CORE PHYSICIANS

an exeter health resource | The Art of Wellness

Acupuncture Health History

Date:_____

(Please Print Clearly)
Name (Last):_____ (First):_____ (MI):_____ Gender: __M __F

Date of Birth:___/___/___ Age:_____ Height:_____ Weight:_____

How did you hear about Acupuncture? Word of mouth / referral / advertisement?
Who and/ or which? _____
Referred By:_____

Can we contact your Health Care provider w/ regard to your treatments: ___Yes ___No
Health Care Provider: _____

Best Means of contacting you: ___ Home ___ Work ___ Cell Phone ____ Email

Do you understand your patient rights? __ Yes ___ No

Do you have Advanced Directives (for example, living will or durable power of attorney for health care)? __Yes __No
If no, would you like more information? ___Yes __ No

Are you allergic to any medications? ____ No ____Yes: (List):_____
Are you allergic to latex? ____No ___Yes___

Please list all medications, herbs and/or supplements you are taking now.

*_____	*_____	*_____
*_____	*_____	*_____
*_____	*_____	*_____

HISTORY OF PRESENT ILLNESS:
Please <u>check</u> any and all symptoms that you are experiencing and <u>circle</u> appropriately to clarify. All symptoms are important for eastern diagnosis, not just your primary concern. Include the **date** the symptom started and **how often** the symptom is present (on average). If you are not sure please estimate.
<u>Please Print Clearly</u>

For example:
[X]Headaches: location**:** **Side and back** date: ***2yrs*** frequency**:** **2 – 3 */wk**

[X]Numbness: location: **Fingers** date: ***6 mo***. frequency**:** **all the time**

Chief Complaint: _____

[ ]Pain
- Tight location:_____date:_____frequency: _____
- Squeezing location:_____date:_____frequency: _____
- Heavy location:_____date:_____frequency: _____
- Sharp location:_____date:_____frequency: _____

Patient Name: _____ DOB:_____

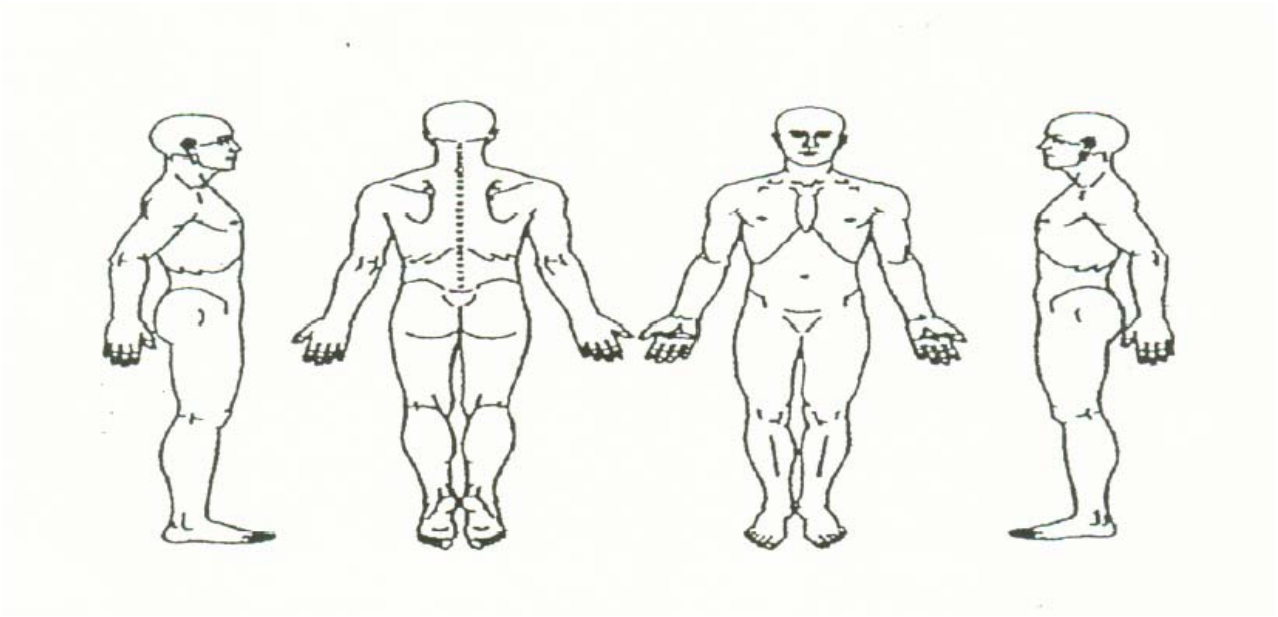
- Burning location:_____date:_____frequency: _____
- Cold location:_____date:_____frequency: _____
- Dull location:_____date:_____frequency: _____
- Other: location:_____date:_____frequency: _____

