

Natural Healing Ways

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Health History Questionnaire

Please take the time to fill in the questionnaire completely and accurately as the information you provide influences the choice of treatment for your particular condition. All of your answers will be held absolutely confidential within the limits of the law. If there is anything you wish to bring to my attention which is not asked on this form, please note it at the end of the questionnaire in the Comments section. Thank you.

I. General Information

Today's Date: _____

Name: _____ Phone: Home: _____ Work: _____

Street: _____ City: _____ State/Zip: _____

Email: _____ Date of Birth: _____ Age: _____

In Emergency Notify: _____

Relationship: _____ Phone: Home: _____ Work: _____

Referred By: _____

Have you been treated with acupuncture or Chinese herbs before? Yes ___ No ___

Other Health Care Providers: _____

II. Insurance Information

Insurance Company: _____ Policy#: _____

Name of Primary Policy Holder: _____

Group#: _____ SS#: _____

Address of Policy Holder (if different from your address):

Street: _____ City: _____

State/ZIP: _____

Relationship to Policy Holder: _____ Marital Status: ___ single ___ married ___ other

III. Present Problem(s)

Principal Health Problem: _____

History of Present Illness/Injury:

Location: _____
(Where is the pain/problem?)

Quality: _____
(What does pain/problem feel like?)

Severity: _____
(On scale of 1-10, what level is pain now?)

Duration: _____
(When did pain/problem start?)

Timing: _____
(Does the pain/problem occur at specific times?)

Context: _____
(Where were you at onset of pain/problem?)

Associated Signs/Symptoms: _____

(What other associated problems have you been having?)

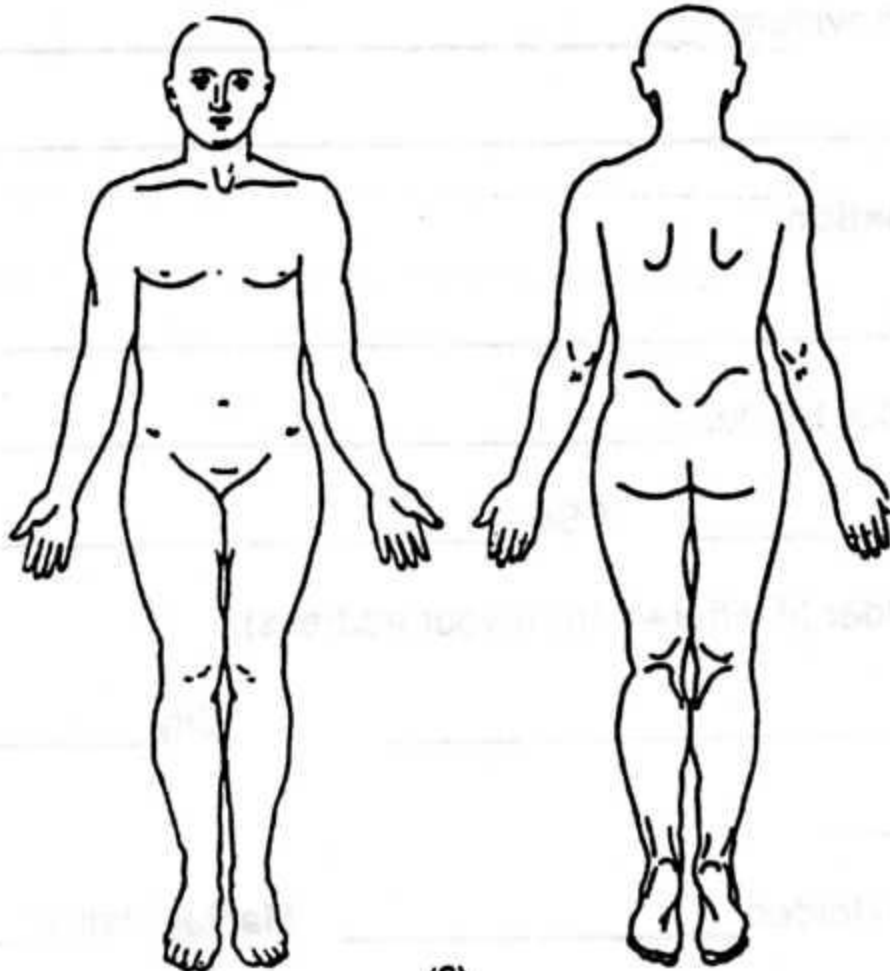
Palliative Factors: _____
(What improves the pain/problem?)

Provocative Factors: _____
(What makes the pain/problem worse?)

Interference of Pain/Problem on Activities of Daily Living: _____

(What are you unable to do, what only with difficulties?)

Please indicate painful or distressed body regions:



Have you ever been given a diagnosis for this problem? ___no ___yes If yes, indicate your diagnosis:

What kind of treatments have you tried:

IV. Past Medical History

Were there complications at your birth? ___no ___yes If yes, what were the complications?

