Transforming Touch Acupuncture
Earl Hinds, L.Ac. Date_____________
Jill Janoff, CMT

Health History Questionnaire

Please help me by taking the time to fill out this questionnaire thoroughly. This information is held in strict confidentiality. If you have any questions, please ask. If there is anything you wish to bring to my attention that isn't asked on this form, please note it in the *Comments* section. Thank you for your help.

Name________________________________ Date of Birth______________ Age______

Phone # (H)__________________ (W)____________________(C)___________________

Address____

Height____________ Weight_________ Gender Male______ Female_____

Employer__________________________ Occupation____________________________

Social Security #___________________ Referred By ___________________________

E-mail Address____

Marital Status [circle one] Single Married Divorced Widowed

Spouse / Partner's Name________________________ phone______________________

Emergency Contact [if other than spouse/partner] ___________________________________

phone__________________________

Primary Care Physician_________________________ Phone ______________________

Physician's Address ____

Have you ever received acupuncture before? (Y) (N) If yes for what reason(s)?

____

____

What is the chief condition or health challenge you are seeking to change?

____

____

How long have you had this condition? ______________________________________

To what extent does it interfere with your daily life? ___________________________

____

Have you been given a Western medical diagnosis for the problem? (Y) (N)

If yes, what? ____

List treatments/medications used for relief of this issue ______________________

____

____

Please note the degree of severity of your chief complaint today:

No Problem ____ Worst Imaginable

1 2 3 4 5 6 7 8 9 10

Please note the greatest degree of severity of your chief complaint to date:

No Problem ____ Worst Imaginable

1 2 3 4 5 6 7 8 9 10

List any other health conditions you are seeking to change

____

____

List any other therapies you currently use and for what purpose

____

____

____

Comments: ____

____

____

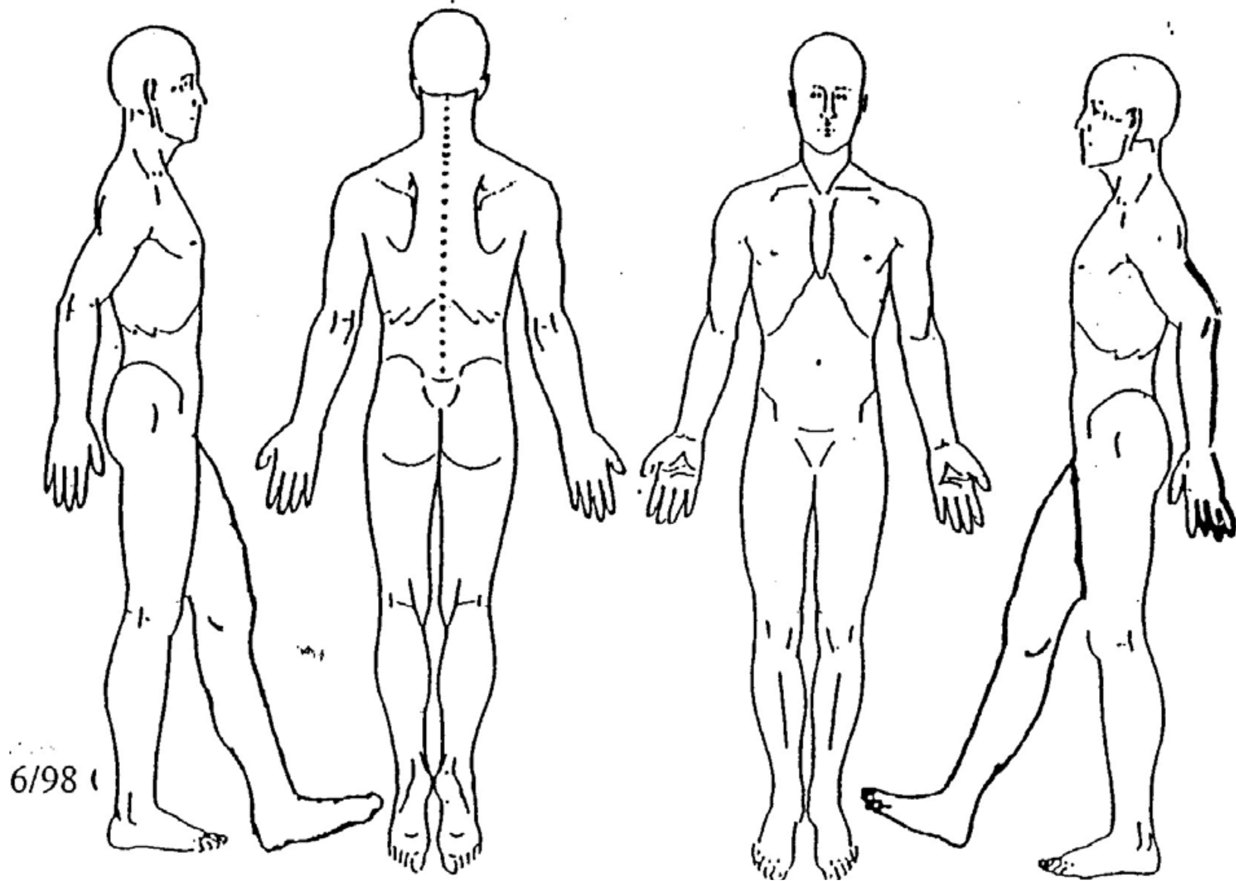
____

On the Chart below please indicate any areas where you currently experience any pain, stiffness or loss of range of motion or decreased function.

Please note the quality of the pain-dull, aching, sharp, or burning

Please mark locations of old injuries or traumas and approximately when they occurred.

Use the space below the chart for any further explanation.



Past Medical History—please elaborate, as appropriate

- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other

Surgeries & Hospitalizations (type & dates) ____

____

Dental History (oral surgery, braces, trauma) ____

____

Mental/Emotional/Physical Trauma ____

____

Known allergies (drugs, chemicals, foods, etc.) ____

____

Occupational Stress (chemical, physical, psychological) ____

____

Your Birth History (prolonged labor, forceps, premature, etc.) ____

____

What medications / vitamins / supplements are you taking? ____

____

Have you undergone any courses of antibiotics recently? Many Moderate Few None

Family Medical History—please elaborate, as appropriate, and note which family member(s)

- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other

Habits & Lifestyle

Do you exercise regularly? Please describe: ____

Please describe the type of foods you eat daily:

Morning ____

Midday ____

Afternoon ____

Evening ____

Please check any of the habits below that apply to you, now or in the past, and indicate your usage per day or week:

☐ Tobacco___________ per___________ Age started___________ Age quit_____________
☐ Alcohol _____________per ___________Age started ___________Age quit _____________
☐ Coffee _____________per ___________Age started ___________Age quit _____________
☐ Marijuana ___________per ___________Age started ___________Age quit _____________
☐ Cocaine ___________per ___________Age started ___________Age quit _____________
☐ Heroin _____________per ___________Age started ___________Age quit _____________
☐ Amphetamines _____per ___________Age started ___________Age quit _____________
☐ Other _____________per ___________Age started ___________Age quit _____________

Have you experienced any of the following conditions?

Please check all the boxes that apply and add any information on the following page.

General

Past Current

- ☐ ☐ Catch cold easily
- ☐ ☐ Recurrent infections
- ☐ ☐ Night sweats
- ☐ ☐ Sweat easily
- ☐ ☐ Bleed or bruise easily
- ☐ ☐ Strong thirst(hot cold)
- ☐ ☐ Thirst
- ☐ ☐ No desire to drink
- ☐ ☐ Fatigue / low energy
- ☐ ☐ Sudden energy drops

  Time of day? ____________________
- ☐ ☐ sudden weight change
- ☐ ☐ low body weight
- ☐ ☐ unable to gain weight
- ☐ ☐ unable to lose weight
- ☐ ☐ Food allergy
- ☐ ☐ perspire easily