Pain Scale:

Please use this scale to indicate by circling your current level of discomfort/pain

0 1-2 3-4 5-6 7-8 9-10

Please circle or mark any areas of pain or discomfort. Please designate any scars with this mark: IIII



[ ]Tingling: location:_____date:_____ frequency: _____
[ ]Numbness location:_____date:_____ frequency: _____
[ ]Cramping: location:_____date:_____ frequency: _____
[ ]Shakiness: location:_____date:_____ frequency:_____
[ ]Twitching: location:_____date:_____ frequency: _____
[ ]Swollen joints location:_____date:_____ frequency: _____
[ ]Swelling location:_____date:_____ frequency: _____
[ ]Headaches: location:_____date:_____ frequency: _____
[ ]Head pressure location:_____date:_____ frequency: _____
[ ]Chilliness location:_____date:_____frequency: _____

- not relieved by heat / relieved by heat

[ ]Cold feet / hands date: _____ frequency: _____
[ ]Feverish sensation of the hands / feet / chest date: _____ frequency: _____
[ ]Slight fever (tidal fever) date: _____ frequency: _____
[ ]Alternating fever and chills date: _____ frequency: _____
[ ]Hot flashes location:_____date: _____ frequency: _____
[ ]Avoidance of wind date: _____ frequency: _____
[ ]Excessive sweating location:_____ date: _____ frequency: _____

- spontaneous sweating / night sweat

Patient Name: _____ DOB:_____

[ ]Cold sweats location: _____ date:_____ frequency: _____
[ ]Sleep disorders date: _____ frequency: _____
- trouble falling asleep / wake up often

[ ]Excessive sleepiness date: _____ frequency: _____
- after meals / after activity / always

[ ]Excessive dreaming date: _____ frequency: _____
[ ]Abnormal taste in the mouth date: _____ frequency: _____
- bitter / sweet / salty / hot / other _____

[ ]Can't taste food date:_____frequency: _____
[ ]Excessive thirst date:_____frequency: _____
[ ]Thirsty but only drink small amount date:_____frequency: _____
- hot drinks / cold drinks / hot and cold drinks

[ ]Drink excessive liquids date:_____frequency: _____
[ ]Preference for hot / cold drinks date:_____frequency: _____
[ ]Excessive salivation date:_____ frequency: _____
[ ]Loss of appetite date:_____frequency: _____
[ ]Hunger without appetite date:_____frequency: _____
[ ]Food cravings type: date:_____frequency: _____
[ ]Taste cravings date:_____frequency: _____
bitter /sweet /salty / sour / spicy
[ ]Heartburn date:_____frequency: _____
[ ]Hiccups date:_____frequency: _____
[ ]Vomiting date:_____frequency: _____
[ ]Nausea date:_____frequency: _____
[ ]Uncomfortable feeling in the stomach date:_____frequency: _____
[ ]Bloated sensation of the abdomen date:_____frequency: _____
- upper / lower / whole

[ ]Excessive gas date:_____frequency: _____
[ ]Constipation date:_____frequency: _____
- hard stools / difficulty having bowel movement

[ ]Diarrhea date: _____frequency: _____
- soft / loose / undigested food / early morning
- loose stool with continued sensation to move bowels