Please list your hospitalizations with reason for hospitalization and year of hospitalization:

What surgeries have you had? Please list the dates of the surgeries:

Have you ever been diagnosed with any of the following conditions?

- | | |
|--|---|
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |

Other:

What are your current medications (drugs, vitamins, supplements, herbs, etc.)

Do you have any allergies (drugs, chemicals, foods, etc.)? ___no ___yes If yes, please list:

V. Social History

What is your education?

What is your occupation?

Please list your hobbies:

Are you exposed to chemicals at work or home? ___no ___yes If yes, please list:

Do you exercise? ___no ___yes If yes, please describe your exercise regimen:

Diet: What types of food do you eat most frequently?

Do you eat regular meals? ___no ___sometimes ___usually ___almost always

What are your preferred beverages? (Please indicate how much of each beverage you consume each day):

Do you drink caffeinated beverages? ___no ___yes

In an average week, how many alcoholic drinks do you consume?:

How many cigarettes do you smoke a day? For how many years?

Are you using recreational drugs? ___no ___yes

VI. Family Medical History

Age	Diseases	If diseased, cause of death/age
Father _____		
Mother _____		
Siblings _____		

Partner _____		
Children _____		

VII. Review of Systems

Please indicate all of the following symptoms which reflect your situation.

1. General Symptoms

- | | |
|---|--|
| <input type="checkbox"/> persistent pain at night | <input type="checkbox"/> body feeling hot |
| <input type="checkbox"/> constant pain anywhere in body | <input type="checkbox"/> heat sensation in palms/soles |
| <input type="checkbox"/> unexplained weight loss | <input type="checkbox"/> low grade fever in afternoon |
| <input type="checkbox"/> loss of appetite | <input type="checkbox"/> low grade fever at night |
| <input type="checkbox"/> unusual lumps, nodules or growths | <input type="checkbox"/> sweating at night |
| <input type="checkbox"/> unwarranted fatigue | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> dream disturbed sleep |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> nightmares |
| <input type="checkbox"/> pain or feeling of heaviness in chest | <input type="checkbox"/> mental restlessness |
| <input type="checkbox"/> pulsating pain anywhere in body | <input type="checkbox"/> dry mouth and/or throat |
| <input type="checkbox"/> constant and severe pain in lower leg or arm | <input type="checkbox"/> thirst |
| <input type="checkbox"/> discolored or painful feet | <input type="checkbox"/> deep yellow urine |
| <input type="checkbox"/> swelling, unrelated to injury | <input type="checkbox"/> constipation |
| <input type="checkbox"/> frequent or severe abdominal pain | <input type="checkbox"/> cold hands/feet |
| <input type="checkbox"/> frequent heartburn or indigestion | <input type="checkbox"/> spontaneous sweating |
| <input type="checkbox"/> frequent nausea or vomiting | <input type="checkbox"/> asthma |
| <input type="checkbox"/> change in or problems with bladder function | <input type="checkbox"/> shortness of breath when lying down |
| <input type="checkbox"/> unusual menstrual abnormalities | <input type="checkbox"/> shortness of breath with exertion |
| <input type="checkbox"/> fever or night sweats | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> recent severe emotional disturbances | <input type="checkbox"/> no energy |
| <input type="checkbox"/> swelling/redness in joints, unrelated to injury | <input type="checkbox"/> poor memory |
| <input type="checkbox"/> changes in hearing | <input type="checkbox"/> depression |
| <input type="checkbox"/> frequent/severe headaches, unrelated to injury | <input type="checkbox"/> nausea |
| <input type="checkbox"/> problems swallowing | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> changes in speech | <input type="checkbox"/> sour regurgitation |
| <input type="checkbox"/> visual changes (blurriness, loss of sight, etc.) | <input type="checkbox"/> abdominal distention |
| <input type="checkbox"/> problems with balance, coordination or falling | <input type="checkbox"/> edema |
| <input type="checkbox"/> fainting spells | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> sudden weakness | |

2. Fei System Symptoms

- | | |
|--|--|
| <input type="checkbox"/> nasal obstruction | <input type="checkbox"/> prone to catching flu/colds |
| <input type="checkbox"/> watery nasal discharge | <input type="checkbox"/> acne |
| <input type="checkbox"/> yellow/green nasal discharge | <input type="checkbox"/> hives |
| <input type="checkbox"/> sore throat | <input type="checkbox"/> itching of skin |
| <input type="checkbox"/> hoarseness (if yes, how long: _____) | <input type="checkbox"/> dry skin |
| <input type="checkbox"/> cough | <input type="checkbox"/> eczema |
| <input type="checkbox"/> coughing up of yellow/green sputum/phlegm | <input type="checkbox"/> rashes |
| <input type="checkbox"/> coughing up of sticky sputum/phlegm | <input type="checkbox"/> allergies |
| <input type="checkbox"/> coughing up of bloody sputum/phlegm | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> chills | <input type="checkbox"/> mucus in stool |
| <input type="checkbox"/> body aches | <input type="checkbox"/> burning sensation of anus |

