**Centered Health Healing Arts**
Andrea Henkels, L.Ac HC

**Please complete all the fields below as accurately as possible, even if you feel certain questions don't pertain to your current condition. All information is kept confidential. Thank You.**

Name: _____ Date: _____
Address: _____
City_____ State_____ Zip_____
Email:_____
Phone: (C) _____ (H) _____ (W) _____
Height: _____ Weight: _____ Sex: _____
Date of Birth: _____ Age: _____
Employer: _____
Occupation: _____ Single/Married/Divorced/Widowed/Other (circle)
Primary Physician:_____ Phone Number: _____
Reason for last physician visit: _____ Date of last visit: _____
Referred by: _____ Phone Number: _____
In Emergency, Notify: _____
Relationship: _____ Phone: _____
Main problem/s & Health Goals you would like help with:
1.
2.
3.
When did the problem/s begin (be specific):
To what extent does the problem/s interfere with your daily activity (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem/s? If so, what?

What kind of treatments have you tried? Other concurrent therapies:

**Medications:**
What medications are you currently taking? Please list name, reason, dosage.

**Supplements/Herbs/Vitamins/Minerals**: (Please list brand, product name, & reason for taking)

**Lifestyle**
Do you have a regular exercise program? Please describe.
Please indicate usage per day or per week:
Water _____ glasses per day Coffee _____ cups per day/week (circle)
Alcohol _____ day/week Type liquor/beer/wine
Cigarettes _____ day/week Sweets _____ day/week
Please describe your average daily diet:

**Muscles/ Bones/ Joints**
Do you have pain or tightness? No / Yes. If Yes, please indicate the location on the chart below.

The pain is (circle all that apply):

Sharp Dull Aching Numb Superficial Pain

Burning Tingling Shooting Deep Pain Pain worse in am/pm

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

I have (circle all that apply):

Swollen joints Arthritis/joint pain Tendonitis Muscle cramping

Muscle pain Repetitive Strain Injury Bone Pain Fractured Bone(s) Where?_____

What makes the pain worse:

What makes the pain better (circle all the apply):

Heat Cold Massage Movement Rest

Treatments: (ex. Ibuprofen, chiropractic)

What number best describes your pain now? *No Pain* 1 2 3 4 5 6 7 8 9 10 *Worst Pain*

**Please indicate areas of pain or distress: Medical History (Check all that apply):**

__AIDS/HIV __Alcoholism/Substance Abuse __Thyroid Disease
__Allergies __Hepatitis A / B / C __Asthma
__Cancer __Herpes __Epilepsy
__Emphysema __Lyme Disease __Endocrine Disorder
__Diabetes __Multiple Sclerosis __Gout
__Heart Disease __Pacemaker __High Blood Pressure
__Seizures __Polio __Surgeries (please list)
__Tuberculosis __Varicose Veins

**Energy:**

How is your energy? Please circle. *Low* 1 2 3 4 5 6 7 8 9 10 *High*

What time of day is your energy:

**Highest**: 6am-12pm/1pm-5pm/6pm-12am & **Lowest**: 6am-12pm/1pm-5pm/6pm-12am

Do you fatigue easily? Yes/ No

**Emotions & Sleep:**

How do you feel emotionally?

Do you have (circle all that apply):

Panic attacks Depression Anxiety Bad temper

Nervousness Fear attacks Poor memory Difficult concentration

How long do you normally sleep? _____hours per night

I have difficulties with (circle all that apply):

Falling asleep Staying asleep Dream-disturbed sleep

Waking up at about _____am/pm and not being able to fall asleep again

**Gastrointestinal:**

I have (check all that apply):

Belching Nausea Vomiting Ulcers Bloating

Heartburn Hernia Acid Reflux Severe stomach pain Other:_____

Bowel movements: How often? _____time(s)/day or _____days/week Use Laxatives? _____

I have (circle all that apply):

Irregular Bowel Movements Constipation Diarrhea Undigested food in stool

Burning sensation Hemorrhoids Itchiness Painful bowel movements
Loose stool Hard stool Blood in stool Gas

**Urination:**

Urination: How often?_____(times per day) Color: Pale yellow / Dark yellow / Orange / Other _____
I have or had (circle all that apply):
Trouble starting stream Frequent urination Incontinence Dribbling when sneezing
Burning Pain Blood in urine Kidney stones
Urinary tract infections Other_____

**Women Only:**

Are you pregnant: Y / N Are you trying to get pregnant: Y / N
Age of first menses: _____ Pre-Menopausal: Y / N Menopausal: Y / N Post-Menopausal: Y / N
Number of days between cycles:_____
Number of flow days:_____ Typical Color: dark red/ bright red/ pale red
I have or had (check all that apply):
Irregular menstruation Heavy flow Light flow No flow Clots
Vaginal itching/burning Spotting between periods Discomfort/pain before period
Irritability Breast Tenderness Cravings Cramps
Vaginal discharge? No / Yes Color_____
Number of pregnancies _____ Number of Children:_____

**Men:**

I have (circle all that apply):
Prostatitis Impotence Penis blood/mucous/discharge Reproductive problems
Other:_____

**Eyes, Ears, Nose, Throat, & Head:**

Do you smoke? No / Yes _____ per day, for _____ years
I have (check all that apply):
Frequent colds Chronic runny nose Frequent sore throat Chronic cough
Coughing blood Cough up mucous Pain inhaling Clogged/popping in ears
Nose bleeds Painful/red eyes Poor vision See spots/floaters Dizziness
Bleeding gums Dry mouth Ear pain Ringing in ears
Shortness of breath on exertion/ or at rest Frequent headaches/migraines

**Cardiovascular:**

I have (circle all that apply):
Chest pain Palpitation Varicose veins Phlebitis Cold hands and feet
Irregular heart beat Poor circulation Hypertension High Cholesterol
Other:_____

**Skin & Hair:**

I have or often have (circle all that apply):
Dry skin Skin rashes Itching Acne Eczema Hives
Hair loss Premature graying Age spots Other:_____

**Are there any other health issues you want to discuss?**

**Acupuncture Informed Consent to Treat**

I hereby request and consent to the performance of acupuncture treatment and other procedures within the scope of practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist Andrea M. Henkels, L.Ac. I understand that the methods of treatment

include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Western Massage, Chinese herbal medicine, and nutritional counseling.
I have been informed that acupuncture is a generally safe method of treatment, but that I may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risk of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although this office uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are potential risks of moxibustion and cupping. 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 doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I will notify the acupuncturist who is caring for me if I am to become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. 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 the results are not guaranteed. I understand the acupuncturist may review my patient records, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told the risks and benefits of acupuncture and other procedures and I have had the opportunity to ask questions. 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.
**Patient Signature: _____ Date: _____**

****Centered Health Healing Arts has a 24 hr cancelation policy.****

**Kindly give a 24 hour notice of cancellation to avoid being charged a fee.**
**Sign below to indicate you understand the 24 hour cancelation policy**
**_____ Date: _____**