

Confidential Patient Health History & Personal Information

Name: _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Contact Phone: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Date of Birth: ____/____/____ Age: _____ Marital status: _____

Height: _____ Weight: _____ Is this your ideal weight: _____

Blood Pressure: What is your most recent blood pressure reading? ____/____
Date taken? _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this confidential questionnaire as thoroughly as possible. Thank you.

Have you received acupuncture treatment before? When? _____

For what reason? _____

Did acupuncture help your condition? _____

Please identify the health concerns for which you are seeking treatment and the date of onset.

a. _____

b. _____

c. _____

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking and dosage:

Check the box if any of the following statements are true:

- I have sensitive skin/rashes
- I have metal implants
- I have Botox/fillers
- I have a pace maker
- I am taking Coumadin/Warafin
- I am taking lithium
- I have a breast implants
- I am taking an opioid (Codeine, Hydrocodone, Meperidine)

Do you have any infectious diseases? Y N

If yes, please identify: _____

Family History:

Illness	You	Mother	Father	Sibling	Spouse
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hospitalizations/Surgeries/Tests (XRays,CAT Scans, MRI, Special Studies):

Please include reason and date:

Please review the following symptoms and indicate any that you experience.

Symptoms of Qi Deficiency	Occasional	Frequent	Symptoms of Yang Deficiency	Occasional	Frequent
Always tired/low energy			Loose stool early in the morning		
Spontaneous sweating			Urinary incontinence or urgency		
Nasal congestion/runny nose			Nighttime urination		
Catches cold easily			Always feels cold		
Chronic sinus infections			Cold feet at night		
Asthma or seasonal allergies			Heating pad helps pain/cramps		
Food sensitivities			Excessive vaginal discharge		
Shortness of breath			Uterine/vaginal prolapse		
Bloating or fatigue after eating			Edema or ankle swelling		
Craves sweets			Symptoms of Qi and Blood Stag.	Occasional	Frequent
Low appetite			Acid reflux/heartburn		
Difficult concentrating			Difficulty digesting fatty foods		
Loose stool or diarrhea			Bitter taste in mouth		
Feels heavy/sluggish			Severe PMS mood symptoms		
Bruises easily			Prone to anger/rage/irritability		
Symptoms of Blood Deficiency	Occasional	Frequent	Difficulty in making decisions		
Vivid dreams or nightmares			Numbness/tingling		
Heart palpitations/anxiety			Heat and cold intolerance		
Muscle spasms or twitching			Varicose/spider veins		
Hair loss or brittle/weak nails			Chest tightness		
Dizziness/fainting			Sighs frequently		
Floater in field of vision			Flatulence and/or belching		
Diminished night vision			Symptoms of heat	Occasional	Frequent
Dry skin or chapped lips			Tongue or mouth sores		
Difficulty relaxing/agitation			Eczema or psoriasis or rashes		
Cold hands and feet			Bleeding gums		
Tendon tightness			Acne		
Symptoms of K Deficiency	Occasional	Frequent	Constipation		
Lower back or knee pain			Excessive appetite		
Fearful or afraid			Blood in the stool		
Low libido			Craves iced drinks		
Long recovery from illnesses			Other symptoms	Occasional	Frequent
Craves salty foods			Headaches/Migraines		
Adrenal fatigue			Neck/shoulder tension		
Symptoms of Yin Deficiency	Occasional	Frequent	Hemorrhoids		
Hot at night/night sweats			Cystic acne		
Ringing in the ears			Oily skin		
Difficulty falling/staying asleep			UTIs		
Vaginal dryness			Yeast infections		
Dry throat/mouth			Retains water easily		

Women's Health:

Are you menstruating Y N Date of last period _____
Age menses began _____ Age of menopause _____
Number of days in cycle _____ Number of days bleeding _____ Number of days spotting _____
Regular Cycle? Y N

Please check any that apply to your menstrual cycle:

Color of blood

- pale/light red
- red
- bright red
- dark red
- dark/brown/black

Amount/type of blood

- light
- heavy
- even throughout
- clots
- thick
- thin/watery

Cramps

- Yes No
- before Period after during
- mild pain moderate severe
- stabbing pain achy Pain
- constant pain comes and goes
- Location of Pain: _____

Other

- Swollen breast
- Weepy/Sad
- Increased appetite
- Excessive fatigue before or after period? _____
- Headaches
- Irritable /Angry
- Decreased appetite
- Insomnia
- Change in bowel movements
- Food cravings _____
- * Other Symptoms: _____

Do any of the following pertain to you?

