CCCA

HEALTH HISTORY

Date: ____ / ____ / _____

Name:	Sex:	Age:

Address:	City:	State:	Zip Code:

Phone #1: Home Cell Other	Phone #2: Work Cell Other	Email:

Date of Birth:	Emergency Contact: *(name & relationship)*	Phone #:

Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other :_____

Occupation:	Employer:

How did you hear of our clinic?: ☐ Word of Mouth ☐ Internet ☐ Yellow Pages ☐ Craigslist ☐ Flyer ☐ Walk / Drive by ☐ Print Ad ☐ Other :_____	Referred by:

Physician: Phone #:	Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____

MAIN COMPLAINTS

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	🧍	_____	👪
Herpes	🧍	_____	👪
AIDS / HIV	🧍	_____	👪
Other STD	🧍	_____	👪
Rheumatic Fever	🧍	_____	👪
Alcoholism	🧍	_____	👪
Allergies *type(s)?* _____	🧍	_____	👪
Mental Illness	🧍	_____	👪
Kidney Disease	🧍	_____	👪
Anemia	🧍	_____	👪

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

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:

MEDICATONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGERIES

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

_____
_____
_____

CCCA

HEALTH HISTORY for WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

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

COLD ——— HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks

- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Unusual sweats

When_____am / pm

Where on body_____

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

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

DRY ——— OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails

- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

Where on your body?:

- ☐ Edema / Swelling _____
- ☐ Rashes _____
- ☐ Itching _____
- ☐ Dandruff

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days

Stools keep shape? ☐ Y ☐ N

- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion

- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite

- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger

- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW ——— HIGH

- ☐ Sudden energy drop

Time of day: _____ am / pm

- ☐ Energy drop after eating
- ☐ Fatigue

- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak

- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy

- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

SLEEP

hours per night _____

- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?*_____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

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

EYES, EARS NOSE THROAT

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

MENSES

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 w/ menses
- ☐ Digestive changes w/ menses
- ☐ Midcycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)

MENOPAUSE

Age at last menses : _____

Year changes began: _____

- ☐ Hot flashes _____x / day
- ☐ Night sweats _____x / week
- ☐ Vaginal dryness
- ☐ Loss of sex drive

CCCA

HEALTH HISTORY for MEN

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- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

URINARY

Fluid in = fluid out? ☐ Y ☐ N

- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Difficulty starting / stopping
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine

REPRODUCTIVE

Are you sexually active? ☐ Y ☐ N

- ☐ Change of sexual drive: ⇧ ⇩
- ☐ Erectile dysfunction
- ☐ Premature ejaculation
- ☐ Sores on genitals
- ☐ Discharge
- ☐ Prostate disease
- ☐ Genital Pain
- ☐ Jock Itch
- ☐ Vasectomy
- ☐ Hernia
- ☐ Hemorrhoids

Consent for Treatment
by Traditional Chinese Medicine

I, the undersigned hereby authorize the licensed Acupuncturists (L.Ac,) of *California Community Clinic for Acupuncture,* to perform Chinese Medicine treatment methods which may include acupuncture, acutonics (tuning forks), moxibustion, cupping, Gua Sha, bleeding, ion pumping cords, herbal therapy, dietary and lifestyle advice.

I understand that these treatments are all safe, natural methods of healing and I recognize the potential risks and benefits of these procedures as described below

POTENTIAL BENEFITS: Relief of presenting symptoms, improved health and wellbeing, reduced stress and an overall balance of bodily energies which may lead to prevention or elimination of your main complaint(s).

POTENTIAL RISKS: ***Acupuncture –*** Although uncommon, there is a potential for acupuncture to cause temporary bruising, swelling, bleeding, numbness, tingling, and soreness at the needle site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage or possibly the aggravation of symptoms existing prior to treatment. Infection is a slight possibility even though our clinic uses only sterile disposable needles and maintains a clean and safe environment.
Moxibustion – Burning of moxa (a Chinese herb – Mugwort) on or near the body has the potential risk of burns, blistering or scarring. ***Cupping and Gua Sha*** – may cause temporary bruising or redness lasting a few days.
Herbal Medicine – Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions. Large doses taken without my practitioner's approval may be toxic and some herbs may be inappropriate during pregnancy.

PREGNANCY: Acupuncture can be very beneficial in the treatment of symptoms during pregnancy, assisting in the birthing process and postpartum. I will notify my acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points or herbs that could induce premature labor or miscarriage.

CANCELATION POLICY: I recognize that scheduling an appointment involves the reservation of time specifically for me and I agree to give at least 24 hours notice to cancel or reschedule an appointment. *A no-show fee of $15 will be charged for sessions missed without such advance notification.*

PRIVACY: Since several people are being treated in the same room at once it is vital that we work together to respect your privacy and the privacy of others. Let us know if there are certain topics that need extra discretion or if you prefer to do your intake in a more private setting. If you happen to overhear someone else's private information, please keep it to yourself, you'd want others to do the same for you.

With this knowledge, I voluntarily consent to the above procedures and policies, realizing that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments regarding the cure or improvement of my conditions. I hereby release California Community Clinic for Acupuncture *and its practitioners from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participating in these procedures at any time.*

Print Name	**Signature of Client or Person Authorized to Consent**	**Date**