Amy Hanks, MS, L.Ac.

Patient Information

Patient's Name_____ Today's Date_____

Street Address_____Apt. #_____

City_____ State_____ Zip_____

Phone number at which I may leave messages for you regarding medical information, appointment confirmations, etc.

(_____)_____ circle one: home mobile office other

Other Phone numbers

(_____)_____ circle one: home mobile office other

(_____)_____ circle one: home mobile office other

Email_____

Birth Date_____ Age_____ Gender_____ Soc. Sec. #_____

❒ single ❒ married ❒ divorced ❒ widowed ❒ domestic partnership ❒ other_____

Referred by_____

*Emergency Contact*_____ Relationship_____

Emergency Contact Phone # Cell (_____)_____ Home or Office (____)_____

*Physician's Name*_____ Phone (_____)_____

Physician's Address_____ Date of last visit_____

Employment Please check all that apply

❒ full-time ❒ part-time ❒ self-employed ❒ student ❒ unemployed ❒ retired

Occupation_____ Number of hours of work/study per week_____

Employer's Name_____ Phone (_____)_____

Employer's Address_____

*Spouse / Domestic Partner Name*_____

Spouse / Partner Employer_____ Phone (_____)_____

Spouse / Partner Employer Address_____

Billing and Insurance

Account paid by ❒ self ❒ Workman's comp ❒ other_____

Note on Insurance

Payment in full is due at the time services are rendered. Upon request a Superbill will be provided. A Superbill is a receipt that you may submit directly to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

*Primary Insurance*_____ Phone (_____)_____

Primary Insurance Address_____

Policy Holder's Name_____ Relationship_____

Policy # / ID #_____ Group #_____

*Secondary Insurance*_____ Phone (_____)_____

Secondary Insurance Address_____

Policy Holder's Name_____ Relationship_____

Policy # / ID #_____ Group #_____

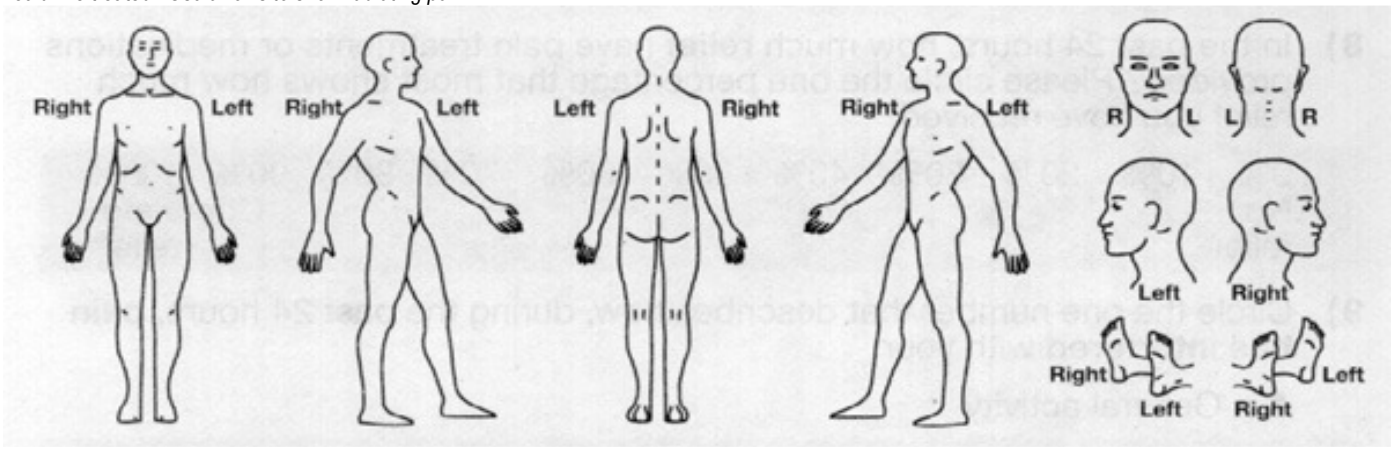
Amy Hanks, MS, LAc – Initial Health History

