

Patient Medical History

Patient Information

Name _____ Date _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____

Other Phone _____ E-mail _____

Birth Date _____ Age _____ Soc. Sec. _____ Gender _____

Single Married Divorced Widowed Domestic partnership Other

Emergency Contact _____ Relationship _____

Emergency Contact Phone _____ Office/Cell _____

Physician's Name _____ Phone _____

Physician's Address _____ Date of last visit _____

Employment: Please check all that apply

Full-time Part-time Self-employed Student Unemployed Retired

Occupation _____ Number of hours of work/study per week _____

Employer's Name _____

Phone _____

Employer's Address _____

AREAS OF PAIN

Head

Past Current

Jaw

Past Current

Neck

Past Current

Throat

Past Current

Shoulder

Past Current
Right Left Both

Upper Arm

Past Current
Right Left Both

Elbow

Past Current
Right Left Both

Lower arm

Past Current
Right Left Both

Wrist

Past Current
Right Left Both

Hand

Past Current
Right Left Both

Fingers

Past Current
Right Left Both

Chest

Past Current

Rib/Flank

Past Current
Right Left Both

Abdomen

Past Current
Right Left Both

Upper back

Past Current

Mid back

Past Current

Lower back

Past Current

Hip

Past Current
Right Left Both

Thigh

Past Current
Right Left Both

Knee

Past Current
Right Left Both

Calf

Past Current
Right Left Both

Shin

Past Current
Right Left Both

Ankle

Past Current
Right Left Both

Foot

Past Current
Right Left Both

Heel

Past Current
Right Left Both

Toes

Past Current
Right Left Both

SYMPTOMS

Nausea

Past Current

Gas

Past Current

Diarrhea

Past Current

Vomiting

Past Current

Constipation

Past Current

Belching

Past Current

Abdominal bloating

Past Current

Abdominal pain

Past Current

Blood/black stools

Past Current

Heartburn

Past Current

Decreased appetite

Past Current

Pus in stools

Past Current

Bad breath

Past Current

Indigestion

Past Current

Hemorrhoids

Past Current

Bleeding gums

Past Current

Other current related symptoms

Low energy / fatiguePast Current **Anal fissures**Past Current **Ulcers**Past Current **Crave sweets**Past Current **Rectal pain**Past Current **Excessive appetite**Past Current **Decreased ability to taste or smell**Past Current **Nose bleeds**Past Current **Change in appetite**Past Current **Sweet taste in mouth**Past Current **Sore throat**Past Current **Often feel pensive / thoughtful**Past Current **Difficulty swallowing**Past Current **Edema**Past Current **Laryngitis**Past Current **Hoarse voice**Past Current **Frequent colds**Past Current **Sinus infection**Past Current **Cough**Past Current **Cough with blood**Past Current **Production of phlegm**Past Current **Hay fever or allergies**Past Current **Asthma**Past Current **Bronchitis**Past Current **Pneumonia**Past Current **Chronic obstructive pulmonary disease**Past Current **Dry skin**Past Current **Itching**Past Current **Acne**Past Current **Rashes**Past Current **Hives**Past Current **Eczema**Past Current **Psoriasis**Past Current **Crave pungent foods**Past Current **Often feel sad**Past Current **Frequent irritation**Past Current **Impotence**Past Current **Urgency to urinate**Past Current **Premature ejaculation**Past Current **Pain on urination**Past Current **Urine / bowel incontinence**Past Current **Weak urine stream**Past Current **Blood in urine**Past Current **Kidney stones**Past Current **Low back pain**Past Current **Sore/weak knees**Past Current **Crave salty foods**Past Current **Often feel afraid**Past Current **Frequent urinary tract infections**Past Current **Pelvic inflammatory disease**Past Current

