PATIENT HEALTH HISTORY FORM

IDENTIFICATION DATA

Name _____ Today's Date

Address _____ Date of Birth _____ Age

City/Zip _____ Place of Birth

Home Phone ( ) _____ Business Phone ( )

Mobile Phone ( ) _____ Email Address

Gender _____ Partner Status _____ Ethnicity

Education _____ Occupation

FAMILY HISTORY

	Father	Mother	Sibling	Children	Other
Allergies:					
Blood Disorder:					
Diabetes:					
Cancer/Tumors:					
Seizures:					
High Blood Pressure					
Kidney/Bladder:					
Stomach/Intestinal:					
Drug Abuse:					
Tuberculosis:					
Heart Disorder					
Stroke:					
Other:					
Age of Death:					

PERSONAL HEALTH HISTORY

Allergies (Food / Drug) Asthma Cancer Hepatitis Diabetes Thyroid
Digestive Tuberculosis Seizures Stroke High Blood Pressure Other

Hospitalizations:

Date:	Illness:	Hospital/Clinic

Pregnancy History / Number of Children:

Reason for seeking treatment today:

Referred by:

Please list all medications/supplements you are currently taking:

Habits:		Current	Past	Frequency
	Cigarettes			
	Marijuana			
	Rec. Drugs			
	Alcohol			
	Caffeine			

Diet:	(List foods eaten on a typical day)
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	
Restrictions	
Cravings	

Date of Last Physical Exam:
Name of Doctor:
Address/Phone:

While Oriental Medicine has a great deal to offer as a health care system, it cannot totally replace the resources available through biomedical physicians. Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal medicine treatment.

To comply with Article 160, Section 8211.1 (b) of NYS Education Law, we request that you read and sign the following statement:

I/We, the undersigned, do affirm that (patient)
has been advised by Cesar Puello L. Ac, to consult a physician regarding the condition(s) for which above named patient seeks acupuncture and/or herbal medicine treatment.

(patient's signature) (date)

(L.Ac.'s signature) (date)

Cesar Puello L.Ac.
119 West 23rd Street, Suite 701
New York, NY 10011

Name:_____ Date:

Please place a "**C**" next to any conditions you currently experience and a "**P**" next to any condition you have experienced in the past.

GENERAL
____ Insomnia
____ Frequent Dreams / Nightmares
____ Fatigue
____ Aversion to Cold
____ Aversion to Heat
____ Frequent Urination
____ Thirst
____ Depression
____ Irritability
____ Agitation
____ History of Psychiatric Treatment
____ Other

MUSCLES & JOINTS
____ Joint Disorder
____ Muscle Soreness
____ Muscle Weakness
____ Difficulty Walking
____ Spinal Curvature
____ Backache
____ Back Pain
____ Other

HEAD & NECK
____ Headaches / Migraines
____ Neck Stiffness
____ Enlarged Lymph Glands
____ Other

EYES
____ Blurred Vision
____ Visual Changer
____ Poor Night Vision
____ Spots / Floaters
____ Eye Inflammation

____ Other

SKIN
____ Hives
____ Acne
____ Eczema
____ Psoriasis
____ Dryness
____ Bruise Easily
____ Night Sweating
____ Excess Sweating
____ Changes in Moles or Lumps
____ Other

RESPIRATORY
____ Chronic Cough
____ Difficulty Breathing
____ Wheezing / Asthma
____ Frequent Colds
____ Coughing Up Blood
____ Coughing Up Phlegm
____ Other

CARDIOVASCULAR
____ Palpitations
____ Rapid Heart Beat
____ Chest Pain or Tightness
____ Heart Murmur
____ Poor Circulation

____ Cold Hands
____ Cold Feet
____ Ankle Swelling
____ Phlebitis
____ Other

NEUROLOGICAL
____ Seizures
____ Tremors
____ Dizziness
____ Fainting
____ Numbness
____ Tingling
____ Pain
____ Paralysis
____ Other

MALE REPRODUCTIVE
____ Pain / Itching of Genitalia
____ Genital Lesions
____ Discharge
____ Impotence
____ Weak Urinary Stream
____ Lumps in Testicles
____ Prostate Disorder
____ Other

FEMALE REPRODUCTIVE
____ Urinary Tract Infections
____ Vaginal Infections
____ Pain / Itching of Genitalia
____ Genital Lesions
____ Discharge

____ Pelvic Inflammatory Disease
____ Abnormal Pap Smear
____ Irregular Menstrual Periods
____ Painful Menstrual Periods
____ Premenstrual Syndrome
____ Abnormal Bleeding

____ Menopausal Symptoms
____ Breast Disorder
____ Other

EARS, NOSE & THROAT

____ Infection

____ Ringing

____ Diminished Hearing

____ Bleeding
____ Sinus Infection
____ Sore throat
____ Hoarseness
____ Difficulty Swallowing
____ Changes in Taste
____ Changes in Smell
____ Oral Ulcer

GASTROINTESTINAL

____ Nausea / Vomiting

____ Reflux

____ Indigestion

____ Stomach Pain

____ Diarrhea
____ Constipation
____ Poor Appetite
____ Excessive Hunger
____ Food Cravings
____ Hemorrhoids
____ Bloody or Black Stools
____ Other

INFECTION SCREENING

____ HIV Risks: Self or Partner
____ TB: Self or Partner
____ Hepatitis: Self or Partner
____ Parasitic Organisms
____ Herpes
____ Other

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Informed Consent to Acupuncture & Herbal Medicine Treatment

I consent to acupuncture and herbal treatments and other procedures associated with Chinese medicine by the acupuncturist named below. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine, and nutritional counseling.

Acupuncture has the effect of normalizing physiological functions, modifying the perception of pain, and of treating certain diseases and imbalances of the body. Most people experience a sense of well-being and relaxation during and after the treatment. I have been informed that acupuncture is a safe method of treatment, but that occasionally bruising, numbness or tingling at the site of needle insertion may occur after treatment. Bruising is also a possible side effect of cupping. Rare side effects include dizziness or fainting, especially if the patient is overdue for a meal. Burns on the skin are a potential risk of moxibustion; again, this rarely happens. I understand that while this document describes the major risks of treatment, other side effects may occur.

I will notify the acupuncturist if I am or become pregnant, since this will affect the treatment.

I do not expect the acupuncturist to be able to anticipate and explain all of the possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment which, based upon the facts then known, the acupuncturist believes is in my best interests.

I understand that all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other 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.

_____
Name of patient, please print

_____ _____
Signature of patient or legal guardian Date

_____ _____
Signature of practitioner Date