The Brand Wellness Center

HEALTH HISTORY

Date: ____ / ____ / _____

Name, first and last (as you would like to be called):		Gender (identity):	Age:
Address:	City:	Zip Code:	
Home Phone #:	Other Phone #: Work Cell Other	Email:	
Date of Birth:	Emergency contact:	Contact #:	Relationship:
Best form of contact:	Want to join our mailing list?	If your legal name is different from your prefered name and you want us to have it, put here:	
What pronouns would you like to be addressed by? (her, him, hir, they, etc.)	Occupation:		
Physician:	Physician's Phone #:		
How did you hear of our clinic? Who can we thank for the referral?	Have you been treated by acupuncture before? ☐ No ☐ Yes ____/____/____		

MAIN CONCERNS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Circle the 🧍 if you have / had the condition and note the year it started.
Circle the 👪 if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?* _____	🧍	_____	👪
Diabetes	🧍	_____	👪
Hepatitis ____	🧍	_____	👪
High Blood Pressure	🧍	_____	👪
Heart Disease	🧍	_____	👪
Stroke	🧍	_____	👪
Seizure Disorder	🧍	_____	👪
Thyroid Disease	🧍	_____	👪
Asthma	🧍	_____	👪
Pacemaker	🧍	_____	👪
Osteoporosis	🧍	_____	👪
Kidney Disease	🧍	_____	👪
Autoimmune Disease	🧍	_____	👪
Anemia	🧍	_____	👪
Rheumatic Fever	🧍	_____	👪
Alcoholism	🧍	_____	👪
Allergies *type(s)?* _____	🧍	_____	👪
Other _____			

Would you like support cutting back on any addictive habits?_____
Are you in recovery?_____
Any recent major life change?_____

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:
_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly (prescribed or otherwise)

_____
_____
_____

SURGERIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

On the following page, please check the appropriate boxes and indicate where you fall on the continuums.

TEMPERATURE

How warm/cold do you feel (not in degrees) relative to other people? (do you wear more or less layers, etc.)

COLD			HOT
☐ Cold hands or feet	☐ Thirst with no desire to drink	☐ Night sweats	☐ Hot hands , feet, chest
☐ Chills	☐ Absence of thirst	☐ Unusual sweats	☐ Hot flashes
☐ Cold "in the bones"	☐ Excessive thirst	When _____am/pm	☐ Hot in the afternoon
☐ Areas of numbness	☐ Thirst for cold / hot drinks	Where on body_____	☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY			OILY
☐ Dry skin/hair/nails	☐ Dry lips	☐ Edema/Swelling _____where on body?	☐ Oily skin/hair
☐ Dry eyes	☐ Dry throat	☐ Rashes _____	☐ Pimples
☐ Dry nose / nosebleeds	☐ Dry mouth	☐ Itching _____	☐ Weight gain / loss

DIGESTION

DIARRHEA			CONSTIPATION
BM: How often? ___ x / every____ days	☐ Gas/ Bloating	☐ Nausea / Vomiting	☐ Dry stools
Stools keep shape? ☐ Y ☐ N	☐ Belching	☐ Bad breath	☐ Difficult to pass
☐ Alternating diarrhea/constipation	☐ Poor appetite	☐ Heartburn	☐ Tired after BM
☐ Indigestion	☐ IBS	☐ Excessive hunger	☐ Foul smelling stools

ENERGY

LOW			HIGH
☐ Sudden energy drop	☐ Dependence on caffeine	☐ Shortness of Breath	☐ Hard to concentrate
Time of day: _____	☐ Wired / ungrounded feeling	☐ Heart palpitations	☐ Poor memory
☐ Energy drop after eating	☐ Body / Limbs feel heavy	☐ Blood pressure high/low	☐ Dizziness / lightheaded
☐ Fatigue	☐ Body / Limbs feel weak	☐ Bleed / Bruise easily	☐ Headaches _____/wk

