HEALTH HISTORY QUESTIONNAIRE

Welcome to the North Jersey Center for Acupuncture and Oriental Medicine. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your answers will be held absolutely confidential in conformation with our Privacy Policy. If you have questions, please ask us.

Name:

Street: City State Zip

Age: Height: Weight:

Home Phone: Mobile Phone:

Date of Birth: Marital Status:

E-mail: Occupation:

Emergency Contact (name & phone number):

Referred by:

Family Physician:

Insurance Carrier: Policy Number:

Have you tried acupuncture or Chinese herbal medicine before?

MAIN PROBLEM(S) YOU WOULD LIKE TO ADDRESS

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

How long has it been since you first noticed any symptoms?

Have you been given a diagnosis for the problem by a physician?

If so, what is it?

What kinds of treatment or therapy have you tried?

PAST MEDICAL HISTORY (PLEASE INCLUDE DATES)

- ☐ Allergies:
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma (prolonged labor, forceps delivery, etc.)
- ☐ Other significant illness (describe)
- ☐ Accidents or significant trauma (describe)

OTHER RELEVANT MEDICAL HISTORY

FAMILY MEDICAL HISTORY

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Seizures
- ☐ Stroke
- ☐ Other

OCCUPATION

Occupational stress factors (physical, psychological, chemical):

LIFESTYLE

Do you follow a regular exercise program? If so, please describe:

Please describe your average daily diet:

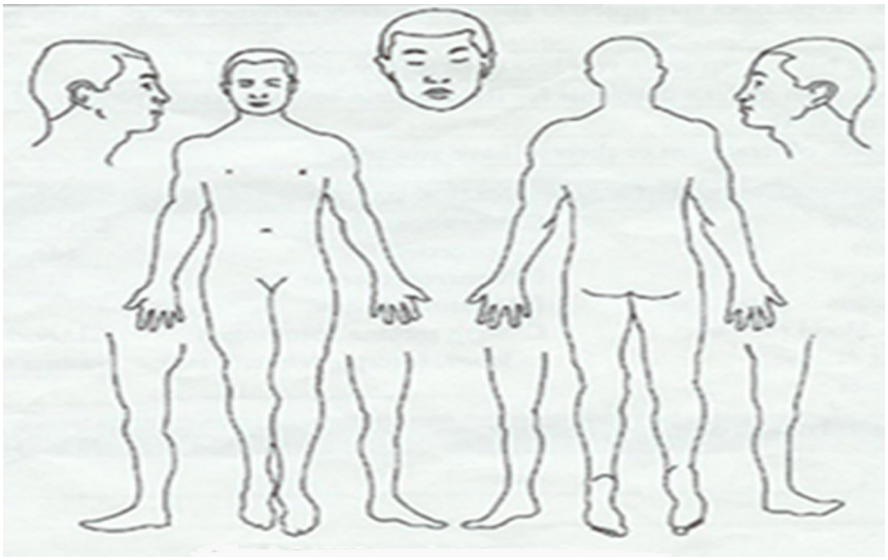
Please check any of the following habits that apply. How much and how often do you use them?

- ☐ Cigarette smoking
- ☐ Coffee, tea or cola
- ☐ Alcoholic beverages

List medications taken within the last two months (vitamins, drugs, herbs, etc.):

Please describe any use of drugs for non-medical purposes:

PLEASE MARK PAINFUL OR DISTRESSED AREAS BELOW



PLEASE PUT A CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

GENERAL

- ☐ Poor appetite
- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Localized weakness
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Changes in appetite
- ☐ Sweating easily
- ☐ Tremors
- ☐ Bleeding or bruising easily
- ☐ Night sweats
- ☐ Fever
- ☐ Chills
- ☐ Sudden energy drop (time of day?)
- ☐ Poor balance

Other unusual or abnormal conditions you have noticed in your general sense of health

SKIN AND HAIR

- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair loss
- ☐ Recent moles
- ☐ Changes in texture of hair or skin

Any other hair or skin problems

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Headaches (where? when?)
- ☐ Jaw clicks

Any other head or neck problems

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis

Any other heart or blood vessel problems

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)

Any other lung problems

DIGESTIVE

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

Any other problems with stomach or intestines

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals

Do you wake up at night to urinate? If so, how often?

Any particular color to your urine?

Any other genital or urinary problems

GYNECOLOGIC

- ☐ Premenstrual changes
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Unusual menses
- ☐ Heavy menstrual flow
- ☐ Light menstrual flow
- ☐ Irregular menses
- ☐ Other problems
- ☐ Premature births
- ☐ Miscarriages
- ☐ Abortions

Age at first menses | Age at menopause | Number of pregnancies

Time between cycles | Duration of bleeding | First day of last menses

Do you practice birth control? | If so, what type? | For how long?