Sleep

Past Current

- ☐ ☐ Difficult to fall asleep
- ☐ ☐ Wake up easily during the night

Times per night?______
- ☐ ☐ Wake too early in morning

What time?___________
- ☐ ☐ Wake too early in morning; can't go back to sleep

What time?___________
- ☐ ☐ Nightmares

Bad dreams

Bad dreams
- ☐ ☐ Vivid dreams
- ☐ ☐ Grinding teeth
- ☐ ☐ Talking in sleep
- ☐ ☐ Sleepwalking
- ☐ ☐ Snoring

  Other

Skin / Hair

Past Current

- ☐ ☐ Dry skin / scalp / hair
- ☐ ☐ Rashes / hives
- ☐ ☐ Itching
- ☐ ☐ Eczema
- ☐ ☐ Warts
- ☐ ☐ Acne
- ☐ ☐ Change in moles
- ☐ ☐ Skin eruptions

Skin / Hair, cont.

- ☐ ☐ Hair loss
- ☐ ☐ Thinning hair
- ☐ ☐ Graying of hair

  Other

Head Eyes/Ears/Nose/Throat

Past Current

- ☐ ☐ Headaches

  Where?____________

  When? ____________
- ☐ ☐ Migraines
- ☐ ☐ Dizziness / vertigo
- ☐ ☐ Earache
- ☐ ☐ Ear Discharge
- ☐ ☐ Hearing Change
- ☐ ☐ Ringing in ears

  High pitch?____

  Low pitch? ____
- ☐ ☐ Blurry vision
- ☐ ☐ Night blindness
- ☐ ☐ Color blindness
- ☐ ☐ Spots before eyes
- ☐ ☐ Sore eyes
- ☐ ☐ Eye pain
- ☐ ☐ Excessive tearing
- ☐ ☐ Dry eyes
- ☐ ☐ Glasses / contacts
- ☐ ☐ Facial pain
- ☐ ☐ Facial paralysis
- ☐ ☐ Nosebleeds
- ☐ ☐ Nasal discharge
- ☐ ☐ Blocked nose
- ☐ ☐ Sinus congestion
- ☐ ☐ TMJ
- ☐ ☐ Teeth / gum problems
- ☐ ☐ Recurrent sore throat
- ☐ ☐ Hoarseness
- ☐ ☐ Loss of voice
- ☐ ☐ Tonsillitis
- ☐ ☐ Swollen glands
- ☐ ☐ Lips / mouth / gums Sores

  Other

Respiratory

Past Current

- ☐ ☐ Pain with breathing
- ☐ ☐ Difficulty breathing
- ☐ ☐ Shallow breathing
- ☐ ☐ Shortness of breath
- ☐ ☐ Production of phlegm

Respiratory, cont.

- ☐ ☐ Recurrent / chronic cough
- ☐ ☐ Coughing blood
- ☐ ☐ Asthma / wheezing
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia

Cardiovascular

Past Current

- ☐ ☐ Pacemaker
- ☐ ☐ High blood pressure
- ☐ ☐ Low blood pressure
- ☐ ☐ Chest discomfort
- ☐ ☐ Chest pain
- ☐ ☐ Heart palpitations
- ☐ ☐ Tachycardia
- ☐ ☐ Cold hands or feet
- ☐ ☐ Swelling of hands or feet
- ☐ ☐ Blood clots
- ☐ ☐ Spider veins
- ☐ ☐ Fainting
- ☐ ☐ Anemia

  Other

Genito-urinary

Past Current

- ☐ ☐ Pain on urination
- ☐ ☐ Urgent urination
- ☐ ☐ Frequent urination
- ☐ ☐ Decreased urination
- ☐ ☐ Blood in urine
- ☐ ☐ Cloudy urine
- ☐ ☐ Change in urinary flow
- ☐ ☐ Urinary incontinence
- ☐ ☐ Incontinence at night
- ☐ ☐ Dribbling urination
- ☐ ☐ Do you wake to urinate?

