dry Mouth/ Throat/ Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & goes
_____ Smokes Cigarettes
_____ Emphysema
_____ Bronchitis
_____ Black / Blood in Stools
_____ Constipation
_____ IBS
_____ Colitis/ Spastic Colon
_____ Diarrhea
_____ Do you Crave : Pungent

SPLEEN / STOMACH

_____ Heaviness Anywhere in the Body
_____ Fatigue on a Scale of 1(**low**) –10 (**high)**
_____ Hard to get up in the Morning
_____ Muscles Feel Tired Often
_____ Edema (swelling) □ hands □ feet
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Nausea/ Vomiting
_____ Difficulty Digesting Fatty Foods
_____ Nausea/ Vomiting
_____ Gas / Belching
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over - Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy
_____ Do you Crave: Sweet

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "**C**" under the appropriate person's column. "**P**" should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the space below.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Anorexia / Bulimia											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_____											
Other:_____											

If any of the above family members are deceased, please list their age at death and cause.

_____

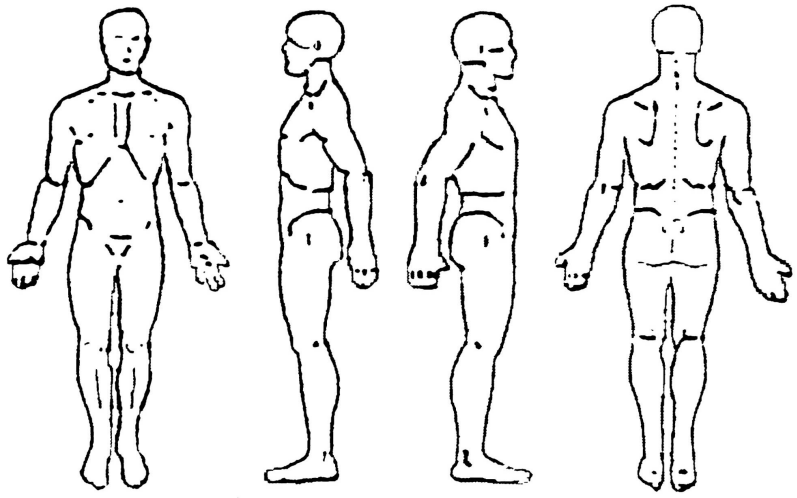
MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

What Makes this Better? : _____

Please mark problem areas on diagram:



Location of Pain			
Is the Pain	☐ Sharp	☐ Burning	☐ Aching
	☐ Fixed	☐ Numbness	
	☐ Tingling	☐ Other:_____	
On a Scale of 1 (Low) – 10(unbearable):			
Is the Pain Better With:	☐ Rest	☐ Activity	☐ Ice
	☐ Heat	☐ Other:_____	
	☐ Massage	☐ ☐ Chiropractic	

Location of Pain			
Is the Pain	☐ Sharp	☐ Burning	☐ Aching
	☐ Fixed	☐ Numbness	
	☐ Tingling	☐ Other:_____	
On a Scale of 1 (Low) – 10(unbearable):			
Is the Pain Better With:	☐ Rest	☐ Activity	☐ Ice
	☐ Heat	☐ Other:_____	
	☐ Massage	☐ ☐ Chiropractic	

Comments:

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No
Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period start? _____

Number of days for menstrual cycle? _____

Number of days bleeding lasts? _____

Describe Menstrual Flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:
☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:
☐ None ☐ IUD ☐ Birth Control Pills
☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*
- ☐ Cramping in Low Back
- ☐ In Groin Area
- ☐ Moderate
- ☐ Severe
- ☐ Before Period
- ☐ Mild
- ☐ Do you feel Ovulation
- ☐ During Period
- ☐ After Period
- ☐ Do you us pain Medication? What Kind of Medication?:

☐ Clotting *(Mark as appropriate)*
- ☐ Bright in Color
- ☐ Brown / Grainy
- ☐ Stringy
- ☐ Dark in Color
- ☐ Size of Clots : Nickel / Dime / Larger

☐ Bleeding Between Periods ☐ Infertility
☐ Pelvic Inflam. Disease ☐ Ovarian Cysts
☐ STD's ☐ Hot Flashes
☐ Endometriosis ☐ Breast Cysts
☐ Mastitis
☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*
- ☐ Fluid Retention
- ☐ Cravings
- ☐ Fluctuating Emotions
- ☐ Irritability
- ☐ Tenderness in Breasts
- ☐ Depression
- ☐ Fatigue
- ☐ Loose Stool
- ☐ Tender / Weepy

Men Only

☐ Impotence ☐ Weak Erection
☐ Discharge from Penis ☐ Prostate Problems
☐ Testicular Pain or Lump ☐ Infertility
☐ Premature Ejaculation ☐ Low Sex Drive
☐ STD's

Men and Women

Supplements

Name	Purpose	How Long

Notes / Anything Else

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture and other oriental medical procedures (or for the patient named below, for whom I am legally responsible) by Martin Herbkersman, D.Ac. and/or any other acupuncturist licensed in South Carolina who now or in the future may be employed by, working or associated with the treating acupuncturist named above, including those working at this clinic or any other office or clinic.

I understand that the methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tui na, Chinese or western herbal medicine, and nutritional counseling. I also understand that I will not be given a medical diagnosis. For a medical diagnosis I will seek the services of a physician. Any diagnosis referred to by the above listed practitioners of this office are related to Traditional Chinese or Asian Medicine. Further, if my condition(s) has not demonstrated clinical improvement within three consecutive months of initial treatment, I understand that I may need to seek a medical diagnosis from a licensed medical doctor or dentist before continuing acupuncture treatments.

I have had the opportunity to discuss with the acupuncturist named above, and/or with the office or clinic personnel, the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the sites of needle insertion that may last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances of spontaneous miscarriages, that may or may not have resulted from treatment, and pneumothorax. There may be some bruising after cupping.

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 some herbs may be inappropriate during pregnancy. If I experience gastrointestinal upset or allergic reaction to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to explain all of the risk and complications, and I wish to rely on the acupuncturists to exercise judgement during the course of the procedure prescribed by the acupuncturist at the time, based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that payment is due at the time of treatment and I accept financial responsibility for all treatment received whether or not 3rd party payers are involved.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about it's content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my current conditions and for which I seek treatment.

To be completed by the Patient:

Patient's Name (Please Print) **Patient's Representative if applicable (Please Print)**

Patient's Signature **Date** **Patient's Representative Signature** **Date**

Martin Herbkersman, D.Ac. is a National Board Certified (NCCAOM) Acupuncturist and Herbologist registered to practice Acupuncture in South Carolina, certificate # 00057.

Cancellation Policy:

Your treatment time has been reserved especially for you. If you need to reschedule or cancel an appointment, I ask that you kindly give a minimum of 24 hours notice.

Messages received after close of business day are considered to have been received the following business day and will not fulfill the 24 hour requirement.

Same day cancellations or no-shows are subject to full charge of service against their account.

Signature_____ Date_____