Any other gynecologic problems

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pains
- ☐ Hip pain

Any other joint or bone problems

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Dizziness
- ☐ Loss of balance
- ☐ Areas of numbness
- ☐ Poor memory
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety
- ☐ Bad temper
- ☐ Easily susceptible to stress

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems

PLEASE LIST ANY OTHER PROBLEMS YOU WOULD LIKE TO DISCUSS:

North Jersey Center for Acupuncture and Oriental Medicine
Henry McCann, DAOM, L.Ac., Dipl. O.M. Candace Sarges, MAc, L.Ac., Dipl. O.M.
12 Main St, Suite 12-3, Madison, NJ 07940 (973) 660-0110

INFORMED CONSENT AND PRIVACY POLICY

I hereby request and consent to the performance of East Asian Medicine (i.e., Oriental Medicine) treatments including acupuncture and other procedures on me by Henry McCann, DAOM, LAc, Candace Sarges, MAc, LAc and/or other licensed acupuncturists/practitioners of East Asian Medicine who now or in the future treat me while employed by, working or associated with the North Jersey Center for Acupuncture and Oriental Medicine, LLC (NJCAOM).

I understand that East Asian Medicine treatments may include, but are not limited to, acupuncture, micropuncture, moxabustion, cupping, Tuina and other East Asian forms of massage, Gua Sha, traditional Chinese herbal medicine, Qigong, and lifestyle/dietary counseling. I understand that herbs may need to be prepared and the teas consumed according to instructions provided to me either orally or in written form. The herbal teas may have an unpleasant smell and taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of herbs.

I understand that acupuncture is generally a very safe method of treatment with few, but some possible side effects, including bruising, pain, numbness at the needle site, dizziness or fainting. Bruising is a common side effect of cupping and Gua Sha. Moxabustion and the use of heat therapies may in rare instances cause burning or scarring. Chinese herbs (which are from plant, animal and mineral sources) that are recommended are traditionally considered safe when practiced by professional practitioners of East Asian Medicine, although some may be toxic in large doses. I understand that some herbs are inappropriate during pregnancy and along with other herbs or prescription medication. I will notify a staff member at NJCAOM if I become or suspect that I am pregnant. I will also notify a staff member at NJCAOM what drugs (medicinal or recreational) and supplements I take and if there is any change in them. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications and I understand results cannot be guaranteed. I understand that a traditional East Asian medicine assessment of my condition is not the same as a conventional medical diagnosis.

I understand NJCAOM clinical and administrative staff may review my patient records, but all records will be kept confidential and will not be released without my written consent. I also understand NJCAOM will from time to time send me information via mail or e-mail including but not limited to receipts, newsletters and office announcements, but that my name and contact information will *never* be released to any other business or organization. I have been notified that the full NJCAOM Privacy Policy is available online and I understand that I may receive a print copy if I request.

By voluntarily signing below, I show that I have read, or have read to me, the above consent to treatment, have been told about the benefits and risks of the above procedures, and have had an opportunity to ask questions. 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. I also understand NJ state Law requires my acupuncturist to advise me of the importance of consulting a licensed physician regarding my condition.

_____

Patient Signature (or patient representative) Date (relation to patient if not self)

_____

Office Signature Date

North Jersey Center for Acupuncture and Oriental Medicine
北澤西中醫中心
12 Main St, Suite 12-3 Madison, NJ 07940
(973) 660-0110 www.newjerseyacupuncture.com

OFFICE POLICIES

Appointments and Scheduling

• Treatments by appointment only. Emergency appointments are available if there is time in the schedule. Please call.

• Please be on time for appointments. Unfortunately, because schedules are often tight, your treatment time may be shortened if you arrive late. However, if we are running late, you will always receive a full treatment.

Fees and Billing

• The fee for acupuncture is $170 for an initial evaluation/treatment and $95 per subsequent treatment. Treatments typically last from between 40 minutes to one hour. The fee for an herbal consultation only is $105 (this *does not* cover the cost of the herbal formula that is supplied by the pharmacy). Follow-up herbal consultations are at $65. Rates are subject to change upon notification.

• *24 HOURS ADVANCE NOTICE IS REQUESTED FOR CANCELLATIONS. PATIENTS WILL BE RESPONSIBLE FOR THE APPOINTMENT FEE FOR ANY MISSED APPOINTMENTS OR NON-EMERGENCY LATE CANCELLATIONS.*

• Payment is requested at the time of visit. Insurance is not accepted unless previously arranged although you may submit claims to your own company for direct reimbursement. *There will be a $35 charge for returned checks*. We accept all major credit cards.

If you have questions or concerns about these policies please ask.

I have read and agree to the above policies.

_____

Date Signature

North Jersey Center for Acupuncture and Oriental Medicine

Please take a few moments to fill out this form.

It will allow us to better treat you during your time in our office. Thanks!

Name: ..... Date .....

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

SYMPTOM 1: .....…….. 0 1 2 3 4 5 6

..... As good as it
..... could be — As bad as it could be

SYMPTOM 2: .....…….. 0 1 2 3 4 5 6

..... As good as it
..... could be — As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

ACTIVITY: .....…….. 0 1 2 3 4 5 6

..... As good as it
..... could be — As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0 1 2 3 4 5 6

As good as it could be — As bad as it could be

How long have you had Symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years

Are you taking any medication FOR THIS PROBLEM ? Please circle: YES/NO

<u>IF YES:</u>

1. Please write in name of medication, and how much a day/week

.....

2. Is cutting down this medication: Please circle:

Not important a bit important very important not applicable

<u>IF NO:</u>

Is avoiding medication for this problem:

Not important a bit important very important not applicable