H. W. Acupuncture, LLC

414 Allegheny River Blvd.
Suite 203
Oakmont, PA, 15139

Health History Questionnaire and Registration

General Information

First Name: _____ **Last Name:** _____ ☐Dr. ☐Mr. ☐Mrs. ☐Ms

Sex: ☐Male ☐Female **Age:** _____ **Date of Birth** (mm/dd/yyyy): _____ /_____ / _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____ **Phone:** _____

Occupation: _____ **Employed By:** _____

Who is responsible for this account? _____

In case of emergency, contact: Name: _____ Phone: _____

To whom should we thank for referring you to this office: _____

Insurance Information

Primary Insurance: _____ **Policyholder Name:** _____

Date of Birth (dd/mm/yyyy): _____ /_____ / _____ **Relation to Patient:** _____

Policy #: _____ **Group #:**_____

Accident Information

Did you accident occur while at work? ☐Yes ☐No

Were you involved in an automobile accident? ☐Yes ☐No Date: _____ Time: _____

Injury reported to employer ☐Yes ☐No Name of supervisor:_____

Description of accident: _____

_____

Were you injured? ☐Yes ☐No How? _____

Location: _____

Were you unconscious?_____ **Fractures:**_____ **Cuts:** _____ **Abrasions:**_____ **Bruises:**_____

Patient taken to_____Hospital for_____Treatment.

* All information is strictly confidential

Confined to hospital for_____Days_____ Hours. **Name of hospital doctor**:_____

Have you had any other personal injury or accident? ☐Past year ☐Past 5 years ☐Over 5 years ☐None

Describe: _____

Do you have an attorney? ☐Yes ☐No **Name & Address:** _____

_____

Reason for Today's Visit

What's your major complaint? _____

_____

- When did this condition start? _____ How? _____
- Other doctors seen for this condition: ☐MD ☐DC ☐DO ☐DDS

  Doctor's Name:_____ Diagnosis:_____

  X-rays:_____ MRI:_____Other:_____

  Treatment: Medication: _____ Physiotherapy:_____

  Results:_____ Length of time under care:_____

  Were you off work? ☐Yes ☐No If yes, how long:_____

  Have you returned to your same job? ☐Yes ☐No If no, why:_____
- What makes it better? _____
- What makes it worse? _____
- Is this condition interfering with your ☐Work ☐Sleep ☐Daily Routine ☐Other _____

Please list any other health problems you would like to address in order of importance:

_____

_____

Medical History

Surgeries, Major illness, Hospitalization, Major accidents (include dates):

_____

_____

Current medications and Supplements (and what they are for):

_____

_____

Do you have Pacemaker? ☐ Yes ☐ No

Have you ever tested positive for HIV? ☐ Yes ☐ No

Do you have any drug allergies (e.g Alcohol)? _____

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IMPORTANT: Please check (X) all present symptoms.

HEAD:
- ☐ Headache
  - ☐ sinus (allergy)
  - ☐ entire head
  - ☐ back of head
  - ☐ forehead
  - ☐ temples
  - ☐ migraine
- ☐ Head feels heavy
- ☐ Loss of memory
- ☐ Light-headedness
- ☐ Fainting
- ☐ Light bothers eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Loss of vision
- ☐ Loss of taste
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Loss of hearing
- ☐ Pain in ears
- ☐ Ringing in ears
- ☐ Buzzing in ears

NECK:
- ☐ Pain in neck
- ☐ Neck pain with movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turn to left
  - ☐ Turn to right
  - ☐ Bend to left
  - ☐ Bend to right
- ☐ Pinched nerve in neck
- ☐ Neck feels out of place
- ☐ Muscle spasms in neck
- ☐ Grinding sounds in neck
- ☐ Popping sounds in neck
- ☐ Arthritis in neck

SHOULDERS:
- ☐ Pain in shoulder joint (R - L)
- ☐ Pain across shoulders
- ☐ Bursitis (R - L)
- ☐ Arthritis (R - L)
- ☐ Can't raise arm
  - ☐ above shoulder level
  - ☐ over head
- ☐ Tension in shoulders
- ☐ Pinched nerve in shoulder (R - L)
- ☐ Muscle spasms in shoulders

ARMS & HANDS:
- ☐ Pain in upper arm
- ☐ Pain in elbow
- ☐ Movement aggravated
- ☐ Tennis elbow
- ☐ Pain in forearm
- ☐ Pain in hands
- ☐ Pain in fingers
- ☐ Sensation of pins & needles in arms
- ☐ Sensation of pins & needles in fingers
- ☐ Numbness in arms (R - L)
- ☐ Numbness in fingers (R - L)
- ☐ Fingers go to sleep
- ☐ Hands cold
- ☐ Swollen joints in fingers
- ☐ Sore joints in fingers
- ☐ Arthritis in fingers
- ☐ Loss of grip strength

MID-BACK:
- ☐ Mid-back pain
- ☐ Location _____
- ☐ Pain between shoulder blades
- ☐ Sharp stabbing
- ☐ Dull Ache
- ☐ Pain from front to back
- ☐ Muscle spasms
- ☐ Pain in kidney area

