Sol Acupuncture
Health Solutions

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Doctor of Acupuncture

Health History Form

This information is strictly confidential.

Date: _____

Name: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home:( ) _____ Work:( ) _____ Cell:( ) _____

Birthdate: _____ Age: _____ Email: _____

What is your primary reason for coming to acupuncture? _____

_____

When did this condition begin? _____

Rate the severity of your condition (10 being the worst): 1 2 3 4 5 6 7 8 9 10

Have you been given a diagnosis for this condition? If so, what? _____

_____

What aggravates your symptoms? _____

What improves your symptoms? _____

Please list any medications you are currently taking, or take as needed: _____

_____

Please list any allergies and/or skin sensitivities (i.e. drugs, chemicals, foods, environmental etc.): _____

_____

Please check if any of the following applies now:
_____Pregnancy _____Flu or Cold _____Hemophilia _____Infection _____Inflammation

Significant Illnesses: Cancer Diabetes Hepatitis High Blood Pressure Auto Immune Diseases
Heart Disease Rheumatic Fever Thyroid Disease Seizures HIV AIDS
Other: _____

Family Medical History: Diabetes Cancer High Blood Pressure Mental Illness Alcoholism
Heart Disease Seizures Asthma Allergies Auto Immune Diseases Other: _____

_____

Surgeries or invasive procedures: (please indicate your age at the time:) _____

_____

_____

Do you have any scars that bother you? _____

Significant traumas/injuries: (auto accidents, broken bones, whiplash, emotional etc.): Please indicate your age at the time. _____

_____

Please check health concerns you have now.

General

□ Always feel Cold □ Poor appetite □ Fatigue
□ Always feel Hot □ Always hungry □ Poor sleeping
□ Sweat easily □ Strong thirst (cold or hot) □ Bleed or bruise easily
□ Night sweats □ Cravings □ Edema
□ Peculiar tastes or smells □ Weight gain/loss □ Sea Sick or Car Sick
□ Tremors □ Anxiety □ Osteopenia/porosis
□ Poor balance □ Depression □ Sudden energy drop. Time of day?

Please circle your energy level on average (from 0-10, 10 being the Best)

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Skin & Hair

□ Rashes □ Pimples □ Hives
□ Itching □ Eczema □ Loss of hair
□ Recent moles □ Dandruff □ Change in hair or skin
□ Dry skin
□ Any other hair or skin problems?

Head, eyes, ears, nose, and throat

□ Seasonal Allergies: What age did this start? _____
Head □ Migraines (what kind / where?)_____ How often?_____
□ Headaches (where?)_____How often?_____
□ Dizziness □ Concussions □ Jaw clicks □ Facial pain
□ Dental problems □ Grinding teeth □ Sores on lips or tongue
Eyes □ Cataracts □ Glaucoma □ Eye strain
□ Glasses □ Eye pain □ Poor vision □ Color blindness
□ Night blindness □ Blurry vision □ Spots in front of eyes
Ears □ Earaches □ Ringing in ears □ Poor hearing □ History of Ear infections
Nose □ Sinus problems □ Nose bleeds □ History of Sinus infections
Throat □ Recurrent sore throats □ Feeling of obstruction in throat

Cardiovascular

□ High blood pressure □ Low blood pressure □ Chest pain
□ Irregular heart beat □ Cold hands and feet □ Fainting
□ Palpitations □ Phlebitis □ Swelling of hands/feet
□ Blood clots □ Difficulty in breathing
□ Any other heart or blood vessel problems?

Respiratory / Immune

□ Cough □ Seasonal Allergies □ Wheeze on inhale
□ Coughing blood □ Asthma □ Wheeze on exhales
□ Bronchitis □ Pneumonia □ Pain with deep breath
□ Difficulty breathing when lying down □ Production of phlegm; what color?
□ Any other lung problems?

