Name: _____ Date: ____/_____/_____
Date of Birth: ____/_____/_____ Gender: _____ Marital Status: _____ Occupation: _____
Height: _____ Weight: _____ Past Maximum Weight _____ When ---_____
When and where did you last receive health care? _____
For what Reason? _____
What concerns brought you to this office?
_____ Previous treatment(s) _____
_____ Previous treatment(s) _____
_____ Previous treatment (s) _____

List any current or recent medications/ supplements:_____
_____
_____
_____

Are you currently under the care of a physician or have any medical diagnosis: _____
_____
_____

List any **allergies or sensitivities**:_____
_____
_____

Are you currently pregnant? If so when are you due?
Do you have any infectious diseases (if so please list)? _____

Please list your parents and siblings with age and any illnesses that have had a significant impact on their health:
_____
_____
_____
_____

Lifestyle:
Do you exercise regularly:_____ _____ days per week. What do you do? _____
_____
You eat ____ meals per day. Are you hungry for meals _____. I have cravings for_____ foods.
Do you overeat on a regular basis _____. I get tired after eating:_____ I am a vegetarian/vegan:____
Describe your typical daily diet: _____
_____
How many caffeinated beverages do you consume in a week? _____
Do you smoke? ____ How many cigarettes per day? _____ How many years _____
How many alcoholic beverages do you consume in a week? _____
Have you used any other drugs or pharmaceuticals recreationally? _____
Do you meditate, pray or practice any sort of contemplative exercise? :_____
How many hours of sleep do you get per night? _____ From ___ to ____ o'clock.
Does this feel adequate? _____ Do you feel well rested when waking? _____
Do you nap during the day? _____
Are you happy with your current occupation/work? _____
Is your home life a source of stress or pleasure? _____
Energy Level:
Is your energy level sufficient for the tasks you do on a daily basis? _____
Do you feel like you have a reserve? _____ Would you do more if you had more energy? _____
What is your best time of day _____ Your worst time of day _____

FOR THE FOLLOWING QUESTIONS PLEASE CHECK THOSE THAT YOU HAVE HAD CHALLENGES WITH IN THE PAST AND DOUBLE CHECK THOSE THAT YOU HAVE HAD PROBLEMS WITH RECENTLY OR ARE CURRENTLY DEALING WITH. (Over)

FOR THE FOLLOWING QUESTIONS PLEASE CHECK THOSE THAT YOU HAVE HAD CHALLENGES WITH IN THE PAST AND CIRCLE THOSE THAT YOU HAVE HAD PROBLEMS WITH RECENTLY OR ARE CURRENTLY DEALING WITH.

General Symptoms:

o Fatigue o Weight Loss o Weight Gain o Insomnia o Nightmares
o Overly sleepy o Heavy Sweating o Fever o Excessive dreaming
o Feeling Hot o Feeling Cold o Chills o Night Sweats o Hyperactive
o Appetite decrease o Appetite Increase

Skin and Hair

o Itching o Dry Skin o Dry rashes o Wet Rashes o Ulcerations o Pigment changes o Eczema
o Psoriasis o Acne o Dandruff o Pattern Bald o Other hair loss o Thin hair
o Dry hair o Moles Other skin conditions: _____
_____

Head, eyes, ears, nose and throat

o Dizziness o Headache o Migraines o Poor vision o Eye strain o Tearing
o Night blind o Color Blind o Cataracts o Itching eyes o Spots in vision o Ear discharge
o Ringing ears o Ear pain o Poor hearing o Waxy ears o Sinus pain o Loss of smell
o Stuffy nose o Post Nasal Drip o Chronic Sinus Infections o Dry nose o Itchy nose
o Nose Bleeds o Sore throat o TMJ o Tooth Grinding o Sores in mouth o Tongue sores
o Tooth pain o Gum bleeding o Loose teeth o Bad breath Other head and EENT problems?
_____