[ ]Dry stool followed by loose stool date:_____frequency: _____
[ ]Pain with bowel movement date:_____frequency: _____
- able to produce bowel movement / not able to produce bowel movement

[ ]Blood in stool date:_____frequency: _____
[ ]Urinary incontinence date:_____frequency: _____
[ ]Bed-wetting date:_____frequency: _____
[ ]Profuse urination date:_____frequency: _____
[ ]Frequent urination date:_____frequency: _____
[ ]Scanty / no urination date:_____ frequency: _____
[ ]Sensation to urinate often date:_____ frequency: _____
[ ]Burning upon urination date:_____ frequency: _____
[ ]Unpleasant sensation after urination date:_____ frequency: _____
[ ]Discolored urine color: date:_____ frequency: _____
[ ]Difficult to urinate date:_____ frequency: _____
[ ]Stuffy nose date:_____ frequency: _____
[ ]Runny nose date:_____ frequency: _____
[ ]Dry nose date:_____ frequency: _____
[ ]Cough wet / dry date:_____ frequency: _____
[ ]Phlegm in throat date:_____ frequency: _____
[ ]Post nasal drip date:_____ frequency: _____
[ ]Sinus pain date:_____ frequency: _____
[ ]Sinus pressure date:_____ frequency: _____
[ ]Sore throat date:_____ frequency: _____
[ ]Ringing in the ears date:_____ frequency: _____

Patient Name: _____ DOB:_____

[ ]Deafness date:_____ frequency: _____
[ ]Eye pain date:_____ frequency: _____
[ ]Blood-shot eyes date:_____ frequency: _____
[ ]Blurry vision date:_____ frequency: _____
[ ]Dizziness date:_____ frequency: _____
[ ]Heart palpitations date:_____ frequency: _____
[ ]Easily tired after activity date:_____ frequency: _____
[ ]Fatigued date: _____frequency: _____
[ ]Weakness in the limbs date:_____frequency: _____
[ ]Frustrated feeling date:_____frequency: _____
Can you pinpoint a cause? If so, what is it? _____
[ ]Excessive worrying date:_____frequency: _____
[ ]Anxiety date:_____frequency: _____
What form does your anxiety take? (ex: trouble sleeping, tight chest, excessive worrying) _____
_____
[ ]Stress date:_____frequency: _____
What is your stress related to? _____
Has it increased lately? _____
[ ]Depression date:_____frequency: _____
What form does your depression take? (ex: sleep a lot, can't eat, feel very sad) _____
_____
Are you on meds for your depression? _ _____
Are you seeing a councilor your depression? _____
[ ]Forgetfulness date:_____frequency: _____
[ ]Difficulty concentrating date:_____frequency: _____
[ ]Sudden weight gain / loss date:_____# of pounds:_____
[ ]Drug use date:_____frequency: _____
[ ]Alcohol use date:_____frequency: _____
[ ]Nicotine use date:_____frequency: _____

Women Only:
Age menstruation began:_____
Length of usual menstruation: _____.
Number of days between menstruation: _____.
Number of pregnancies: _____.
Number of miscarriages: _____.
Are you on birth control pills? Y / N If so, how long? _____
Are you pregnant now? Y / N If so, how many weeks? _____
[ ]Menstruation pain date:_____frequency: _____
- before / during / after

[ ]Irregular menstruation date:_____ frequency: _____
- menstruation comes before 28 days (over 8 days early)
- menstruation comes after 28 days (over 8 days late)
- irregular cycle
- spotting between menstruation
- dark / light / excessive blood clots

[ ]Menopause age:_____.
[ ]Ended menstruation age:_____.
[ ]Fibroids age:_____.
[ ]Hysterectomy age:_____.
[ ]Toxemia age:_____.
[ ]Infertility

Patient Name: _____ DOB:_____

Musculo-Skeletal

[ ]Scoliosis date:_____
[ ]Osteoporosis date:_____
[ ]Rheumatic disease date:_____
[ ]Muscular dystrophy date:_____
[ ]Fibromyalgia date:_____
[ ]Bone, joint or muscular disease/disorder date:_____
[ ]Other:_____ date:_____