Other current related symptoms

Frequent vaginal infectionsPast Current **Abnormal PAP smear**Past Current **Irregular periods**Past Current **Premenstrual syndrome**Past Current **Painful menstrual bleeding**Past Current **Abnormal bleeding**Past Current **Menopause symptoms**Past Current **Breast lumps**Past Current **Testicular lumps**Past Current **Prostatitis**Past Current **Genital itching/pain**Past Current **Genital lesions/discharge**Past Current **Decreased libido**Past Current **Ear ringing – low pitch**Past Current **Ear ringing – high pitch**Past Current **Decreased hearing**Past Current **Ear infections**Past Current **Total****Pregnancies**

Living

Ectopic

Miscarriages

Induced

Abortions**Dry eyes**Past Current **Red eyes**Past Current **Eye inflammation**Past Current **Blurred vision**Past Current **Poor night vision**Past Current **Floaters**

(spots in visual field)

Past Current **Visual changes**Past Current **Glasses/contact lenses**Past Current **Cataracts**Past Current **Crave sour foods**Past Current **Insomnia**Past Current **Excessive/vivid dreams**Past Current **Grinding teeth**Past Current **Depression**Past Current **Anxiety/stress**Past Current **Irritability**Past Current **Treated for emotional/
psychological problems**Past Current **Indecisiveness**Past Current **Often feel angry**Past Current **Migraine**Past Current **Dizziness**Past Current **Fainting**Past Current **Seizures**Past Current **Localized weakness**Past Current **Numbness or tingling of limbs**Past Current **Tremors**Past Current **Poor circulation**Past Current **Paralysis**Past Current **Aversion to wind**Past Current **Other current related symptoms**

Tendinitis

Past Current

Gallstones

Past Current

High blood pressure

Past Current

Low blood pressure

Past Current

Palpitations

Past Current

Irregular heart beat

Past Current

Chest pain or pressure

Past Current

Jaw, neck, shoulder, arm pain

Past Current

Nausea

Past Current

Swollen hands or feet

Past Current

Blood clotting

Past Current

Phlebitis

Past Current

Poor memory

Past Current

Crave bitter foods

Past Current

Usually feel happy

Past Current

Fevers

Past Current

Frequent or strong thirst

Past Current

Often feel warmer than others

Past Current

Tend to feel colder than others

Past Current

Concussion

Past Current

Night sweats

Past Current

Sweat easily

Past Current

Chills

Past Current

Cold hands/feet

Past Current

Cold sweats

Past Current

Headache

Past Current

Neck stiffness

Past Current

Enlarged lymph glands

Past Current

Prefer warm food and drink

Past Current

Prefer cold food and drink

Past Current

Tumor or lumps

Past Current

INFECTIOUS DISEASES

HIV

Past Current

TB

Past Current

Hepatitis

Past Current

Gonorrhea

Past Current

Chlamydia

Past Current

Syphilis

Past Current

Genital warts

Past Current

Herpes oral/genital

Past Current

Other current related symptoms

Have you ever had acupuncture before? Yes No

If so, for what condition?

Family history: Complete for each family member, placing an X in the appropriate box:

	Self	Mother	Father	Sisters	Brothers	Spouse	Child
Allergies							
Blood disorder/anemia							
Diabetes							
Cancer or tumors							
Seizures							
High blood pressure							
Kidney or bladder disorder							
Stomach or intestinal disorder							
Drug abuse							
Tuberculosis							
Heart disease							
Stroke							
Depression/mental illness							
Other							
Age at death							

Major Hospitalizations – Please list any hospitalizations or surgeries you have undergone

Operation or illness _____ Year _____

Name of hospital _____

City _____ State _____

Medicines, Herbs, and Supplements

Check any medications you are currently taking

- | | | |
|---|---|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Fiber or other laxatives | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Anti-depressants |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Oral contraceptives |
| <input type="checkbox"/> Sleeping pills | <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Allergy medication |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Diet pills | |

Western drugs _____

Herbs _____

Supplements _____

Allergies Yes No

Medication _____

Food _____

Habits

Please check any habits which apply to you now or in the past

Coffee	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____
Tobacco	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____
Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____
Crack	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____
Cocaine	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____
Heroin	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____
Marijuana	Yes <input type="checkbox"/> No <input type="checkbox"/>	per day/week _____	age started _____	age quit _____

Please describe any restricted diet you follow(ed) now or in the past

Please describe your typical daily diet

Breakfast

Morning snack

Lunch

Afternoon snack

Dinner

Evening snack

Please describe any regular program of exercise.

