Galter LifeCenter
Part of NorthShore

Acupuncture Client Health History

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention that is not asked on this form, please note it in the comments section. Thank you.

Name____Pronouns____________________Date__________________

Name of Client's Representative (if applicable)____

Address____Zip Code__________________

Phone: Home___________________________Cell_____________________________Work______________________________

Email____ Occupation____

Emergency contact name/phone____

Date of birth_____/_____/______ Age _________ Referred by____

Physician____ Address/phone____

Main problem(s) you would like to address:

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To what extent does this problem affect your daily activities (work, sleep, eating, etc.)

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How long has it been since you first noticed any symptoms?

____

Have you been given a diagnosis for the problem by your physician? ☐ Y ☐ N If so, please describe.

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What kinds of treatment have you tried?

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Have you tried acupuncture or Chinese herbal medicine before? When/why?

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Past Medical History

☐ Allergies	☐ Accidents/Trauma	☐ Cancer
☐ Diabetes	☐ Hepatitis	☐ Heart disease
☐ High blood pressure	☐ Rheumatic fever	☐ Seizures
☐ STD	☐ Thyroid disease	☐ HIV

Please elaborate on checked boxes including dates:

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Family Medical History

Please indicate any significant family medical history:

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Lifestyle

Do you exercise regularly? ☐ Y ☐ N If so, please describe

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Describe your average daily diet:____

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____

Please check any of the following habits that apply. Indicate how much & how often you consume them.

☐ Cigarettes ___________________ ☐ Coffee, tea ___________________ ☐ Alcohol ________________________

Medications taken within the last two months (include vitamins, herbs, etc.)

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Please put a check next to the conditions you have experienced within the **last three (3) months**. Indicate the length of time you have had this condition:

General

- ☐ Bleeding or bruising
- ☐ Weight gain/loss
- ☐ Localized weakness
- ☐ Strong thirst
- ☐ Insomnia
- ☐ Night sweats
- ☐ Disturbed sleep
- ☐ Sweat easily
- ☐ Poor balance
- ☐ Fever or Chills
- ☐ Sudden energy drop

Please elaborate on checked boxes:

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Skin & Hair

- ☐ Acne/pimples
- ☐ Rashes
- ☐ Ulcerations
- ☐ Hives
- ☐ Eczema
- ☐ Recent moles
- ☐ Itching
- ☐ Dandruff
- ☐ Hair loss
- ☐ Changes in hair or skin texture
- ☐ Other _________________________

Please elaborate on checked boxes:

____

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Head, Eyes, Ears, Nose, & Throat

- ☐ Headaches
- ☐ Migraines
- ☐ Concussion
- ☐ Facial pain
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Jaw clicks
- ☐ Tooth problems
- ☐ Grinding teeth
- ☐ Recurrent sore throat
- ☐ Blurry vision
- ☐ Poor vision
- ☐ Glasses
- ☐ Cataracts
- ☐ Color blindness
- ☐ Night blindness
- ☐ Eye pain
- ☐ Eye strain
- ☐ Spots in front of eyes
- ☐ Poor hearing
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Other __________________________

Please elaborate on checked boxes:

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Cardiovascular

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Difficulty breathing
- ☐ Fainting
- ☐ Swelling of hands/feet
- ☐ Low blood pressure
- ☐ Blood Clots
- ☐ Cold hands or feet

Please elaborate on checked boxes:

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Respiratory

- [ ] Asthma
- [ ] Cough
- [ ] Frequent colds
- [ ] Production of phlegm
- [ ] Bronchitis
- [ ] Coughing up blood
- [ ] Pain with deep breath
- [ ] Other________________________________
- [ ] COPD/emphysema
- [ ] Difficulty breathing when lying down
- [ ] Pneumonia

Please elaborate on checked boxes:

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Gastrointestinal

- [ ] Abdominal pain or cramps
- [ ] GERD
- [ ] Indigestion
- [ ] Poor appetite
- [ ] Gas
- [ ] Belching
- [ ] Nausea
- [ ] Changes in appetite
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Hemorrhoids
- [ ] Blood in stool
- [ ] Rectal pain

Please elaborate on checked boxes:

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Genito-urinary

- [ ] Frequent urination
- [ ] Urgency to urinate
- [ ] Pain during urination
- [ ] Unable to hold urine
- [ ] Blood in urine
- [ ] Decrease in flow
- [ ] Kidney stones
- [ ] Impotence
- [ ] Sores on genitals
- [ ] Other___________________

- [ ] Do you wake at night to urinate? If so, how often? ____

Please elaborate on checked boxes:

____

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Female Reproductive & Gynecologic

- [ ] Heavy menses
- [ ] Light menses
- [ ] Fibroids
- [ ] Irregular / unusual menses
- [ ] Painful menses
- [ ] Bleeding during / after sex
- [ ] Menstrual clots
- [ ] Vaginal discharge
- [ ] Infertility
- [ ] Breast tenderness
- [ ] Endometriosis
- [ ] Vaginal dryness

Do you use birth control? ☐Y ☐N If so, what type and how long? ____

Age of first menses ________________ Time between menses ______________ Duration ___________________________

First day of last menses _____________ Miscarriages ☐Y ☐N Abortions ☐Y ☐N

Number of pregnancies _____________ Number of births __________________ Premature births ___________________

Menopause ☐Y ☐N What age?_____________

Please elaborate on checked boxes:

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Male Reproductive

- ☐ Prostate Cancer
- ☐ Erectile dysfunction
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Difficulty urinating
- ☐ Premature ejaculation

Please elaborate on checked boxes:

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Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Foot/ankle pain
- ☐ Muscle weakness
- ☐ Hand/wrist pain
- ☐ Knee pain
- ☐ Muscle pain
- ☐ Other ___________________
- ☐ Shoulder pain
- ☐ Hip pain

Please elaborate on checked boxes:

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Neuropsychological

- ☐ Anxiety
- ☐ Easily susceptible to stress
- ☐ Concussion
- ☐ Lack of coordination
- ☐ Depression
- ☐ Areas of numbness
- ☐ Seizures
- ☐ Loss of balance
- ☐ Bad temper
- ☐ Poor memory
- ☐ Dizziness
- ☐ Tremors

Have you ever been treated for emotional problems? ☐Y ☐ N

Please elaborate on checked boxes:

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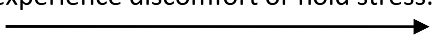
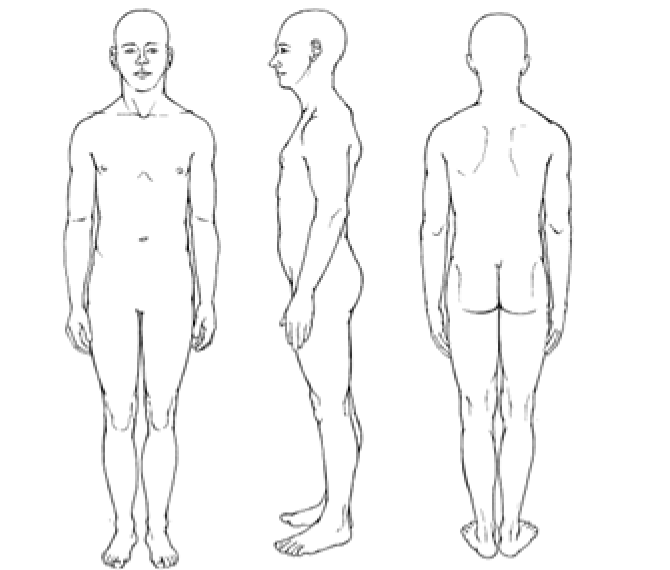
____

On the figures to the right, please indicate the areas where you carry tension, experience discomfort or hold stress.





On a scale of 0 (no tension) to 10 (high levels of stress) please indicate the amount of tension in your life: __________________

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Any additional information/comments

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All of the information is correct and current to the best of my knowledge, and I will update my health history form with any changes in my health and medication.