Name_____ Age_____ Gender_____ Date_____

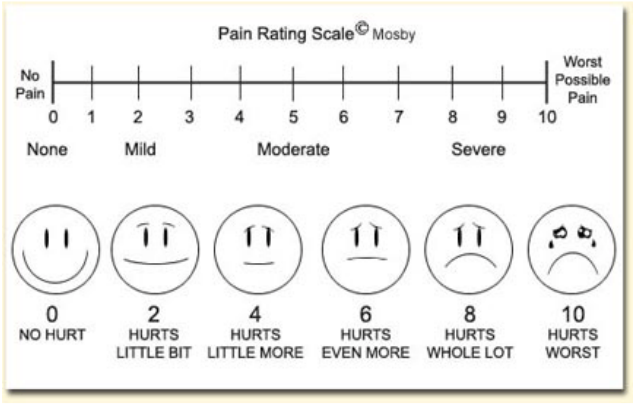
If any of your top 3 health concerns are pain, complete this page as appropriate. *If not, skip to the next page.*

Circle the area(s) where you feel pain. Inside each circle rank the priority of this condition for treatment today.

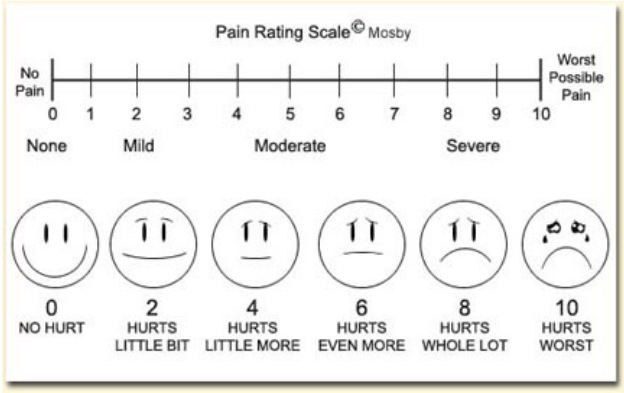
1 = the most important condition you would like treated, 2 = the second most important condition you would like treated, 3 = the third most important condition you would like treated. *Use arrows to show radiating pain.*



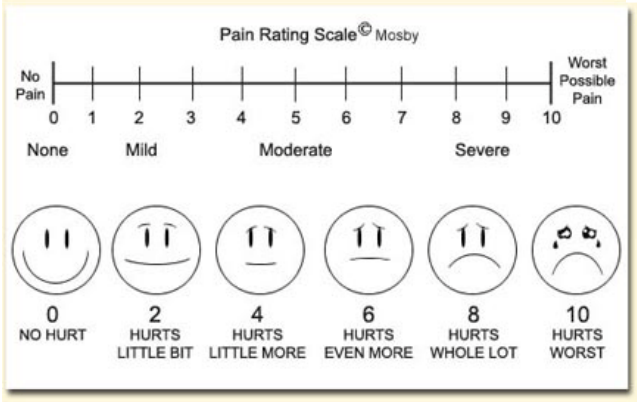
❶ If your **primary** health concern is pain please circle your pain range



❷ If your **secondary** health concern is pain please circle your pain range



❸ If your **third** health concern is pain please circle your pain range



Name_____ Age_____ Gender_____ Date_____

Please write in your top 3 health concerns in order of importance to you and answer the questions about each

❶ _____ When did this begin?_____ ago

Diagnosis from MD or other specialist _____ Date of diagnosis_____

Circumstances of onset / unusual life events that occurred prior to onset (car accident, death of a loved one, excessive stress, gradual onset, cause unknown, etc.)