Do you have a religious or spiritual practice? If so, please describe.

Informed Consent To Treatment and Treatment Policies

I, _____
print first and last name

give consent to receive acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Marnie McCurdy, LAc., and /or any guest acupuncturist working under her supervision. I understand that the methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electric stimulation, Tui-Na massage, herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including, but not limited to: bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Other risks of acupuncture treatment could include (although unusual and extremely rare) spontaneous miscarriage, nerve damage, and organ puncture (including lung puncture - pneumothorax).

Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is another possible risk of treatment. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the acupuncturist to be able to anticipate all possible complications from treatment, but I do wish to rely on the acupuncturist to exercise judgment during the course of treatment which based upon the facts known and my condition, is in my best interests.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are safe in the practice of Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatments are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided verbally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify my practitioner of any unpleasant effects associated with the consumption of herbal teas or products.

- **I will notify my practitioner if I am or become pregnant.**
- **I agree to follow all treatments only as recommended/prescribed. If I am experiencing any side effects or difficulties I will notify practitioner as soon as possible.**
- **I understand the practitioner and clinic staff may review my lab reports, but all my records will be kept strictly confidential and will not be released without my consent.**

Informed Consent To Treatment and Treatment Policies

By voluntarily signing below, I am demonstrating that I have read (or have had read to me) this consent to treatment and treatment policies, have been told about the risks of acupuncture and other procedures, and have had the opportunity to ask questions. I understand this consent is intended to cover my entire course of treatment for my present and future conditions for which I seek treatment at this office.

_____ Date: _____
Patient's/Representative Signature:

By voluntarily signing below, I am consenting to acupuncture and herbal medicine for the sole purpose of labor induction.

_____ Date: _____
Patient's/Representative Signature:

Privacy Policy

All patient information is confidential and private. East-West Integrative Medicine will not share or disclose any personal information for any reason without your consent. Please sign and date to acknowledge that you have read and understand the above statement.

_____ Date: _____
Patient's/Representative Signature:

Should you wish East-West Integrative Medicine to release your information or consult with other physicians regarding your treatment, please initial below.

_____ Date: _____
Initial

I permit East-West Integrative Medicine to leave me phone messages for me.

_____ Date: _____
Initial

Cash and Personal Insurance Financial Agreement

We would like to take a moment to welcome you to our office and familiarize you with our financial policies.

You are financially responsible for all services rendered to you in this office. Payment is made in full (100%) for each visit at the time of visit unless special arrangements have been made with your provider.

Cancellation Policy

No charge will be made for cancellations or appointment changes if 24 hours notice is given. For cancellations with less than 24 hours full price will be charged. Payments need to be made in full by you. Your insurance company will not pay for missed appointments.

Direct Billing Insurance:

1. Discuss your financial situation with your provider if you have special needs.
2. Fill out the insurance portion of the initial intake form.
3. Payment must be made in full for the first visit, and until deductible is met. Co-payments and full payment for supplements must be paid at the time of treatment.
4. If the insurance company does not pay for your treatments within 60 days of the billing by our office, we reserve the right to demand that you pay in full at that time and that you assume the responsibility for collecting payment from your insurance company.
5. Any charge that your insurance company excludes or reduces will need to be paid as soon as they become evident.
6. Insurance coverage is an agreement between you and your insurance company. As a courtesy to you, we will bill your insurance provider, but you are responsible for monitoring and pursuing payment.

I have read and agree to the above. I authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Date: _____

Relationship