JADE & CINNABAR
ACUPUNCTURE AND ORIENTAL MEDICINE

MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Date: _____

Name: _____

Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone _____ Work Phone: _____

Male / Female Date of Birth: _____ Age: _____ Height/ Weight: _____

E-mail: _____ Occupation: _____ Marital Status: _____

Guardian if under 18: _____ Relationship to patient: _____

Emergency contact name/phone _____ Relationship to patient: _____

Referred by: _____

Primary Physician's name/ address/ phone: _____

_____

Condition(s) your physician is currently treating you for? _____

Prior experience with acupuncture and Chinese herbal medicine: _____

Medical History

Illness, hospitalization, surgery or accidents. Please list in chronological order and indicate length of injury or trauma.

Age _____ Event _____ Outcome _____

Age _____ Event _____ Outcome _____

Age _____ Event _____ Outcome _____

Please list all medications including prescriptions, vitamins, herbs, and supplements taken within the last six months, dosage and frequency with which you take them, and the condition or symptoms you take them for.

Medication	Dose / Frequency	Condition/Symptoms
1.		
2.		
3.		
4.		
5.		

Health Concerns

Please list complaints in order of importance to you.

1. _____

2. _____

3. _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)? _____

_____

How long has it been since you first noticed any symptoms? _____

Have you been given a diagnosis by a physician or chiropractor? If so, what is it? _____

What kinds of treatment or therapy have you tried? _____ Is the condition getting better? _____

Do you have an opinion or insight on what might have caused your complaint? _____

Lifestyle

What is your definition of health? _____

What are your health goals? _____

Rate your general health (1 being very low, 10 being excellent)_____Rate your general satisfaction with life: _____

Do you enjoy your family life? _____Who lives with you? _____

Do you enjoy your job?_____ Do you often feel overworked? _____

What are the areas of stress in your life? ☐ Finances ☐ Work ☐ Interpersonal ☐ Marriage ☐ Children ☐ Family ☐ Health

☐ Expectations ☐ Other: _____Rate your overall stress levels: (1 being very low, 10 being very high) _____

How does stress impact you and how do you deal with it?_____

When was your last vacation? _____ What do you do for recreation?_____

Do you follow any religious or spiritual practice? _____ Please specify:_____

Do you meditate or use relaxation exercises?_____

What emotions seem to predominate in your life? _____

What do you enjoy the most in your life?_____

Do you follow a regular exercise program? _____What activities are involved?_____

How often do you exercise? ☐ Never ☐ Occasionally ☐ Once a week ☐ Several times a week ☐ Daily. Workout length:_____

Average number of hours you sleep per night? _____What is the quality of your sleep? _____

Is there difficulty falling asleep or staying asleep? _____ Do you wake up well rested? _____

What time of the day do you have the most energy?_____ What time of the day do you have the least energy? _____

Are you following a specific diet? _____

Please describe your typical daily meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Please check any of the following habits that apply:

☐ Cigarette smoking ☐ Coffee, tea or soda ☐ Alcoholic beverages ☐ Recreational drugs – please specify :_____

How much and how often do you use them?

___x day / week ___x day / week ___x day / week ___x day / week

Health History

Personal Medical History Please check any conditions or symptoms you might have experienced over lifetime.

☐ Allergies	☐ High / Low blood pressure	☐ Tuberculosis	☐ Liver / Gall bladder disease
☐ Asthma	☐ Elevated blood cholesterol	☐ Measles / Mumps / Chicken pox	☐ Gastritis / Pancreatitis
☐ Cancer	☐ Arthritis	☐ Mononucleosis	☐ Diverticulitis / IBS
☐ Diabetes	☐ Thyroid imbalance	☐ Chronic fatigue	☐ Venereal disease
☐ Hepatitis	☐ Anemia	☐ Chronic pain condition	☐ HIV
☐ Heart disease	☐ Meningitis	☐ Lyme disease	☐ Mental illness
☐ CVA/Stroke	☐ Seizures	☐ Kidney disease	☐ Alcoholism

Any acute illness / symptoms are you prone to? _____How often have you experience it I the last 2 years? _____

Other relevant medical history:_____

Family Medical History Please check any condition that applies to your immediate family.