_____

Severity Mark on the scale the severity of the condition. 1= minimal, 10 = worst imaginable

1 2 3 4 5 6 7 8 9 10

How has this condition decreased your range of motion or limited your activities?_____

Frequency	**This condition feels <u>better</u>**	**This condition feels <u>worse</u>**
❑ constant	❑ when I press / massage _____	❑ when I press / massage_____
❑ frequent	❑ when I'm tired	❑ when I'm tired
❑ sometimes	❑ when I wake up / get out of bed	❑ when I wake up / get out of bed
❑ occasional	❑ after moving around for a while	❑ after moving around for a while
❑ rare	❑ with vigorous exercise	❑ with vigorous exercise
❑ random times	❑ in hot weather or after a hot shower	❑ in hot weather or after a hot shower
❑ only when I _____	❑ in cold weather or when I apply ice	❑ in cold weather or when I apply ice
❑ each episode lasts for_____	❑ in damp or foggy weather	❑ in damp or foggy weather
❑ only during the day / night (circle one)	❑ _____ am / pm	❑ _____ am / pm
❑ wakes me at night	❑ before / during / after my period (circle all that apply)	❑ before / during / after my period (circle all that apply)
Other_____	Other_____	Other_____

Accompanying symptoms _____

Treatments tried / Anything else I should know about this condition_____

For Pain Only Describe the quality of this pain by checking all that apply

❑ dull ❑ sharp ❑ throbbing ❑ numb ❑ pins & needles ❑ tight band sensation ❑ heavy
❑ aching ❑ stabbing ❑ burning ❑ tingling ❑ hollow sensation ❑ swollen / enlarged sensation ❑ other _____

❷ _____ When did this begin?_____ ago

Diagnosis from MD or other specialist _____ Date of diagnosis_____

Circumstances of onset / unusual life events that occurred prior to onset (car accident, death of a loved one, excessive stress, gradual onset, cause unknown, etc.)

_____

Severity Mark on the scale the severity of the condition. 1= minimal, 10 = worst imaginable

1 2 3 4 5 6 7 8 9 10

How has this condition decreased your range of motion or limited your activities?_____

Frequency	**This condition feels <u>better</u>**	**This condition feels <u>worse</u>**
❑ constant	❑ when I press / massage _____	❑ when I press / massage_____
❑ frequent	❑ when I'm tired	❑ when I'm tired
❑ sometimes	❑ when I wake up / get out of bed	❑ when I wake up / get out of bed
❑ occasional	❑ after moving around for a while	❑ after moving around for a while
❑ rare	❑ with vigorous exercise	❑ with vigorous exercise
❑ random times	❑ in hot weather or after a hot shower	❑ in hot weather or after a hot shower
❑ only when I _____	❑ in cold weather or when I apply ice	❑ in cold weather or when I apply ice
❑ each episode lasts for_____	❑ in damp or foggy weather	❑ in damp or foggy weather
❑ only during the day / night (circle one)	❑ _____ am / pm	❑ _____ am / pm
❑ wakes me at night	❑ before / during / after my period (circle all that apply)	❑ before / during / after my period (circle all that apply)
Other_____	Other_____	Other_____

Accompanying symptoms _____

Treatments tried / Anything else I should know about this condition_____

For Pain Only Describe the quality of this pain by checking all that apply

❑ dull ❑ sharp ❑ throbbing ❑ numb ❑ pins & needles ❑ tight band sensation ❑ heavy
❑ aching ❑ stabbing ❑ burning ❑ tingling ❑ hollow sensation ❑ swollen / enlarged sensation ❑ other _____

Name_____ Age_____ Gender_____ Date_____

❸ _____ When did this begin?_____ ago

Diagnosis from MD or other specialist _____ Date of diagnosis_____

Circumstances of onset / unusual life events that occurred prior to onset (car accident, death of a loved one, excessive stress, gradual onset, cause unknown, etc.)

_____

Severity Mark on the scale the severity of the condition. 1= minimal, 10 = worst imaginable

1 2 3 4 5 6 7 8 9 10

How has this condition decreased your range of motion or limited your activities?_____

Frequency
- ❑ constant
- ❑ frequent
- ❑ sometimes
- ❑ occasional
- ❑ rare
- ❑ random times
- ❑ only when I _____
- ❑ each episode lasts for_____
- ❑ only during the day / night (circle one)
- ❑ wakes me at night

Other_____

This condition feels <u>better</u>
- ❑ when I press / massage _____
- ❑ when I'm tired
- ❑ when I wake up / get out of bed
- ❑ after moving around for a while
- ❑ with vigorous exercise
- ❑ in hot weather or after a hot shower
- ❑ in cold weather or when I apply ice
- ❑ in damp or foggy weather
- ❑ _____ am / pm
- ❑ before / during / after my period (circle all that apply)