How many times?_____
- ☐ ☐ Recurrent bladder infections
- ☐ ☐ Recurrent yeast infections
- ☐ ☐ Kidney stones
- ☐ ☐ Prostate problems
- ☐ ☐ PSA Level? ____
- ☐ ☐ Sexual drive Change
- ☐ ☐ Impotence
- ☐ ☐ Rashes / itching

  Other

Gynecological
Past Current
☐ ☐ Irregular periods
☐ ☐ Painful periods
☐ ☐ Premenstrual syndrome
Age of first menses____
days between menses ___________________
menses duration ______
1st day of last menses ___________________
☐ ☐ Menstrual cramping
Usual days of flow _____
flow type
Light__Medium__Heavy__
☐ ☐ Clots
☐ ☐ Discharge between cycles
☐ ☐ Endometriosis
☐ ☐ Menopausal syndrome
☐ ☐ Abnormal PAP smear
☐ ☐ Abnormal bleeding
☐ ☐ Postcoital bleeding
☐ ☐ Postcoital pain
☐ ☐ Fibroids
☐ ☐ Infertility
Hysterectomy surgery date__________
☐ ☐ Vaginal dryness
☐ ☐ Vaginal discharge
☐ ☐ Vaginal sores
☐ ☐ Vaginal pain/infections
☐ ☐ Genital herpes
☐ ☐ Sexual dysfunction
☐ ☐ Breast pain
☐ ☐ Breast lumps
☐ ☐ Nipple discharge
Last mammogram date: ____________
Other
Are you now pregnant?
yes ___ no ____
Do you practice birth control?
yes ___ no ____
what type & how long? ___________________
# of pregnancies ______
births ______________
premature births _____
abortions ___________
Cesareans __________
D&C's _____________
Age of menopause ___________________

Gynecological, cont.
Date of last PAP ______
other female concerns not addressed____________ ___________________

Digestive
Past Current
☐ ☐ Little appetite
☐ ☐ Strong appetite
☐ ☐ Hunger, no desire to eat
☐ ☐ Bad breath
☐ ☐ Belching
☐ ☐ Nausea
☐ ☐ Vomiting
☐ ☐ Heartburn
☐ ☐ Indigestion
☐ ☐ Bloating
☐ ☐ Abdominal pain
☐ ☐ Weight gain
☐ ☐ Weight loss
☐ ☐ Loose stools
☐ ☐ Diarrhea
☐ ☐ Dysentery
☐ ☐ Strong smelling stools
☐ ☐ Bloody stools
☐ ☐ Pale stools
☐ ☐ Green stools
☐ ☐ Black, tarry stools
☐ ☐ Constipation
☐ ☐ Dry stools
☐ ☐ not daily
☐ ☐ with difficulty
☐ ☐ Pain with passing stools
☐ ☐ Gas / flatulence
☐ ☐ Rectal pain
☐ ☐ Hemorrhoids
☐ ☐ Gall bladder problems
☐ ☐ Appendicitis
☐ ☐ Hernia
☐ ☐ Anorexia nervosa
☐ ☐ Bulimia
Other

Musculoskeletal
Past Current
☐ ☐ Neck pain
☐ ☐ Shoulder pain
☐ ☐ Back pain
☐ ☐ Hand / wrist pain
☐ ☐ Knee pain
☐ ☐ Foot / ankle pain
☐ ☐ Joint / bone problems
☐ ☐ Muscle pain

Musculoskeletal, cont.
☐ ☐ Muscle weakness
☐ ☐ Osteopenia
☐ ☐ Osteoporosis
☐ ☐ Herniated disc level _________
☐ ☐ Sciatica
Other

Neurological / Mental
Past Current
☐ ☐ Seizures
☐ ☐ Paralysis
☐ ☐ Tremors
☐ ☐ Stroke
☐ ☐ Concussion
☐ ☐ Nerve damage
☐ ☐ Numbness / tingling
☐ ☐ Dizziness / vertigo
☐ ☐ Lack of coordination
☐ ☐ Loss of balance
☐ ☐ Poor memory
☐ ☐ Difficulty concentrating
Other

Psychological / Behavioral
Past Current
☐ ☐ Depression
☐ ☐ Manic Behavior
☐ ☐ Anxiety / nervousness
☐ ☐ Panic attacks
☐ ☐ Often stressed
☐ ☐ Easily angered
☐ ☐ Aggressive behavior
☐ ☐ Lose control of emotions
☐ ☐ Substance abuse
Other
Have you ever been treated for emotional problems?
yes____ no____
Have you ever considered or attempted suicide?
yes____ no____