Circulatory and Respiratory

[ ]Abnormal Blood pressure High BP / Low BP (/) **Controlled with Pills?** Y / N
[ ]Heart condition date:_____
[ ]Varicose veins date:_____
[ ]Blood clots date:_____
[ ]Stroke date:_____
[ ]Allergies type:_____ date:_____
[ ]Asthma date:_____
[ ]Other:_____ date:_____

Digestive

[ ]Nervous stomach date:_____
[ ]Irritable bowel syndrome date:_____
[ ]Crohn's Disease date:_____
[ ]Other:_____ date:_____

Skin

[ ]Rashes location:_____ date:_____
[ ]Athlete's Foot date:_____
[ ]Warts location:_____ date:_____
[ ]Acne location:_____ date:_____
[ ]Cosmetic surgery location:_____ date:_____
[ ]Other: _____ date:_____

Nervous System

[ ]Herpes/shingles location:_____ date:_____
[ ]Spinal cord injury location:_____ date:_____
[ ]Epilepsy date:_____
[ ]Post/Polio Syndrome date:_____
[ ]Parkinson's disease date:_____
[ ]Other:_____ date:_____

Miscellaneous

[ ]Fainting date: _____ frequency:_____
[ ]Chronic fatigue date:_____
[ ]Diabetes date:_____
[ ]Cancer location:_____ date:_____
[ ]Infectious disease type:_____ date:_____
[ ]Other: _____ date:_____

Please list ANY other diseases or disorders that you may have:_____
_____
_____
_____

Are you receiving other "Alternative" treatments? Y / N
If Yes, what type of treatment are you receiving?:_____
Reason for treatment:_____

Patient Name: _____ DOB:_____

Family History: **Age if deceased, list cause of death** **Medical and Psychological Illness**
Mother: _____
Father: _____
Brother(s): _____
Sister(s): _____
Partner/Spouse: _____
Children: _____

Social History:
Is English your primary language ___ Yes ___No If no, what is? _____
Highest level of education: _____
Do you exercise? ___Yes ____No If Yes, what type and how often?_____
How do you relax? _____
What brings you joy? _____
Do you meditate or practice a relaxation technique?_____
How do you best learn? ____Seeing __ Hearing ___Doing ___Reading

Are there any religious, cultural or spiritual needs pertinent to your treatment? ___Yes ___ No

Are you interested in learning more about your health condition? ___ Yes ___ No

Do you use an assistive device, including wheelchair, splint or cane?_____

Do you need assistance with daily activities?	___Yes	___No
Do you need assistance with transportation?	___Yes	___No
Do you live alone?	___Yes	___No
Have you smoked, or do you smoke tobacco of any kind?	___Yes	___No
How much?_____How long?_____Have you quit?	___Yes	___No
If not, would you like assistance in quiting?	___Yes	___No
Do you chew tobacco	___Yes	___No
Do you use recreational drugs?	___Yes	___No

How many drinks of alcohol do you average daily? _____ Weekly?_____
In the last year, have you ever drank alcohol or used drugs more than you meant to? ___Yes ___No
In the last year, have you ever felt you wanted, or needed, to cut down on drinking or drug use? ___Yes __No

I understand that the treatment I will receive is intended as complementary care to western medical treatment. I know that it is my responsibility to consult a qualified physician for any ailment I may have.

Printed Name: _____. Signature:_____.Date: _____

Provider Signature : _____ Date:_____

Reviewed:
Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____
Initials:_____ Date:_____ Initials:_____ Date:_____ Initials:_____ Date:_____

CORE PHYSICIANS

an exeter health resource | The Art of Wellness

PATIENT INFORMATION

Please complete all information

Date: _____

Name:_____
Last Name First Name Middle Initial

Date of Birth: _____/_____/ _____

Address: _____
Street PO Box

_____
City State Zip Code

Phone: _____ _____
Home Work

Fax : _____ [ ] Home [ ] Work

Email address _____

Employer: _____

Employer address:_____Phone:_____

INSURANCE INFORMATION

First Insurance Co:

_____ID#:_____

Subscriber:_____Group #:_____COPAY_____

Insurance Co address:_____

Second Insurance Co:_____ID#:_____

Subscriber:_____Group #:_____COPAY_____

Insurance Co address:_____

Contact in case of Emergency

Name: _____

Phone _____ _____
Home Work

CORE PHYSICIANS
an exeter health resource | The Art of Wellness

Post-session Information

1. It is normal to feel energized or tired after the acupuncture session, depending on the individual. **We suggest you rest after each acupuncture session to increase the benefits of acupuncture**. However, if you feel strange or uncomfortable, please tell a staff member so you can be treated.

2. Your first session is a light one. It allows Kenji to judge how your body reacts to his Chi stimulation. Don't be disappointed if you do not feel much change after your first session. Make sure you keep track of your symptoms and any strange feelings you may have. All information will help Kenji adjust your treatment.

3. You should try NOT to do other modalities (such as massage extreme exercise or chiropractic treatment) after acupuncture. You can do any modalities before acupuncture or on another day.

4. All follow-up appointments should be on a weekly basis unless Kenji feels that another schedule is more appropriate for your condition. We suggest making several appointments at a time so you are guaranteed the time slot that is best for you. Remember, we need 24 hours notice for any cancellations.

5. Acupuncture results depend on your age, how long you have had your symptoms and how many symptoms you have. You should look for changes in the frequency, intensity and/or duration of all your symptoms. We will create a symptom list that includes your chief complaint and all other symptoms that will be checked at each follow-up.

6. Some patients may experience a strange feeling or sensitivity at acupuncture sites for several days. This is normal and should diminish. If it becomes bothersome, rub the area to stimulate the Chi.

7. Once in a while, you may notice a drop of blood or a bruise at the acupuncture site. This is normal and can be treated with ice. The bruise should disappear in a few days depending on the patient's healing rate. If the bruise becomes worse or painful, please contact the office.

8. If you are sent home with press seeds or magnets, they should be removed after 3-14 days. If your skin becomes irritated from the tape, remove immediately.

9. If you are sent home with press tacks, they should be removed within 10 days. Kenji will remove them on your next weekly visit. If your skin becomes irritated from the tape or the needle, please remove immediately. However, because they are a biohazard, please fold them up and bring them in to be disposed of properly.

10. Effects from acupuncture should be mild. If you have any symptoms that you are unsure of or worried about, please contact the office. If you have any severe symptoms, please contact the office or your physician immediately.

Kenji Fukunaga Lic. Ac.
603-778-6777

Video Sign-off

Name:_____ Date:_____.

You will watch a short video on the day of your initial acupuncture session. This form lists the subjects that are to be discussed during the video. **Please do not sign this form until <u>AFTER</u> you watch the video.**

---

1. Definition of terms:
   - *Chi*- energy or life force
   - Meridian – line of *Chi*
   - Acupuncture point or point – adjustment point
2. Theory of health according to Traditional Chinese Medicine
3. Theory of illness according to Traditional Chinese Medicine
4. Acupuncturists job to adjust *Chi* and bring body back to peak healing potential.
5. Diagnosis:
   - Health history
   - Pulse
   - Abdominal Palpation
   - Tongue
   - Meridian Test
6. Use and feeling of disposable needles
7. Contact needling with the silver needle
8. Surface needling with the "baby" needle
9. Scalp acupuncture
10. Chi stimulation/ adjustment
11. Feelings of heaviness, cramping, zinging and other sensations
12. Patient should always be comfortable
13. Let Kenji know if you are uncomfortable, dizzy or nauseous
14. Session length (10-30 minutes per side)
15. The weekly session
    - Symptom list
16. Healing needs 6 to 15 sessions
17. Today is light session
18. If you have any questions, call the office

I have watched and understood the video about acupuncture and oriental medicine. I comprehend the techniques available and will use this knowledge to decide on a treatment with my practitioner.

Signature:_____. Date:_____.