Other_____

This condition feels <u>worse</u>
- ❑ when I press / massage_____
- ❑ when I'm tired
- ❑ when I wake up / get out of bed
- ❑ after moving around for a while
- ❑ with vigorous exercise
- ❑ in hot weather or after a hot shower
- ❑ in cold weather or when I apply ice
- ❑ in damp or foggy weather
- ❑ _____am / pm
- ❑ before / during / after my period (circle all that apply)

Other_____

Accompanying symptoms _____

Treatments tried / Anything else I should know about this condition_____

For Pain Only Describe the quality of this pain by checking all that apply

❑ dull ❑ sharp ❑ throbbing ❑ numb ❑ pins & needles ❑ tight band sensation ❑ heavy
❑ aching ❑ stabbing ❑ burning ❑ tingling ❑ hollow sensation ❑ swollen / enlarged sensation ❑ other _____

In the last month, I have frequently experienced (check all that apply)

<u>SLEEP</u>
- ❑ falling asleep takes _____hours
- ❑ waking_____ times per night @ _____ am/pm, for_____ hour(s)
- ❑ vivid dreams / nightmares
- ❑ not rested on waking
- ❑ Bedtime _____, # of hours / night ___

<u>ENERGY LEVEL</u>
- ❑ fatigue
- ❑ energy drop after meals
- ❑ sudden energy drop at _____ am / pm
- ❑ dependence on caffeine
- ❑ body or limbs feel weak / heavy

<u>APPETITE / THIRST</u>
- ❑ excessive appetite
- ❑ low appetite
- ❑ excessive thirst
- ❑ mouth / throat dry but no desire to drink

<u>GENERAL GI</u>
- ❑ acid reflux
- ❑ nausea / vomiting
- ❑ bad breath
- ❑ abdominal bloating
- ❑ excessive gas
- ❑ noises from the lower abdomen

<u>BOWEL MOVEMENTS</u>
- ❑ ragged edges
- ❑ loose
- ❑ diarrhea
- ❑ constipation
- ❑ thin stools
- ❑ stools broken into small pieces
- ❑ alternating between loose & difficult
- ❑ undigested food particles
- ❑ accompanied by blood or mucus
- ❑ bowel incontinence

<u>URINATION</u>
- ❑ frequent
- ❑ urgent
- ❑ small quantity
- ❑ excessive quantity
- ❑ dark yellow
- ❑ no color / very pale yellow
- ❑ wake to urinate _____times per night
- ❑ slow stream / dribbling
- ❑ difficulty starting / stopping
- ❑ pain on urinating
- ❑ burning
- ❑ blood in urine
- ❑ cloudy urine
- ❑ urinary incontinence

<u>TEMPERATURE</u>
- ❑ feel colder than others
- ❑ cold hands / feet
- ❑ chills
- ❑ prefer warm food and drink
- ❑ feel warmer than others
- ❑ hot hands, feet, chest
- ❑ hot at night
- ❑ hot flashes
- ❑ prefer cold food and drink

<u>SWEATING</u>
- ❑ night sweats _____ times / week
- ❑ unusual sweating @ _____ am / pm which area(s) of body_____ _____

<u>EMOTIONS</u>
- ❑ anger / irritability
- ❑ frustration
- ❑ anxiety / worry
- ❑ obsessive thinking
- ❑ sadness
- ❑ grief
- ❑ depression
- ❑ fear
- ❑ indecision
- ❑ other _____

<u>CRAVINGS</u>
- ❑ sweet foods
- ❑ salty foods
- ❑ sour flavors
- ❑ spicy foods
- ❑ bitter flavors
- ❑ other_____

<u>MISCELLANEOUS</u>
- ❑ red / itching eyes
- ❑ spots in front of eyes
- ❑ sinus congestion
- ❑ phlegm (color_____)
- ❑ cough
- ❑ headaches _____x/ week
- ❑ migraines _____ x / month
- ❑ sore throat
- ❑ frequent colds
- ❑ mouth sores
- ❑ palpitations
- ❑ bleed / bruise easily
- ❑ difficult to concentrate
- ❑ poor memory
- ❑ dizziness / lightheaded
- ❑ ear ringing – high / low pitch
- ❑ diminished hearing
- ❑ erectile dysfunction
- ❑ premature ejaculation
- ❑ decrease in libido