Heart and Lungs

o High Blood Pressure o Low Blood Pressure o Chest pain o Fainting o Palpitations
o Rapid heartbeat o Irregular heartbeat o Leg swelling o Swelling o Difficulty Breathing
o Clotting disorder o Spider Veins o Cold extremities o Phlegm o Cough
o Difficult breathing o Asthma o Yawning o Sighing o Shallow breathing
o Panting w/ exertion o Frequent colds (3+yr) Other Respiratory or Circulatory Problems: _____
_____

Gastrointestinal:

o Nausea o Poor Appetite o Vomiting o Belching o Reflux o Bad Breath
o Bloating o Thirst o Overfull Feeling o Always Hungry o Anorexia o Bulimia
o Phlegm after eating o Slow digestion o Indigestion o Gas o Colitis
o Bloating o Hemorrhoids o Diarrhea o Constipation o IBS o Abdominal Pain
o Crohn's o Rectal Pain o Blood in stool Other GI problems: _____
_____

Frequency of Bowel Movements : _____ Is it generally comfortable and easy: _____ Is there urgency: ____

Genito-Urinary/Men's Health (Women please check those that apply):

o Frequent urination o Urinary Urgency o Pain with urination o Blood in urine
o Frequent UTI o Dribbling Urination o Incontinence o Cloudy Urine
o Genital Itching o Genital Sores o Genital Warts o Increased Libido
o Decreased Libido o Impotence o Non orgasmic o Kidney Stones
o Prostate Enlargement o Prostatitis o Venereal Disease o Premature Ejaculation
How many times per day do you urinate: _____ Do you wake at night to urinate: ____ How many times? ____
Other Urogenital Problems: _____
_____

REPRODUCTIVE AND GYNECOLOGICAL

Is it possible that you are pregnant: _____ Start of last menses: ___/____/____
Number of pregnancies: _____ Live Births: _____ Miscarriages: _____ Abortions: _____
Age at first menses: _____ Days in typical cycle: _____ Duration of Menses: _____
History of birth control use: _____
o Irregular Menses o Painful Menses o Heavy Clotting o Heavy Bleeding o Breast Tenderness
O Breast Lumps o Bloating o Vaginal Discharge o Vaginal Dryness o Fibroids
o Genital Sores o Genital Itching o PCOS o Infertility Other OB GYN issues: _____
_____

Please continue on the following page

Please describe any significant physical pain that you feel on a regular basis, including: frequency, intensity (light=1 to severe=10), duration, things that improve and make it worse, any diagnosis you have received, and possible precipitating events or habits that may have contributed to the pain:_____

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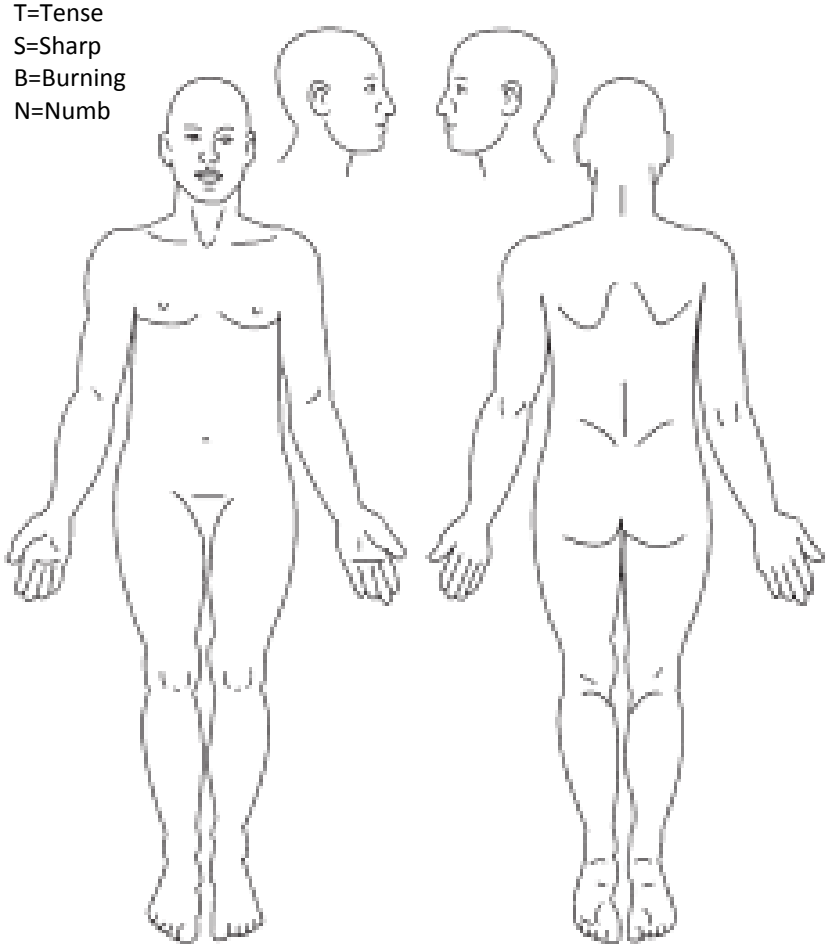
Use these marks to show different types of sensation:

A=Aching
T=Tense
S=Sharp
B=Burning
N=Numb



Please use this space for any other information that you consider pertinent to your condition or treatment:

Please turn over and read and sign the following consent to treatment and acknowledgement of office policies form

Paer Scott, Therapeutic Bodywork Acupuncture and Oriental Medicine
Emergency Contact Information/Informed Consent Form:

Please print all information clearly:

Full Name: _____
Address: _____
_____
Phone: _____
Email: _____

In case of emergency contact: _____ Phone: _____

Relationship to the undersigned: _____

Please read the following and then sign the bottom:

-- I (the undersigned) understand the treatment modalities used, including: massage, Cranio-Sacral Therapy, acupressure, positional release, acupuncture (including electro-acupuncture and dermal needle) moxabustion, application of topical herbal products, scraping (gua sha) and cupping, as well as the administration of internal herbal medicine.
--I (the undersigned) understand that in the course of therapeutic bodywork/acupuncture emotions can arise, and I will inform Paer Scott as to my level of comfort with the techniques he is employing as soon as a feeling should come up. This is especially true if I have areas on my body that I don't like being touched or exposed in particular ways. I understand it is my right to stop the treatment at any time or request a different type of treatment.
--I (the undersigned) understand that if I have withheld information regarding my health history or current state of health, it may complicate the accurate assessment of my condition, and assert that all accountings of my health history are complete and accurate to the best of my recollection.
--I (the undersigned) understand that therapeutic bodywork will occasionally provoke painful or unpleasant responses in the body, at times due to discharge of metabolic waste (frequently as a flu like episode), at times due to underlying structural issues (where muscular tension guards an underlying joint problem) and at times due to bruising. Should I feel discomfort during or after a treatment I will communicate with him and inform him about the problem. I absolve Paer Scott from responsibility for these reactions.
--I (the undersigned) understand that acupuncture can potentially leave bruising and can result in persistent pain in the area needled. Both of these phenomena usually resolve within a week.
--I (the undersigned) understand that there is a risk for burns with the use of moxabustion.
--I (the undersigned) understand that Gua Sha and Cupping can leave unsightly skin discoloration and tenderness that typically resolve within ten days.
--I (the undersigned) understand that I should take herbal products as directed and if my health status changes in a substantial way (e.g., catching cold, nausea, vomiting, diarrhea, digestive upset, rash, etc.) I should immediately cease taking them and consult with Paer Scott as soon as possible. Reactions to herbs typically include: mild digestive discomfort, changes in sleep patterns and energy levels, bowel consistency or urinary output. Specific problems that might arise due to the nature of your prescription will be mentioned at the start of your treatment.
--I (the undersigned) understand that I will be responsible for the full cost of a treatment if I fail to cancel it in a timely manner (at least 24 hours in advance) and my credit card will be billed.
--I (the undersigned) have read the above and understand and agree with what is stated there, I understand that I may request further information at any time regarding material risks of treatment, or the therapeutic purpose of a treatment: I understand that treatment is not meant to replace the services of an allopathic (Western) physician, and diagnoses offered are made in the context of Traditional Chinese Medicine and not meant to be interpreted as an allopathic medical diagnosis.

_____ Patient _____ Date

_____ Parent or Guardian if patient is under 18 years of age