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

Date_____

Health History Questionnaire

Thank you for 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 our 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

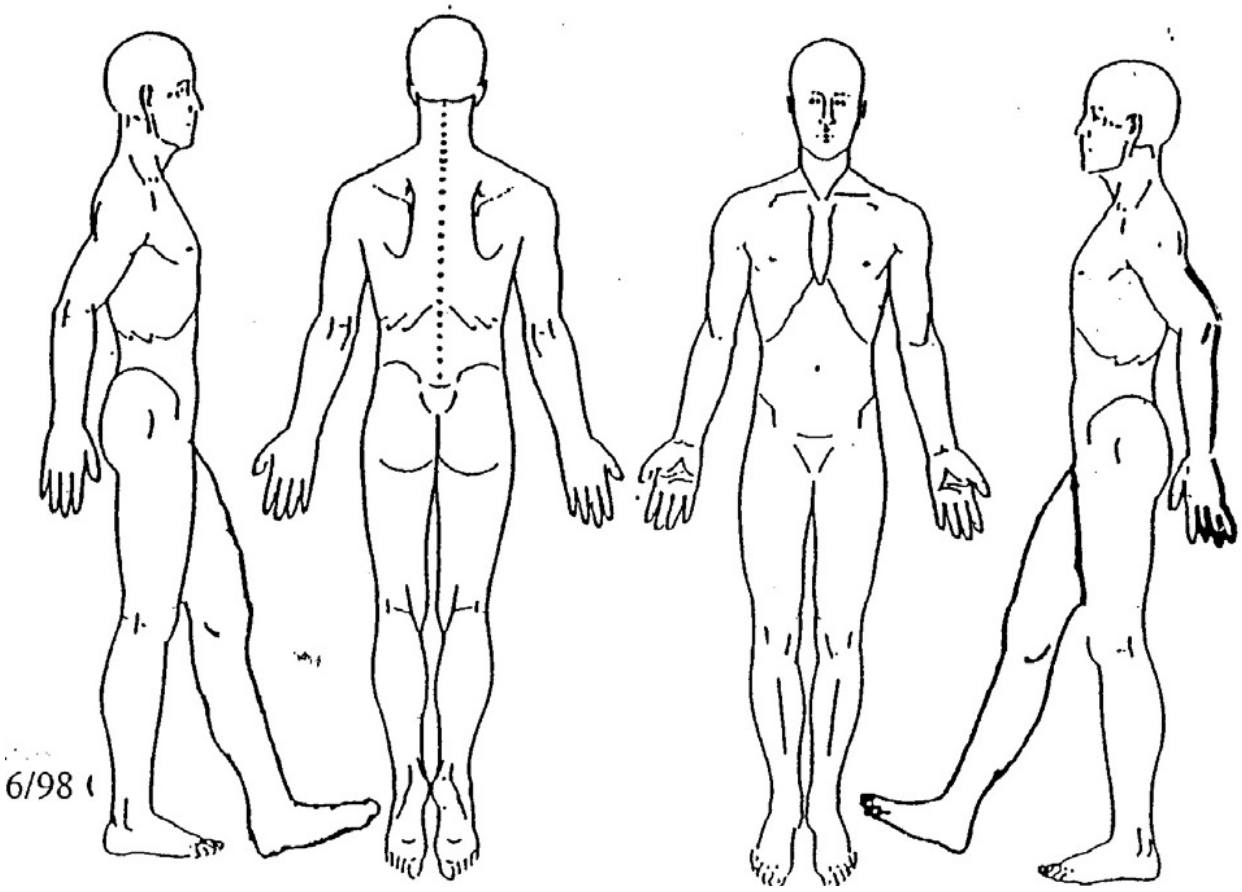
Comments: _____

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

Surgeries & Hospitalizations (type & dates) _____

_____

Significant Traumas _____

_____

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

_____

Occupational Stress (chemical, physical, psychological) _____

_____

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	☐ Drug/Alcohol Abuse	☐ Seizures
☐ Asthma	☐ Heart Disease	☐ Stroke
☐ Cancer	☐ Hepatitis	☐ Thyroid Disease
☐ Diabetes	☐ High Blood Pressure	☐ 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 _____
miscarriages _____
premature births _____
abortions _____
Cesareans _____
D&C's _____

Gynecological, cont.
Age of menopause____
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
Earl Hinds, L. Ac.
Jill Janoff, CMT

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