Other recent health concerns_____

Name_____ Age_____ Gender_____ Date_____

Check all that you have experienced to a significant degree, currently or in the past. ***If in the past, write approximate year next to the checkbox.***

past	current		past	current		past	current	
❑	❑	high blood pressure	❑	❑	fainting	❑	❑	attempted / considered suicide
❑	❑	low blood pressure	❑	❑	seizures	❑	❑	emotional, physical / sexual abuse
❑	❑	shortness of breath	❑	❑	paralysis	❑	❑	pneumonia
❑	❑	irregular heart beat	❑	❑	gallstones	❑	❑	tuberculosis (TB)
❑	❑	chest pain or pressure	❑	❑	kidney stones	❑	❑	hepatitis
❑	❑	jaw/neck/shoulder/arm pain	❑	❑	frequent urinary tract infections	❑	❑	HIV
❑	❑	nausea	❑	❑	frequent vaginal infections	❑	❑	sexually transmitted disease(s)
❑	❑	swollen hands or feet	❑	❑	frequent vaginal infections			_____
❑	❑	blood clotting disorders	❑	❑	pelvic inflammatory disease			_____
❑	❑	phlebitis	❑	❑	abnormal PAP smear	❑	❑	genital warts

tumors or lumps_____

other_____

Family History	Self	Mother	Father	Sister	Brother	Spouse	Child
Allergies							
Tuberculosis							
Blood Disorder/ Anemia							
Diabetes							
Cancer / Tumors							
Seizures							
Stroke							
High Blood Pressure							
Heart Disease							
Kidney / Bladder Disorder							
Stomach / Intestinal Disorder							
Depression / Mental Illness							
Drug / Alcohol Use or Abuse							
Other							
Age at death							

Major Hospitalizations Surgeries – Please list any hospitalization or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State

Medicines, Herbs, Supplements – Please check any that you are currently taking and list details below

❑ aspirin	❑ antacids	❑ blood thinners	❑ sleeping pills
❑ ibuprofen	❑ fiber / laxatives	❑ blood pressure pills	❑ tranquilizers
❑ acetaminophen (Tylenol)	❑ diet pills	❑ insulin	❑ anti-depressants
❑ oral contraceptives	❑ allergy medication		❑ other, please list

Western Drugs	Herbs	Vitamins and Supplements

Medication Allergies_____

Food Allergies_____

Name_____ Age_____ Gender_____ Date_____

==========

Women Only

Have you had unprotected sex with a male partner since your last period? ❑ yes ❑ no

Date of first bleeding of most recent menstrual period_____ Total days of bleeding_____ Length of full cycle _____

Age at first menses_____ Please list all birth control methods used, past and present_____

Total Number of Pregnancies_____ Living_____ Ectopic_____Miscarriages_____ Induced Abortions_____

Check all that apply to your menstrual periods in the last 3 months

Cycle	PMS	PMS (continued)	During menses	Color of flow
❑ late	❑ anger / irritability	❑ breast tenderness	❑ abdominal cramps on day(s) _____	❑ pink
❑ early	❑ sadness / crying	❑ abdominal pain	❑ low back pain on day(s) _____	❑ light red
❑ irregular	❑ depression	❑ low back pain	❑ thigh / leg pain on day(s)_____	❑ medium red
❑ no menses	❑ disturbed sleep	❑ thigh / leg pain	❑ clots, size_____	❑ dark red
❑ mid-cycle spotting	❑ cravings for	❑ other	❑ overall heavy flow	❑ purple
❑ other abnormal bleeding	_____	_____	❑ overall light flow	❑ brown / black

MENOPAUSE

Age menopause symptoms began_____ Age at last menses_____ Internal/Topical hormones used _____

❑ hot flashes_____ x / day ❑ night sweats_____ x / night ❑ low back pain ❑ vaginal dryness ❑ decrease in libido ❑ other _____