SLEEP

Hours per night _____
☐ Difficulty falling asleep
☐ Wake ____x night @ ____am/pm
☐ Wake to urinate *How often?*___
☐ Disturbing dreams
☐ Restless sleep
☐ Not rested on waking

EMOTIONS

☐ Anger	☐ Grief
☐ Irritability	☐ Depression
☐ Anxiety	☐ Joy
☐ Worry	☐ Fear
☐ Obsessive thinking	☐ Timid/Shy
☐ Sadness	☐ Indecision

EYES, EARS, NOSE THROAT

☐ Poor vision	☐ Poor hearing
☐ Night blindness	☐ Ringing in ears
☐ Red eyes	☐ Excess earwax
☐ Itchy eyes	☐ Sore throat
☐ Spots in front of eyes	☐ Dental problems
☐ Sinus congestion	☐ Mouth sores
☐ Phlegm (color_____)	☐ Cough

HORMONAL BALANCE / HORMONAL CHANGES

Age at last menses:_____ Year changes began:_____

☐ Hot flashes _____x/day ☐ Night sweats _____x/wk ☐ Vaginal dryness ☐ Loss of sex drive ☐ Other

Age at first menses: _____
Length of full cycle _____ days
Length of menses: _____ days
Last menses start date ____/____
# of pregnancies _____
# of births ____ premature ____
# of abortions/miscarriages ____

☐ Heavy periods
☐ Light periods
☐ Painful periods
☐ Irregular periods
☐ Changes in body/psyche prior to menstruation (pms)
☐ Cramps
☐ Before bleeding
☐ First day
☐ During period
☐ Clots
☐ Breast tenderness
☐ Mood changes
☐ Fatigue with menses
☐ Digestive changes w/menses
☐ Midcycle spotting
☐ Yeast infections

URINARY

Fluid in = fluid out ☐ Y ☐ N
☐ Decrease in flow/dribbling
☐ Difficulty starting/stopping
☐ Incontinence
☐ Kidney stones
☐ Urgent urination
☐ Frequent urination
☐ Pain/burning sensation
☐ Cloudy urine
☐ Blood in urine

OTHER

☐ Change in sex drive: ⇑ ⇓
☐ Erectile dysfunction
☐ Premature ejaculation
☐ Infertility
☐ Discharge
☐ Prostate disease
☐ Genital pain
☐ Fibroids/cysts
☐ Hernia
☐ Hemorrhoids

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW? PLEASE DESCRIBE ON THE BACK OF THIS FORM OR A SEPARATE SHEET OF PAPER. THANKS!

Consent Form

Financial Policy

Payment is due at the time of treatment. The sustainability of our office depends on our patients keeping their appointment times or making these appointments available to others who need them in a timely fashion. We ask for 48 business hours notice for any rescheduling or cancellation so that we may fill the appointment time. All appointments that are rescheduled or cancelled with less than 48 business hours notice or appointments missed without notice will be charged the regular fee for that appointment.

I agree to the above policy. _____ _____
SIGNATURE **DATE**

Patient Advisory to Consult a Physician

New York State law requires that we advise you to consult a physician regarding any condition or conditions for which you are seeking Microcurrent Point Stimulation and/or Acupuncture. These modalities have a lot to offer as a health care system, but they are not a substitute for the resources available through a biomedical physician.

THE UNDERSIGNED AFFIRMS THAT_____ (**PATIENT NAME**)
HAS BEEN ADVISED BY_____ (**LICENSED PRACTITIONER**)
TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

Privacy Policy

As we do not transmit health information electronically, we are not technically covered under HIPPA. However, your privacy is important to us and we do not share your information under any circumstances without your consent.

I consent to receive Microcurrent Point Stimulation and/or Acupuncture treatment at The Brand Wellness Center, and that it is possible that other people will overhear conversations between my practitioner and myself. I understand that I can choose not to mention, or have my practitioner not mention, any sensitive health information in the treatment room. This information can be addressed in writing or in private.

I understand the privacy policies of this office in regards to my written health record.

I agree to the above policy. _____ _____
SIGNATURE **DATE**