



Susquehanna Acupuncture Patient Information & Healing Arts Center

CONFIDENTIAL

The Susquehanna Acupuncture & Healing Arts Center □ 44 W. Market Street □ Marietta, PA 17547
www.SusquehannaAcupuncture.com

Phone: 1-717-429-3166

Welcome to The Susquehanna Acupuncture & Healing Arts Center

Please take a moment to provide us with some information about yourself and your health conditions so that we may do our best to treat you. The Susquehanna Acupuncture & Healing Arts Center considers this information privileged physician/patient communication and will hold it in confidence.

NAME (LAST, FIRST, MIDDLE)	DATE
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AGE	DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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PHONE	EMAIL ADDRESS
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HOME ADDRESS		
CITY	STATE	ZIP

OCCUPATION

EMPLOYED BY		
EMPLOYERS ADDRESS		
CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER
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SPOUSE'S NAME

CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP	PHONE
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ADDITIONAL INFORMATION / NOTES

I understand that I should be evaluated by a physician for the condition for which I am requesting consultation. I understand that treatments through The Susquehanna Acupuncture & Healing Arts Center are based upon Traditional Chinese Medical treatments, including Chinese herbal therapy, and that a Traditional Chinese Medical diagnosis does not necessarily replace a Western Medical diagnosis. I am responsible for my own health, which includes seeking out health care options that are appropriate for the condition for which I am seeking treatment. If no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a Western medical doctor.

Finally, I know that I am free to incorporate the advice of a Western medical doctor into my healthcare regimen, and if I do so, is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

SIGNATURE

DATE



Confirmation Of Care Of Western Medical Physician

Dear Doctor/Patient:

In an effort to update our records and provide the highest standard of care to possible we are requesting you complete the following documentation. It will become part of your file in our office and remain confidential at all times.

Patient please complete the following prior to physician office visit:

Patient Name: _____ Social Security #: _____ - _____ - _____ DOB: ____/____/____

Patient Signature Authorizing Release Of Information: _____

Physicians please complete the following and return to patient or send medical information to:

Name of Physician

Name of Clinic/Hospital

Street Address

City, State, Zip Code

_____ Height _____ Weight: _____ Blood Pressure:

Physician Signature

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44 West Market Street
Marietta, PA 17547**

Thank you, for your prompt completion of this document and return to our office. Your assistance is greatly appreciated. If you have any questions please call (717)-426-3166 we will be happy to help in any way.



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Medical History

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MAJOR COMPLAINT / HEALTH PROBLEM

HOW DID THIS CONDITION DEVELOP?

HOW LONG HAS THIS CONDITION PERSISTED?

IS THERE ANYTHING THAT MAKES IT BETTER?

IS THERE ANYTHING THAT MAKES IT WORSE?

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KIND(S) OF TREATMENT?
WHAT WERE THE RESULTS OF THE TREATMENT?	

LIST ANY SUBSTANCES THAT YOU ARE ALLERGIC TO:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING: MEDICATION	STRENGTH	HOW MANY PER DAY	HOW LONG
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ANY MAJOR SURGERIES YOU HAVE HAD: DATE	PROBLEM / SURGERY
_____	_____
_____	_____
_____	_____

SIGNIFICANT TRAUMA (AUTO ACCIDENTS, FALLS, ETC.)

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Connective Tissue Disease	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> AIDS	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Ruptured Appendix	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	



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Health History

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Please check any symptoms you currently have or have had in the past year.

General

- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

Head & Neck

- Blurred vision
- Heaviness in the head
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache
- Ear discharge
- Eye pain/strain
- Corrected vision
- Nasal obstruction
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems
- Vision – see halos

Respiratory

- Asthma
- Hay fever
- Persistent cough
- Coughing blood
- Shortness of breath
- Recurrent bronchitis
- Phlegm production

- Difficulty inhaling
- Difficulty exhaling

Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain
- Distention in chest or hypochondrium

Gastrointestinal

- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Difficulty swallowing
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Poor appetite
- Stomachache
- Nausea
- Vomiting
- Vomiting blood

Diet/Lifestyle

- Vegetarian
- Healthy diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs
- Eat a lot of sweets
- Take melatonin
- Take steroids
- Exercise regularly
- Exercise excessively

Weight

- Underweight
- Normal for height
- Overweight
- Very overweight

Genitourinary

- Dilute urine
- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Scanty urine
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Musculoskeletal

Pain, weakness, numbness in:

- Arms
- Feet
- Hands
- Joints
- Legs
- Hips
- Neck
- Shoulders
- Pain all over
- Cold limbs
- Knee problems
- Low back pain
- All over weakness
- Lack of strength
- Broken bones

Skin

- Thick skin
- Thin skin
- Broken blood vessels
- Blood not clotting
- Bruise easily
- Discoloration
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps underarm
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out

Neurologic

- Fainting
- Convulsions
- Handwriting change
- Paralysis
- Stroke
- Seizures

- Tremor
- Recent clumsiness
- Drowsiness
- Vertigo

Emotional

- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

Men Only

- Genital pain
- Impotence
- Genital sores
- Lump in testicles
- Penis discharge
- Nocturnal emission
- Low sexual energy

Women Only

- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy periods
- <25 day cycle
- >35 day cycle
- Endometriosis
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitalia
- Low sexual energy
- Vaginal discharges
- Menopausal
- Uterine prolapse
- Facial hair
- Loss of head hair
- May be pregnant



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Women's Fertility History

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Age at which menses began _____

Have your cycles changed since they began? Yes No

How _____

Are your periods painful? Yes No

How many days does the pain last? _____

How many days do you normally bleed? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple
 Brown Black

Is there clotting? Yes No

Do you have premenstrual tension? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you bleed or spot between periods? Yes No

Are your menstrual cycles spaced irregularly? Yes No

How many days are there from one period to the next? _____

Date of last menstrual period _____

Number Years

How many pregnancies have you had? _____

How many children do you have? _____

How many abortions have you had? _____

How many miscarriages have you had? _____

How many times has a D&C been performed? _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a cervical biopsy, operation, cauterization or conization? Yes No

Have you ever had a venereal disease? Yes No

Do you get yeast infections regularly? Yes No

Have you ever been diagnosed with a chlamydial infection? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease? Yes No
Were you treated for it? Yes No

How _____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you been diagnosed with any pelvic abnormalities? Yes No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken oral contraceptives? Yes No

When _____ How long? _____

Have you ever had an IUD? Yes No

When _____ How long? _____

Have you ever taken DepoProvera? Yes No

When _____ How long? _____

Have you had a diagnosis relating to infertility? Yes No

What was it? _____

How long have you been trying to conceive? _____



Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? Yes No

When _____ How long? _____

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No

What were the results? _____

Do you have a single partner
with whom you have been trying to conceive? Yes No

How long have you been married or living together? _____

Has he had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? Yes No

How is your sexual energy? Low Normal High

Do you douche regularly? Yes No

With what? _____

Do you use vaginal lubricants? Yes No

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Do you have excessively oily skin? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

Was your mother exposed to
diethylstilbestrol (DES) when she was pregnant with you? Yes No

Have you been exposed to any
known environmental toxins or hormones? Yes No

Are you presently taking steroids? Yes No

COMMENTS/NOTES