CHEST:
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Pain around ribs
- ☐ Breast pain
- ☐ Dimpled or orange peel breast
- ☐ Irregular heartbeat

ABDOMEN:
- ☐ Nervous stomach
- ☐ Foods can't eat _____
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

LOW BACK:
- ☐ Low back pain
  - ☐ Upper lumbar
  - ☐ Lower lumbar
  - ☐ Sacroilliac
- ☐ Low back pain is worse when:
  - ☐ working
  - ☐ lifting
  - ☐ stooping
  - ☐ standing
  - ☐ sitting
  - ☐ bending
  - ☐ coughing
  - ☐ lying down (sleeping)
  - ☐ walking
- ☐ Pain relieves when _____
- ☐ Slipped disk
- ☐ Low back feels out of place
- ☐ Muscle spasms
- ☐ Arthritis

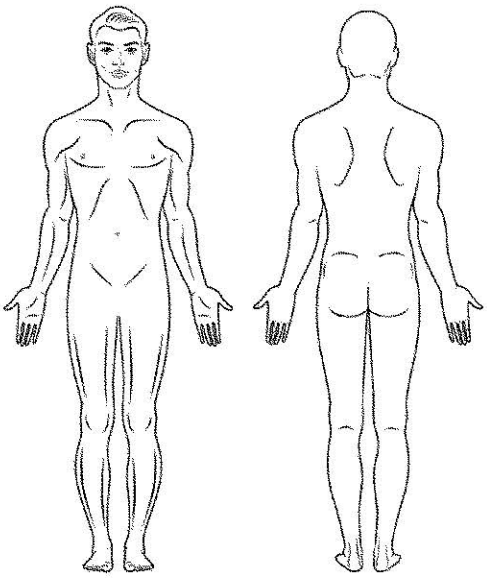
HIPS, LEGS & FEET:
- ☐ Pain in buttocks (R - L)
- ☐ Pain in hip joint (R - L)
- ☐ Pain down leg (R - L)
- ☐ Pain down both legs
- ☐ Knee pain
  - ☐ Inside
  - ☐ Outside
- ☐ Leg cramps
- ☐ Cramps in feet (R - L)
- ☐ Pins & needles in legs (R - L)
- ☐ Numbness of leg (R - L)
- ☐ Numbness of feet (R - L)
- ☐ Numbness of toes
- ☐ Feet feel cold
- ☐ Swollen ankles (R - L)
- ☐ Swollen feet (R - L)

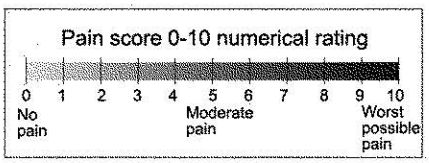
WOMEN ONLY:
- ☐ Menstrual pain _____ (where)
- ☐ Cramping
- ☐ Irregularity
- ☐ Cycle _____ days
- ☐ Birth control _____ (type)
- ☐ Hysterectomy
- ☐ Genital cancer _____
- ☐ Discharge
- ☐ Menopause _____
- ☐ Tumors
- ☐ Abortions
- ☐ Are you or do you think you are pregnant?

MEN ONLY:
- ☐ Urinary frequency
- ☐ Difficulty in starting
- ☐ Night urination
- ☐ Prostate pain/swelling

GENERAL:
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Generally feel run-down
- ☐ Normal sleep _____
- ☐ Loss of sleep _____ hrs./night
- ☐ Loss of weight _____ lbs.
- ☐ Gain weight _____ lbs.
- ☐ Coffee _____ cups/day
- ☐ Tea _____ cups/day
- ☐ Cigarettes _____ pack/day
- ☐ Other _____
- ☐ Diabetes
- ☐ Hypoglycemia

If you're experiencing pain, please circle the pain site and score below:





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Consent For Acupuncture

I, _____ , HEREBY CONSENT TO BE TREATED WITH ACUPUNCTURE AND OTHER SUPPLEMENTAL TECHNIQUES IN THE SCOPE OF ACUPUNCTURE PRACTISE BY WEI HU, L. Ac.

I understand that Acupuncture is performed by the insertion of special needles through the skin, with or without addition of heat or electrical stimulation, to certain points on body with the intent of improving bodily functions and relieving pain. I further understand that only sterilized disposable needles will be used in my treatment.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects including localized bleeding and/or bruising, discomfort or tingling near the needling sites, dizziness or fainting. Bruising is a common side effect of cupping.

I also understand that acupuncture is not a replacement for western medical treatment, including regular checkups with my primary care physician.

Print Name: _____

Patient Signature: _____ **Date**: _____

CONSENT TO TREATMENT A MINOR CHILD (AGE 14-18): I authorize Wei Hu, L.Ac, to administer acupuncture and other supplemental techniques as deemed necessary to _____ (Print name) who is my _____(Relationship).

Adult's Print Name: _____

Adult's Signature: _____ **Date**: _____

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