- live births # _____
- miscarriage # _____
- termination # _____
- C-section # _____
- traumatic birth experience
- birth control, type used/ how long? _____
- fibroids /cysts
- endometriosis
- vaginal discharge
- vaginal odor
- STD/PID _____
- human papillomavirus (HPV)
- breast/ovarian/uterine cancer
- fibrocystic breast

Are you pregnant now? Are you trying to pregnant? If yes, how long? _____

Have you been diagnosed with infertility?
When? _____
Cause of infertility? _____

Have you/ Are you/ Do you plan on using IVF or other ART (Assisted Reproductive Technology)? Y N
If you have used IVF or other ART was it successful? Y N
Please detail your history or plan with any medicated Assisted Reproductive Technology:

Lifestyle:

Do you exercise Y N If so, describe what you do and how often _____

How many hours per night do you sleep? _____ Do you wake rested? Y N
If you do not sleep well, explain the issue: _____

Occupation: _____ How many work hours/week: _____

Do you like your work? _____

How stressful is your work on a scale from 1 (no stress) to 10 (high stress)? _____

Other stresses in your life? _____

Please indicate the use of the following:

Coffee/Black tea: Y N How many/day: _____ Tobacco: Y N How much: _____

Water intake: Y N How many glasses/day: _____ Soda: Y N How many/week: _____

Non-Medical Drugs: Y N How often: _____ Alcohol: Y N How many /week: _____

Describe your typical diet:

breakfast

lunch

dinner

snacks

Other information you would like to report:

Consent to Treatment Form

By signing below, I (or the patient named below, for whom I am legally responsible) do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by **Michelle Luiz, LAc** at **The Womb Wellness Center**. I understand that Chinese Medical Practitioners practicing in the state of Ohio are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxa, gua-sha/cupping, Chinese herbal medicine and nutritional counseling.

Acupuncture and Moxa: I understand that acupuncture is performed by the insertion of needles through the skin and that moxa is the application of heat at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I have been informed that acupuncture and moxa are generally safe methods of treatment, but that it may have some side effects. Side effects may include: **bruising, numbness or tingling, and dizziness or fainting**. I understand that I should not move while the needles are being inserted or retained or while moxa is being performed and that doing so may cause pain or burning. Unusual and rare risks of acupuncture include, but are not limited to, nerve damage, organ puncture and infection. **This clinic uses sterile disposable needles and maintains a clean and safe environment.**

Gua Sha/Cupping: I understand that if I receive Gua Sha or Cupping that there will be sub-cutaneous blemishing/discoloration that will last 3 or 4 days. I understand that I may refuse this therapy.

Chinese Herbs: I understand that I may refuse taking herbs. 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, although some may be toxic in large doses. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I understand that some herbs may be inappropriate during pregnancy and will notify the clinic if I become (or suspect I am) pregnant. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

Should I experience any problems, which I associate with these substances, I should stop taking them and call The Womb Wellness Center as soon as possible.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

The Womb Wellness Center 24 Hour Cancellation Policy:

24 hour advance notice is required when canceling or rescheduling your appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give 24 hours notice you will be responsible for paying the full amount of your appointment fee.

Please initial your understanding of this policy _____

Signature: _____ **Date:** _____

Printed Name: _____

How did you hear about us? Please check all that apply:

Web Social media Friend or family Professional/provider

Who referred you? _____

May we thank them? Yes No



COVID19 Safety Form

Additional Health Questions:

- Have you had a fever in the last 24 hours of 100°F or above? Y/N
- Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, cough, or shortness of breath? Y/N
- Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Y/N

Modified Cancellation Policy

24-hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24-hours advance notice you will be charged the full amount of your appointment. *If you are experiencing respiratory or flu like symptoms including, fever, cough, or shortness of breath you must reschedule your appointment and you will not be charged the cancellation fee. Please give us as much notification as possible.*

I understand that if at anytime in the future I reply yes to any of the above health questions prior to my appointment in the studio I must call to reschedule my appointment. _____ initial

Consent

I understand that, because acupuncture and massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive acupuncture and/or massage from a practitioner at The Womb Wellness Center.

Client Name _____

Signature _____

Date _____