

Oriental Medicine Questionnaire

Date _____

Name _____ DOB _____ Sex: M F

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

At which place(s) do I have permission to contact you? Cell / Home / Email

Emergency Contact _____ Relationship _____

Occupation _____ Height _____ Weight _____

Name of your Physician _____

Who referred you to this office? _____

1. What brought you here today? _____

2. When did you first notice any problems related to your chief complaint and what symptoms did you notice? _____

3. Describe what has happened from the first symptoms until today _____

4. What previous medical workups, diagnosis, and treatment have you had for this problem? How have these been helpful or not? _____

5. Please list any allergies to drugs or medications: _____

6. What medications or supplements are you currently taking?

<u>Medication</u>	<u>Dose</u>	<u>How long have you been taking it?</u>
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7. Other illnesses, surgeries, injuries:

Illnesses

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injuries/Trauma

<u>Year</u>	<u>Illness</u>	<u>Treatment/Medications</u>	<u>Outcome</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Family History

- Allergies
 Diabetes
 Emotional Difficulties
 Glaucoma
 Heart Problems
 Stroke
 Cancer
 Seizure Disorders
 Tuberculosis
 Thyroid Problems
 Hypertension/High BP

Please check any conditions or symptoms that you presently have or have had in the past:

	<u>Presently Have</u>	<u>Had in Past</u>		<u>Presently Have</u>	<u>Had in Past</u>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Cough with blood	<input type="checkbox"/>	<input type="checkbox"/>	Sputum/Phlegm	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Lack of perspiration	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Excessive perspiration	<input type="checkbox"/>	<input type="checkbox"/>
Chronic colds	<input type="checkbox"/>	<input type="checkbox"/>			
Nasal or sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	*High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	*treatment _____		

	<u>Presently</u>	<u>Had in</u>		<u>Presently</u>	<u>Had in</u>
	<u>Have</u>	<u>Past</u>		<u>Have</u>	<u>Past</u>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting with blood	<input type="checkbox"/>	<input type="checkbox"/>	*Laxative use	<input type="checkbox"/>	<input type="checkbox"/>
Gas	<input type="checkbox"/>	<input type="checkbox"/>	*Product_____		
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea & constipation	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>	Rectal Pain	<input type="checkbox"/>	<input type="checkbox"/>
Acid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>
Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements every_____days		
			_____number of bowel movements/day		
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime urination	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	*Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	*Where_____		
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (lower)	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (middle)	<input type="checkbox"/>	<input type="checkbox"/>	*Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (upper)	<input type="checkbox"/>	<input type="checkbox"/>	*Where_____		
Pain down leg(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Eye tiredness / strain	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Seeing spots	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Eye dryness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Eye redness	<input type="checkbox"/>	<input type="checkbox"/>
Eyes feel swollen	<input type="checkbox"/>	<input type="checkbox"/>	Eye itchiness	<input type="checkbox"/>	<input type="checkbox"/>
Pressure in the eye	<input type="checkbox"/>	<input type="checkbox"/>	Eye tearing	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>			
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>			
Sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Mouth dryness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Presently</u>	<u>Had in</u>		<u>Presently</u>	<u>Had in</u>
	<u>Have</u>	<u>Past</u>		<u>Have</u>	<u>Past</u>
Bad taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in tongue	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores/ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>
Changes in the skin color	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>
Skin bruising	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Skin acne	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
Body hair changes	<input type="checkbox"/>	<input type="checkbox"/>			
Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Problems with alcohol/drug use	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Psychological crisis	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Psychoactive medications	<input type="checkbox"/>	<input type="checkbox"/>
Hot tempered	<input type="checkbox"/>	<input type="checkbox"/>	if yes, which ones? _____		
Stress	<input type="checkbox"/>	<input type="checkbox"/>	Emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
General chilliness	<input type="checkbox"/>	<input type="checkbox"/>	Shaking / tremors	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	Cysts / tumors	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Edema / water retention	<input type="checkbox"/>	<input type="checkbox"/>
General warmth	<input type="checkbox"/>	<input type="checkbox"/>	Night sweating	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	if yes, difficulty falling asleep / staying asleep?		
Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>

Smoking: How much per day? _____

Alcohol: How much per day? _____

Nutrition

What do you typically eat for the following:

Breakfast: _____

Lunch: _____

Dinner: _____

Exercise

What is your daily activity level related to your occupation?

- Sedentary (mostly sitting) Somewhat active Moderately active
 Very active (moving around or up most of the time) Heavy duty(lifting, moving things)

In what kind of physical activities (exercise, sports) do you participate? Intensity level? How often per week? How long each time? _____

Miscellaneous:

How much water do you drink per day? _____

How many caffeinated products (coffee, tea, carbonated pop) do you drink per day?

Snacks: _____

Male Patients – please fill out the following section

Please check any conditions or symptoms that you presently have or had in the past

	Presently <u>Have</u>	Had in <u>Past</u>		Presently <u>Have</u>	Had in <u>Past</u>
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>
Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>

Female Patients – please fill out the following section

Pregnancy:

Are you pregnant? Y N Not sure

Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), and/or abortions (A). Whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum, etc.)

Year

Menstruation

Age of onset _____ Last Menstrual Period (first day) _____

Date of last Pap exam ____/____/____ Result _____

Length of usual period _____ days Length between periods _____

Regularity:

regular irregular usually early by ____ days usually late by ____ days varies between being early or late

Flow is: even uneven heavy light

Color is: pale pink light red red deep red purplish brown

Consistency is: thin thick clotted

Discomfort with Period

lower abdominal distention before during after menstruation

lower back soreness before during after menstruation

cramping before during after menstruation

other _____

Premenstrual Syndrome (PMS)

irritability bloating mood swings breast tenderness

other _____

Vaginal Discharge

No Yes If yes, color and amount: _____

Menopause

Age of onset _____ Any difficulties/symptoms? _____

Uterine bleeding (not related to periods)? No Yes Color _____ Amount _____

comes on suddenly all the time

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, Frank Scott, L.Ac., and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including local bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration. 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. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable needles, maintains clean needle technique, and a 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 individual doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand that I may stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic channels of the same name.

I acknowledge that Frank Scott, L.Ac, is not and does not profess to be a western-trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does he give any substances by injection. I acknowledge that the practitioner has completed academic training at an accredited school of Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM), and a Licensed Acupuncturist (L.Ac). in the state of Illinois.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment and have had the opportunity to ask questions. This consent covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient _____ Date _____ (or patient representative)

Frank Scott, L.Ac.
1565 Sherman Ave, Evanston, IL 60201