Gastrointestinal

□ Nausea	□ Constipation	□ Rectal pain
□ Vomiting	□ Diarrhea	□ Blood in stools
□ Belching	□ Gas	□ Black stools
□ Abdominal pain or cramps	□ Indigestion	□ Hemorrhoids
□ Poor appetite	□ Bad breath	□ Chronic laxative use

□ Any other problems with your stomach or intestines?

Genito-Urinary

□ Pain upon urination	□ Blood in urine	□ Urgency to urinate
□ Unable to hold urine	□ Kidney stones	□ Decrease in urine flow
□ Frequent Urination	□ Sores on genitals	□ Dribbling urine
□ How many times per day do you urinate?		□ History of urinary tract infections

□ Any particular color/odor to your urine:
□ Do you wake up to urinate? If so, how often?
□ Any other problems with your genital or urinary system?

Musculoskeletal

□ Neck pain	□ Hip pain	□ Back pain
□ Shoulder pain	□ Knee pain	
□ Hand/wrist pain	□ Foot/ankle pain	

□ Any other joint or bone problems?

Female

# pregnancies _____	□ Menstrual pain / cramps	□ Irregular periods
# live births _____	□ Breast tenderness	□ Unusual period (heavy, light, etc)
# premature births _____	□ Vaginal Discharge	□ Menstrual Clots
# miscarriages _____	□ Menopause: age _____	□ Spotting or pain between periods
Age of first menses _____	□ Infertility	□ Low libido

Date of last period _____
Number of days period lasts _____ Number of days between cycles _____
Changes in body/psyche prior to period:
Do you practice birth control? If so, what kind?_____

Male

___ Prostrate Gland Problem	___Vasectomy
___ Nighttime urination	___Low libido

Who is your primary care physician?

Are you under the care of any other healthcare practitioners (Chiropractic, Orthopedic, massage therapist, naturopath, etc.)? If so, who?

Additional Comments: Please describe any other conditions that you would like to discuss.

Consent to Treat and Promise to Render Payment

I, _____, hereby authorize Heidi Eberhardt, Licensed Acupuncturist at Sol Acupuncture Health Solutions, to perform any of the following procedures as necessary to give proper assessments, determine treatment approaches, and treat or otherwise address my health concerns.:

Methods, Procedures and Therapeutic Approaches

- **General Diagnostic Procedures:** including but not limited to general physical exam, observation, palpation, and musculoskeletal assessments.
- **Dietary Advice and Therapeutic Nutrition**; **Lifestyle Counseling; Exercise/Stretching/Yoga Prescriptions**
- **Acupuncture:** insertion of sterilized, disposable needles at specific points on the body.
- **Topical Treatments:** cupping, a technique using glass suction cups on the surface of the skin;
- **Thermal Therapies:** includes heat therapies using moxibustion and/or an infrared heat lamp. Moxibustion involves the use of a slow burning Chinese herb for direct or indirect warming of an acupuncture point.
- **Electromagnetic therapies:** includes the use of electrical stimulation, polarity devices and/or magnets applied to acupuncture points.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I also understand that any diagnosis given in the context of acupuncture treatment does not constitute a Western medical diagnosis, and that recommendations may be made to pursue further medical advice or intervention if necessary. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or me or otherwise permitted or required by law.

Financial Obligations

A missed appointment is a loss for everyone; office policy requires 24-hour notice if you are unable to make your appointment, so that the time slot may be offered to someone on the waiting list for treatment. A $35 no show fee will be expected if you miss an appointment, without 24-hour notice. The full treatment fee of $85 will be expected if a second missed appointment occurs.

I, _____, hereby agree to meet all financial obligations as pertains to my treatments in a timely fashion. Discounted payments are allowed on the day of service only. I agree to submit the above missed appointment fees if I do not cancel my appointment with 24-hour notice.

Signature of Patient, Guardian or Legal Representative: **X**_____

Printed Name of Patient, Guardian or Legal Representative: _____

Date: _____