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?

Medication **Dose** **How long have you been taking it?**

_____

_____

_____

_____

7. Other illnesses, surgeries, injuries:

Illnesses

Year	Illness	Treatment/Medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

Year	Illness	Treatment/Medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Injuries/Trauma

Year	Illness	Treatment/Medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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:

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

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

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

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 Have	Had in Past		Presently Have	Had in Past
Prostate enlargement	☐	☐	Premature ejaculation	☐	☐
Prostatitis	☐	☐	Impotence	☐	☐

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 difficulities 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

AMERICAN ACUPUNCTURE COUNCIL PROTOCOL
INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face
We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure
To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit.___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___
- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___

- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Practitioner Date

Office Safety Precautions in Effect During the Pandemic

My office is taking the following precautions to protect our patients and help slow the spread of the coronavirus.

- The waiting room at Wellspring will not be used for reception or checkout until further notice.
- My staff and I wear masks.
- My staff maintains safe distancing.
- Restroom soap dispensers are maintained and everyone is encouraged to wash their hands.
- Hand sanitizer that contains at least 60% alcohol is available in the therapy/testing rooms, the waiting room and at the reception counter.
- We schedule appointments at specific intervals to minimize the number of people in the waiting room.
- We ask all patients to wait in their cars or outside until no earlier than 5 minutes before their appointment times.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Tissues and trash bins are easily accessed. Trash is disposed of on a frequent basis.
- Common areas are thoroughly disinfected throughout the day with CDC approved disinfectants and UV-C light.

Frank Scott Acupuncture

Reopening Safety Measures and Client Health Guidance

My fellow practitioners and I are following the guidance for safety of our state and national organizations. In addition, we have added other safeguards from the CDC to optimize your safety and confidence while being treated at Wellspring (detailed below). Traffic in the office will be reduced to maintain social distancing. Treatment rooms and surfaces will be disinfected with UV light (a hospital standard disinfectant procedure) and EPA/CDC approved disinfectants. We will not be using the waiting room for reception or checkout until further notice, but will bring patients directly into treatment rooms as described below.

I am eager for life at the practice (and everywhere!) to normalize soon, as we all are. Your help moves that progress forward every day. **Thank you for your compliance with the following procedures:**

- If you have any COVID-19 symptoms (cough, fever, shortness of breath, chills, muscle aches, new loss of taste or smell, headache, sore throat, rash) stay home and call your doctor. If you have tested positive for COVID-19 in the past or suspect you had it and self-quarantined, please check to see that you meet the CDC's criteria for how to discontinue home isolation. If you test positive for COVID-19 within 14 days AFTER your appointment, please notify your practitioner. If you'd like to be treated with herbs for COVID-19, Telehealth and non-contact, curbside pick-up can be arranged.
- When your appointment is scheduled you should complete the American Acupuncture Council's Informed Consent protocol which establishes a contract with all staff and patients at Wellspring to safeguard the collective community at our practice. Please sign it and arrive with the signed form.
- It is very important that you arrive on time, but not more than five minutes early. We are trying to schedule appointments to limit patient overlap so I may not be able to accommodate you if you are late.
- Use provided hand sanitizer or wash hands upon arrival.
- Wear a mask and keep it on for the duration of the session. I will, too. If yours breaks or you don't have one, a disposable surgical mask will be provided.
- Wait at the inner door at the top of the stairs until I greet you and bring you directly into a treatment room. I will open doors so you need not touch doorknobs.

- Please do not remain in the waiting room or by the front desk after your treatment. Scheduling will be done online or by phone.
- Pay with the contactless payment methods below.

Options pay:
1.If you are a Chase Bank customer use Chase QuickPay with Zelle. Send to Frank Scott's phone number 847-791-9214.
2. If you are not a Chase customer use your bank's online bill pay service to send a check to: Frank Scott, 1565 Sherman Ave., Evanston, IL 60201
3. Mail a check (or leave in box at the front desk) made out to to Frank Scott to 1565 Sherman Ave., Evanston, IL 60201
4. We appreciate your payments for treatments/herb pick ups within 24 hours to ease tracking and bookkeeping.

I am so happy to be returning to in-person treatments. Be assured that everyone's safety is a preeminent consideration in developing and evolving our plans for the practice. I look forward to seeing you or talking together soon.