3. Xin System Symptoms

- feeling of constriction in chest
- pain in heart region
- palpitations
- history of heart murmurs
- irregular heart beat
- flushed face

- sore tongue
- fidgetiness
- listlessness
- feeling of agitation
- manic feeling
- fainting

4. Pi System Symptoms

- general fatigue
- poor appetite
- craving for particular foods
- sudden drop of energy during day
- muscular weakness of limbs
- bearing down sensation of stomach
- indigestion
- unusual bleeding
- skin blotches
- non-healing sores
- always feeling hungry
- feeling of stuffiness in stomach
- burning sensation in stomach

- bad breath
 - bitter taste in mouth
 - sticky saliva
 - bleeding gums
 - gas
 - food allergies
- do you have regular bowel movements?
- yes no
- how frequent are your bowel movements? _____
- recent changes in bowel movement habits
 - hemorrhoids
 - uterine bleeding

5. Shen System Symptoms

- ringing in ears
- hearing loss
- hair loss
- problems with teeth
- grinding of teeth
- aversion to cold
- achy bones
- soreness of lower back
- cold sensation in back
- soreness/weakness of knees
- frequent urination
- clear, watery urination
- dribbling after urination
- incontinence

- do you wake up to urinate?
 - yes no
- if yes, how many times per night? _____
- bed wetting
 - cloudy appearing urine
 - urgency to urinate
 - dark yellow urine
 - burning of urethra
 - blood in urine
 - kidney stones
 - prolapse of uterus
 - loss of sexual desire
 - infertility

6. Gan System Symptoms

- seizures
- feeling of distention of head
- headaches
- vertigo
- painful eyes
- blurry vision
- itchy eyes
- dry eyes
- cataract
- glaucoma
- color blindness
- night blindness
- nose bleeds
- feeling of distention of abdomen
- vomiting of blood
- hiccup

- belching
- churning feeling of stomach
- muscle spasms
- tremors of extremities
- brittle finger and/or toenails
- moodiness
- sighing
- depression
- irritability
- easily angered
- easily susceptible to stress
- anxiety

- have you ever been under the care of a
counselor/psychiatrist? yes no
- have you ever felt suicidal? yes no
- have you ever attempted suicide? yes no

Three words which describe your emotions:

number of pregnancies: _____

live births: _____

premature births: _____

abortions: _____

miscarriages: _____

are you pregnant now: yes no possibly

date of last GYN exam: _____

results: _____

age at first period: _____

date of last period: _____

do you have regular cycles: yes no

length of cycle: _____ days

duration of period: _____ days

are your periods: yes no

- painful yes no

- irregular yes no

with your period, do you have

- breast distention: yes no

- changing emotions: yes before during no

- excessive bleeding: yes no

- very scanty bleeding: yes no

- dark menstrual blood: yes no

- watery menstrual blood: yes no

- menstrual blood with clots: yes no

- bleeding between periods: yes no

do you do breast exams: yes no

VIII. Comments

If you have any other area of concern, please let me know:

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Informed Consent to Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments, the prescription of herbal remedies and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now, or in the future, treat me while employed by, work with, are associated with, or serve as a back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I have been informed that acupuncture and herbal remedies have the effect of normalizing physiological functions and modifying pain, and are employed to treat certain diseases. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, slight bleeding or tingling near the needle site that may last for a few days. I understand that only disposable needles are used in this clinic to minimize possible infections. There have been rare instances reported of fainting, infection or scarring. There have been extremely rare instances of reported spontaneous miscarriages, pneumothorax and death.

I have been informed that herbs are a safe method of treatment. However, I understand that herbal remedies occasionally may cause dizziness, nausea, vomiting, diarrhea, or constipation. Modifying or stopping the herbal remedy usually reverses these side effects. In extremely rare circumstances herbal remedies may cause irreversible damage and death.

I have had an opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture and herbal remedies. I understand that results cannot be guaranteed.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgement on the best course of treatment based on the facts then known.

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

(Signature of Patient or Patient's Representative)

(Date signed)

(Print Name of Patient or Patient's Representative)

Release of Information to Process Insurance Claim

I hereby grant permission to the acupuncturist named above to release all necessary information to my insurance company to process my insurance claim.

(Signature of Patient or Patient's Representative)

(Date signed)

Cancellation of Appointment

I understand that unless I cancel my appointment at least 24 hours in advance, I will be charged the full amount for the missed appointment. I understand that my insurance will not cover these charges.

(Signature of Patient or Patient's Representative)

(Date signed)

Pregnancy

During pregnancy a number of acupuncture points and herbs are contra-indicated. Therefore, should I become pregnant during the course of my treatment, I will inform the acupuncturist named above of my pregnancy.

(Signature of Patient or Patient's Representative)

(Date signed)