5 Star Oriental Medicine

Patient Medical Questionnaire *Date:*

Full Name:		***Date of Birth:***
Occupation:		***Age:***
Marital Status:		***Height:***
Place of Birth:		***Weight:***
Address:		
City:	***State:***	***Zip Code:***
Home Phone:		***Work Phone:***
Email:		
Family Physician:		
Emergency Contact:		***Phone Number:***

Have you received acupuncture before?

How did you hear about us? friends/relatives (name)

website advertising referral location

Chief Complaint:

What is your chief complaint?

How long have you had this problem?

What diagnosis, if any has been made?

What treatments have you tried?

What aggravates the condition?

What helps relieve condition?

Is there a family history of this condition?

Medical History: *please check all that apply*

cancer	*arthritis*	*high blood pressure*
diabetes	*breathing problems*	*high cholesterol*
hepatitis	*alcoholism*	*venereal disease*
heart disease	*depression*	*emotional disorders*
seizures	*anxiety*	*thyroid disease*
digestive disorders	*epilepsy*	

Surgeries/Hospitalizations and when?

Significant Traumas

Allergies *(drugs, chemicals, foods, environmental)*

When did allergies begin?

Birth History *(if known) i.e. prolonged labor, forceps delivery*

Occupational Stress? *(chemical, physical, psychological)*

How long have you worked at this job?

Diet & Nutrition

Please list all medications, vitamins, minerals, supplements, etc that you take regularly or have been prescribed. Indicate dosages as well. Attach a separate list if necessary.

Do you drink alcohol? _____drinks per week

Caffeine intake- Coffee?_____ozs/day Colas/Sodas?_____ozs/day Tea_____ozs/day

Are you or have you ever been on a restricted diet? *(professionally or self-proscribed)*

Please describe.

How much water do you drink per day?

Are you vegan? Vegetarian? Other?

Do you eat a lot of spicy food?

How many times do you eat out per week?

Please describe your average daily diet. *(please be as specific as possible)*

Morning

Afternoon

Evening

Snacks

Do you feel you have excessive gas (burping and/or flatulence) and/or bloating?

Habits

What time do you go to bed?

How long do you sleep?

What is the quality of your sleep?

How often do you get up to urinate?

Do you exercise? Regularly?

Please describe your routine?

Do you smoke?_____How many packs per day?_____

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

Family & Relationships

Do you have children? *Please list age(s).*

Significant other?

Are you a caretaker for someone?

Other stress in your life?

What do you do to help relieve stress?

Please circle any symptoms that you have experienced within the past 3 months.

General

night sweats	*fatigue*	*cravings*	*poor balance*
sweat easily	*change in appetite*	*desire hot/cold food*	*tremors*
fevers	*poor appetite*	*strong thirst hot/cold*	*local weakness*
chills	*peculiar tastes*	*weight loss/gain*	*numbness*
sudden energy drop? (what time of day?)		*bleed or bruise easily*	

Skin, Hair, Nails

rashes	*ulcerations*	*loss of hair*	*fungus*
itching	*hives*	*dry skin*	*peeling nails*
pimples	*eczema*	*dandruff*	*change in texture*
acne	*psoriasis*	*recent moles*	*change in color*
any other skin, hair or nail changes/problems?			

Head, Eyes, Ears, Nose, Throat

dizziness	*cataracts*	*ringing in ears*	*sores on lips/tongue*
concussions	*eye pain*	*poor hearing*	*grinding teeth*
migraines	*eye strain*	*spots in front of eyes*	*facial pain*
headaches	*night blindness*	*sinus problems*	*teeth problems*
where?	*color blindness*	*nose bleeds*	*jaw lock/click*
glasses	*blurry vision*	*loss of smell*	
poor vision	*earaches*	*recurrent sore or dry throat*	
Any other issues in these areas?			

Cardiovascular

high blood pressure	*blood clots*	*chest pain*	*difficulty breathing*
low blood pressure	*dizziness*	*fainting*	*phlebitis*
irregular heartbeat	*swelling of hands*	*swelling of feet*	*cold hands or feet*
any issues that occur with exertion?		*numbness, itching, loss of feeling in hands or feet*	
loss or lapses of memory		*confused thinking*	

Respiratory

cough	*influenza*	*phlegm or mucus*	*pain with breathing*
coughing blood	*pneumonia*	*profuse?*	*chest pain*
dry cough	*asthma*	*hard to expectorate?*	*chronic issues?*
bronchitis	*wheezing*	*what color?*	

Gastrointestinal

nausea	*flatulence*	*diarrhea*	*abdominal pain/cramps*
vomiting	*hot feeling*	*constipation*	*chronic laxative use*
indigestion	*black stools*	*rectal pain*	*parasites*
bad breath	*bloody stools*	*loose stools*	*hemorrhoids*
belching	*hard to pass*	*greasy stools*	
Bowel Movements - Frequency?	*Color?*	*Form/Texture?*	

Genitourinary

pain on urination	*incontinence*	*blood in urine*	*warts*
urgency	*burning sensation*	*dribbling*	*venereal disease*
difficulty	*kidney stones*	*soreness or pain of genitals*	*itching*
frequent	*what is the color?*	*ulcerations/rashes*	
How many times per day do you urinate?			