____________________________	____________________________	__________
Client's (Representative's) Signature	Indicate relationship if signing for Client	Date

About Acupuncture and Chinese Medicine

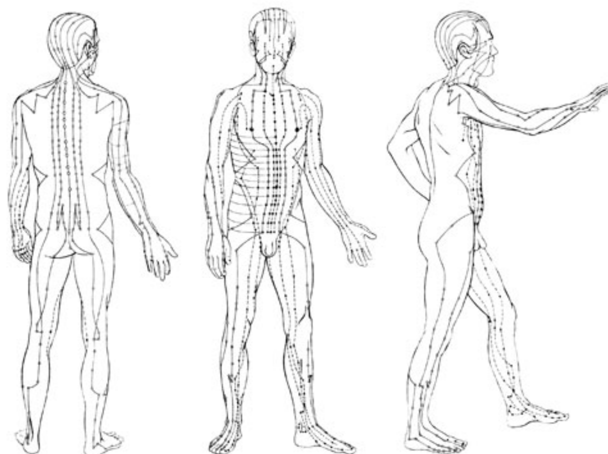
Our Acupuncturists are licensed and trained to tailor their treatment sessions to incorporate Chinese Medicine techniques for wellness and medically based populations. Each session is customized to meet the needs, concerns, and circumstances of each individual. Your practitioner will take the considerations below and may use any one of the following techniques to address your concerns. Other techniques not listed may be used, but your practitioner will inform you of any additional techniques, and ask your permission before proceeding.

How Chinese Medicine Works: Using a meridian mapping system, acupuncture utilizes the harmonious flow of qi, blood, and bodily fluids to assist in healing and facilitate proper functioning of organs. Your practitioner will take into account your past health history, pulse, and tongue qualities. By inserting fine, disposable needles into specific points along the body's energetic pathways, or "meridians," your practitioner will regulate the flow of qi, blood, and bodily fluids.

Qi: Qi is pronounced "Chee". It encompasses all vital activities and substances in the human body and is the life force of all living things. It is responsible for warming and protecting the body, powers the movement of blood and bodily fluids, and promotes growth and development while controlling and regulating metabolic processes.

Tongue & Pulse: The tongue is a map of the organ system. Its shape, color, moisture, and coating show how the body is metabolizing fluids, whether there is any pathological heat, or if there is any blood stasis within the organ system. The pulse tells the practitioner how qi and blood are moving through the organ systems.

Meridians: Pathways or channels of energy that connect the body's organs and physical structure to one another.



Frequency and Number of Treatments Needed: The frequency of treatments vary for each individual. Factors include your general constitution as well as the severity and duration of the problem you are coming for. Acute conditions may be treated with one or two treatments, while chronic conditions may take months to treat effectively. Your practitioner may suggest you receive treatment one to two times per week or simply once a month for health maintenance and seasonal "tune ups".

Gua Sha: Gua sha is defined as instrument-assisted unidirectional press-stroking of a lubricated area of the body surface to intentionally create transitory therapeutic petechiae called "sha" representing extravasation of blood in the subcutis. Conditions commonly treated with gua sha include acute and chronic pain, asthma, bronchitis, colds, flus, fever, heatstroke, fibromyalgia, strains, sprains, and muscle spasms.

Cupping: Cupping removes and moves stagnation of qi, blood, and bodily fluids. This is done by creating a suction with glass or plastic cups in the desired area. Cupping can loosen muscles, encourage blood flow, and sedate the nervous system.

Moxibustion: Moxibustion, or "moxa", is derived from the mugwort plant. Its leaves are dried and refined for acupuncture treatment. Moxa is placed on or above the desired acu-point and warmed to create heat on and in the body. It increases blood cell counts, especially that of white blood cells, thus strengthening the immune system. The heat penetrates deeply into underlying tissues, improving circulation, and helping to reduce pain and inflammation.

Electrical Stimulation: the application of a pulsating electrical current to acupuncture needles as a means of stimulating the acu-points.

Nutritional Counseling: Nutrition is viewed quite differently in the Chinese medical system. Many foods are used in herbal formulas, thus herbs are food, and foods are herbs. The foods we eat are categorized into flavors and temperatures. Your practitioner will decided which foods are best to include and avoid based on your Chinese medical diagnosis.

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INTEGRATIVE THERAPY CLIENT POLICIES AND PROCEDURES

I understand and agree to the following:

General Policies for the Therapy Session.