==========

All Clients

Please check any habits which apply to you now or in the past

Coffee	❑ yes ❑ no	# per day_____	age started_____	age quit_____	
Tobacco	❑ yes ❑ no	# per day_____	age started_____	age quit_____	
Marijuana	❑ yes ❑ no	# per day_____	age started_____	age quit_____	
Alcohol	❑ yes ❑ no	# per day_____	age started_____	age quit_____	
Crack/Cocaine	❑ yes ❑ no	times per day_____	age started_____	age quit_____	
Speed	❑ yes ❑ no	times per day_____	age started_____	age quit_____	
Heroin	❑ yes ❑ no	times per day_____	age started_____	age quit_____	
Other_____		times per day_____	age started_____	age quit_____	

Height_____ Current Weight_____

Please describe any restricted diet you follow(ed) now or in the past_____

Please describe you typical daily diet

Breakfast_____ Morning Snack_____

Lunch_____ Afternoon Snack_____

Dinner_____ Evening Snack_____

Please describe any regular program of exercise

What are the top priorities in your life?

What are your goals for your health?

Have you ever had acupuncture? If so, for what condition(s)?

Please provide any additional information about yourself or your condition(s) not covered by the above questions

Please bring relevant lab, X-ray, MRI, etc. <u>reports</u> to your appointment (No need to bring actual images, copies of X-rays, etc.)

INFORMED CONSENT FOR TRADITIONAL CHINESE MEDICINE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist(s) who now or in the future treat me while employed by, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

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

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

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 judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand that clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient:

PATIENT'S NAME_____
(please print)

PATIENT'S SIGNATURE_____

DATE SIGNED_____

ARE YOU PREGNANT? _____YES _____NO

To be completed by the patient's representative, if necessary, e.g., if patient is a minor or is physically or legally incapacitated:

NAME OF PATIENT_____
(please print)

PATIENT'S REPRESENTATIVE_____
(please print)

REPRESENTATIVE'S SIGNITURE_____

AS:_____
Relationship or Authority of Patient's Representative

DATE SIGNED_____

WITNESS_____

NAME(S) OF TREATING ACUPUNCTURIST(S)_____Amy Hanks, MS, L.Ac._____

APPROVED BY CALIFORNIA ACUPUNCTURE ASSOCIATION (Rev. 12/92)

Getting the Most From Your Acupuncture Treatments

Before and After Treatment

When you brush your teeth, please do not brush your tongue.
The color and texture of the tongue coating are important diagnostic clues in Chinese medicine. Please avoid brushing your tongue for at least 48 hours before a visit. If you habitually brush your tongue to prevent bad breath, discuss this with your practitioner. Persistent bad breath may be a sign of stomach imbalance, and may be an important fact for your practitioner to know.

Have a little food in your stomach when you arrive for a treatment.
It's best not to have acupuncture on an empty stomach. Also, refrain from using drugs or alcohol for at least several hours before a treatment.

Relax for a few minutes after a treatment.
Some patients feel a sense of euphoria after receiving acupuncture. If you feel a little "spacey," sit quietly for a few minutes until you feel normal. Sipping some warm water or tea may help.

In the hours after a treatment…
…your body is still going through a physiological rebalancing process. To maximize the treatment effect avoid vigorous exercise, hot tubs, over-eating, and drugs or alcohol for several hours before and after a treatment.

Regarding Herbal Formulas

Some herbal formulas may not be appropriate to take if you are catching a cold.
If you feel you are catching a cold, call your acupuncturist to discuss your symptoms and find out if it is appropriate to continue taking your current formula.

If you have difficulty adjusting to the taste of your herbs…
…try swallowing them while holding your breath. It is also acceptable to clear the palette with a few raisins after drinking your herbs. Please do not mix the herbs with juice, honey, or any other sweetener, as this can compromise their efficacy.

If you experience gastro-intestinal upset or new symptoms while taking herbs…
…notify your acupuncturist. A little queasiness is not unusual when first getting used to the taste of herbs, but new symptoms may require modification of your formula.

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