Male Reproductory

erectile dysfunction	*impotence*	*testicular pain*
loss of function	*premature ejaculation*	*any pain?*
Have you been treated for any sexual dysfunction?	*discharge*	

Female Reproductory

_____ *number of pregnancies*	_____ *premature births*	*character of menses heavy/light*	
_____ *number of births*	_____ *age at first menses*	*irregular cycle*	*clots*
_____ *miscarriages*	_____ *length of cycle*	*irregular flow*	*size?*
_____ *abortions*	_____ *duration of menses*	*pain - before- during- after*	
birth control use	*changes in body/psyche prior to period? (PMS, PMDD)*		
how long?	*Please describe*		
what type?	*Please describe cramps/pain and where.*		
breast lumps	*breast tenderness*	*hot flashes*	*ovarian cysts*
vaginal infections	*pelvic infection*	*fibroids*	*early menopause*
vaginal discharge	*infertility*	*endometriosis*	*perimenopause*

Neuropsychological

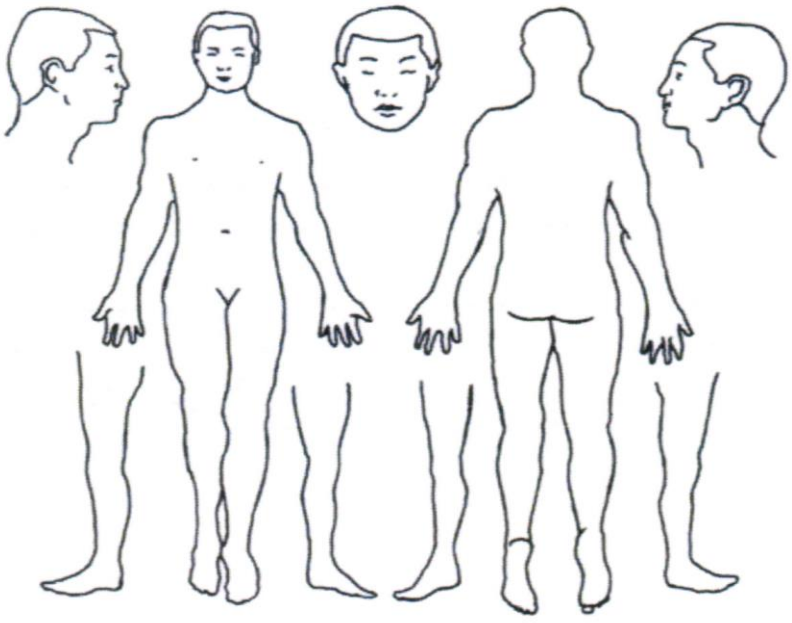
stress	*bipolar*	*concussions*	
Have you ever been treated for emotional problems?	*anxiety*	*seizures*	*irritability*
Have you ever considered or attempted suicide?	*depression*	*lack of coordination*	*burning pains*
Any other neurological or psychological problems?		*learning problems*	*loss of balance*

Muscluoskeletal

deformity (congenital, trauma, or age related)

muscle pains	*joint pain*	*tremors*	*loss of use*
muscle weakness	*tendonitis*	*stiffness*	*joint immobility*

Indicate painful or distressed areas.



5 Star Oriental Medicine

28 Church Street, Mathews, Virginia 23109

Informed Consent to Oriental Medical Health Care

I hereby consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by the licensed acupuncturist(s) and/or certified Asian body worker(s) employed by 5 Star Oriental Medicine: acupuncture and other Oriental medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on my body, observation, range of motion tests, muscle and orthopedic tests, modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy, electric and/or magnetic stimulation, cupping, moxabustion, the prescription of herbal preparations, recommendation of dietary supplements, dietary, exercise and lifestyle recommendations.

I understand I have the opportunity to discuss with my practitioner(s) and/or other clinic personnel the nature and purpose of acupuncture and Oriental medical procedures. I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice of Oriental medicine, there are some risks to treatment. I understand that though these risks are unlikely to occur, they are possible. I understand these risks include, but are not limited to: bruising, bleeding, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, and general aches. Other uncommon but possible risks include pnuemothorax (punctured lung), puncture of other organs, sprains, strains, dislocation, fractures, disc injuries and strokes. I do not expect the practitioners to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioners to exercise such judgment during the course of my treatment, based on the facts then know, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures and conditions of treatment. I intend this consent form to cover the entire course of treatment for my present condition(s) and any future condition(s) for which I seek treatment at 5 Star Oriental Medicine.

_____	_____
Print Patient Name	Patient Signature
_____	_____
Print Patient's Representative Name	Representative Signature
_____	_____
Representative's Relationship or Authority	Date

5 Star Oriental Medicine

28 Church Street Mathews Virginia 23109

I acknowledge that I have been provided access to the 5 Star Oriental Medicine "Notice of Privacy Policies". I understand that I have the right to review the "Notice of Privacy Policies" prior to signing this document.

I understand that 5 Star Oriental Medicine practitioner(s) and employee(s) may need to contact me with information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine, or with anyone who answers the phone.

_____ _____

Patient Name (Print) Patient Signature

_____ _____

Privacy Officer Date

(Optional)

I, _____, hereby authorize 5 Star Oriental Medicine the use or disclosure of my individually identifiable health information to the party(s) described below. I understand this authorization is voluntary. I understand if the party(s) authorized to receive my information is/are not a health plan or health provider, the released information may no longer be protected by federal privacy regulations. The person(s) below may receive my health information over the phone or in print or be involved in discussion of my health history, and may be present for my treatments.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

Patient's Signature Date