Infection Screening
Have you ever tested positive? When?
☐ ☐ HIV ___________
☐ ☐ Tuberculosis ___
☐ ☐ Hepatitis _______
☐ ☐ Gonorrhea _____
☐ ☐ Syphilis ________
☐ ☐ Herpes (oral / genital) _____________

Explain special areas of concern from the list

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Mandatory Disclosure of Information

Please read this document carefully and sign where indicated

You are the most important person on your health-care team and as such, are entitled to receive clear and comprehensive information about the modalities and techniques of your therapy. Becoming informed and understanding what to expect from your treatment at the beginning will help make your experience more comfortable and more effective. If you have questions about your health, your treatment, or any aspect of acupuncture, therapeutic bodywork or traditional Chinese medicine, please feel free to contact me.

Before Your Treatment

To facilitate your treatment, please wear loose, comfortable clothing that can be pulled high enough to expose your elbows and knees. It's a good idea to have a light meal before acupuncture, but don't arrive uncomfortably full. Avoid consuming alcohol and caffeine before and immediately after your visit; likewise with strenuous exercise.

Please do not brush or scrape your tongue before coming in for treatment—the tongue's natural coating is one of our primary diagnostic tools and, once brushed off, is lost to us for the day. Coffee, cigarettes, and artificially colored foods, while not advisable under most circumstances, can also stain your tongue coat and are best avoided in the hours before a treatment.

After Your Treatment

Though most people feel extremely relaxed after acupuncture, some report feeling a bit lightheaded. If this happens to you, please rest awhile and go for a short walk. It will pass in short order.

Some patients occasionally experience a worsening of their symptoms after an acupuncture treatment. This can be a part of the healing process and is usually soon followed by a marked improvement in overall wellbeing. Please contact our office if you have any concerns or feel any unpleasant effects after your visit. Supplements, herbal prescriptions and herbal patent medicines are intended solely for the person for whom they are dispensed. Please do not share your prescriptions with others.

Cancellation & Late Arrival

If you need to cancel or reschedule your appointment, **please give me at least twenty-four hours' notice**. Without such notice, and except in emergency situations, I reserve the right to charge for missed appointments. Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

Your Privacy

I believe absolutely in the right to privacy of my patients and will never disclose any of your personal information without your express consent, unless required to do so by law.

Please sign and date below to indicate that you have read and understood this information.

____ Date________________________

Signature of patient (or patient's representative, if the patient is a minor or is physically or legally incapacitated)

____

Print name of patient (and representative, if applicable)

We treat many people with allergies and chemical sensitivities.

We value our patients and gratefully appreciate your assistance as we seek to provide a healthy environment for everyone.

For all of our comfort and health please refrain from wearing scented products, especially perfumes. Please also refrain from smoking prior to your appointment.

Thank you,

Transforming Touch

Informed Consent to Treatment

I, ________________________the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of traditional Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by Earl Hinds. L.Ac. and/or other licensed acupuncturists who may treat me now or in the future while working with or associated with Earl Hinds, or who may serve as a substitute for Earl Hinds.
I understand the benefits and risks of acupuncture treatment, other traditional Chinese medicine methods of treatment and therapeutic bodywork.
I understand that some acupuncture points may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform Earl Hinds. Additionally, I will inform Earl Hinds if I have a severe bleeding disorder or if I am wearing a pacemaker or other electronic medical device.
I have had an opportunity to discuss with Earl Hinds and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that there is no implied or stated guarantee of the effectiveness of a specific treatment or series of treatments.
I hereby release Earl Hinds from all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.
I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its 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 present condition and for any future condition(s) for which I seek treatment.

Please sign and date below to indicate that you have read and understood this form.

____ ____________________
Signature of patient (or patient's representative, if the patient is a minor or is physically or legally incapacitated) — Date

____
Print name of patient (and representative, if applicable)

____
Street address of patient (and representative, if applicable)

____
City, state, ZIP code

____
Telephone number

Revised 9/28/17