1. Integrative therapy is primarily for stress reduction, relief from muscular tension, pain reduction, general relaxation and improvement of circulation;
2. The integrative practitioners do not diagnose illness, disease, or physical or mental disorders and do not prescribe medical treatments or pharmaceuticals, nor do they perform spinal manipulations;
3. Integrative therapy is not a substitute for medical treatment and it is recommended that I see a physician for any physical ailment that I might have;
4. All the information I have provided is correct and current to the best of my knowledge, and I will update my health history form with any changes in my health and medications;
5. If I have a condition that is contagious (such as impetigo, pink eye, athlete's foot) I will inform the therapist before the session. If preventative accommodations to protect the practitioner and other clients cannot be made, the practitioner reserves the right to cancel the session.
6. Any information provided by the practitioner is for client educational purposes only and is not prescriptive or diagnostic in nature;
7. I am encouraged to state my preferences and requests to the practitioner, so that the practitioner may develop an effective treatment plan for my session. I understand that it is important for me to communicate my preferences during the session as well, in order to allow the practitioner to adjust any aspect of the work;
8. If I experience pain or discomfort during a session, I will immediately inform my practitioner so that the technique may be adjusted for my comfort.
9. Treatments start and end within the scheduled session time including conversations with the practitioners. After the session, the practitioner may follow up by email or phone;
10. I will direct any questions or concerns I have to the practitioner. I am aware that if I feel that the practitioner cannot adequately address my concern, I am encouraged to speak to the Integrative Therapy Department Manager;
11. I will turn my cell phone off while in the treatment space.
12. Open Integrative Therapy products, such as Chinese herbs, Biofreeze, etc., are non-refundable.

Galter LifeCenter has a 24-hour cancellation policy.
If you need to cancel your appointment, contact your practitioner or the Courtesy Desk. Clients who call and cancel with less than 24 hours' notice or do not show up for an appointment and do not call to cancel will be charged for the full session.

For Galter LifeCenter members, I hereby authorize Galter LifeCenter to draw by electronic funds 100% of my session rate from the Galter LifeCenter membership account number for any missed or "no show" appointments without notice, or understand that a series sale will be used. I hereby request and authorize Galter LifeCenter to draw by electronic funds from the Galter LifeCenter membership account number for any appointments cancelled with less an 24 hours' notice. Please sign and date.

Signature: ________________________________ Date: ________________
Client's (Representative's) Signature

Galter LifeCenter has a no-gratuity policy.
The best gift you can give is a referral or to come back and see us again.

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments 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 indicated below, and/or other licensed acupuncturists who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, gua sha, Tui Na (Chinese massage), Chinese herbal medicine and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although sterile disposable needles are used and acupuncture is performed in a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. The herbs may have an unpleasant smell or taste. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant side effects associated with the consumption of the herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify the acupuncturist who is caring for me if I am or become pregnant.

While I do not expect the acupuncturist to be able to anticipate and explain all 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, is in my best interest. I understand that results are not guaranteed.

From time to time in order to create and provide a safe and effective treatment plan, it may be helpful for the acupuncturist to discuss my health history or my condition with my health care provider including but not limited to my physician, physical therapist or others. I will be provided with a separate authorization for the acupuncturist to discuss my health information with my health care provider and I will notify my health care provider of the same. The information discussed will be shared with me and will otherwise remain confidential. All of my acupuncture records will be kept confidential and will not be released without my written consent.

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ACUPUNCTURE INFORMED CONSENT TO TREAT

By voluntarily signing below, I acknowledge that I have read, or have had read to me, the above 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 acupuncture treatment.

______________________________	______________________________
Patient Name	Date
Patient/Representative Signature	Indicate Relationship If Signing For Patient
Acupuncturist Name	Date
Acupuncturist Signature	

Additional items:

I understand that the Acupuncture and Oriental Medicine Services is not a substitute for medical examination or diagnosis by a physician. I further understand that it is strongly recommended that I see a physician for any physical/mental ailment that I might have, regardless of when it may arise.

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Initial

I have stated all known medical conditions on this Acupuncture and Oriental Medicine Services Medical History & Consent Form. I shall promptly notify Galter LifeCenter and the Acupuncturist of any changes to my physical health including, but not limited to, any changes in the medications that I am taking.

____
Initial

I have received the Integrative Therapy Client Policies and Procedures and agree to comply with them.

____
Initial