Put an M (mother) F (father) S (sister) B (brother) GM (grandmother) GF (grandfather) next to selection.

☐ Allergies	☐ Heart Disease	☐ Kidney disease	☐ Tuberculosis
☐ Asthma	☐ High blood pressure	☐ Alcoholism	☐ Other_____
☐ Diabetes	☐ Seizures	☐ Mental illness	
☐ Cancer	☐ SVA / Stroke	☐ Obesity	

Please check the symptoms you have experienced in the last 3 months.

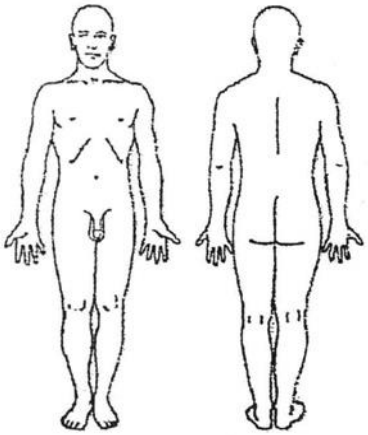
General

- ☐ Insomnia
- ☐ Disturbed sleep
- ☐ Restlessness
- ☐ Memory problems
- ☐ Low Energy / Fatigue
- ☐ General weakness
- ☐ Propensity to catch colds
- ☐ Allergies (food / seasonal)
- ☐ Feeling worse after exercise
- ☐ Difficulty concentrating or staying on task
- ☐ Feeling spacey
- ☐ Not feeling refreshed in the morning
- ☐ Feeling moody in the mornings
- ☐ Feeling angry / irritable / depressed / frustrated / stressed out
- ☐ Sudden weight gain / Loss
- ☐ Poor / Excessive appetite
- ☐ Cravings
- ☐ Bruising easily
- ☐ Organ prolapse
- ☐ Sensation of heaviness in the body
- ☐ Strong thirst
- ☐ Sweating easily
- ☐ Night sweats
- ☐ Unusual sweating (palms/ soles/ chest)
- ☐ Sensation of chills /fever
- ☐ Bitter taste in mouth
- ☐ Sudden energy drop.
- ☐ Poor balance
- ☐ Getting car, sea or air sickness

Musculoskeletal

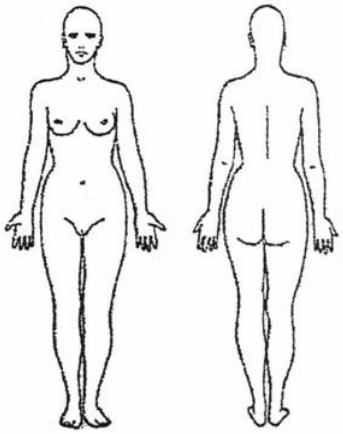
- ☐ Muscle pains
- ☐ Muscle spasms
- ☐ Muscle weakness
- ☐ Numbness / Tingling
- ☐ Limited range of motion (where?_____)
- ☐ Neck pain / Tightness
- ☐ Shoulder pain
- ☐ Rotator cuff pain
- ☐ Hand / Wrist pain
- ☐ Carpal tunnel syndrome
- ☐ Back pain low __ middle __ upper __
- ☐ Sciatica
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot / Ankle pain
- ☐ Sprains / Strains
- ☐ Joint pain (where? _____)

Any other musculoskeletal problems? _____



Please identify any painful or distressed areas and mark the degree of pain on the pain intensity scale below.

No Pain _____ Worst Pain



Is the pain constant or intermittent?_____ Please describe the quality of your pain:

- ☐ Achy
- ☐ Dull
- ☐ Sharp
- ☐ Better with rest
- ☐ Worse with rest
- ☐ Constant
- ☐ Intermittent
- ☐ Hot / Burning
- ☐ Better after exertion
- ☐ Worse with exertion
- ☐ Fixed
- ☐ Moving
- ☐ Cramping
- ☐ Better with heat
- ☐ Worse with heat
- ☐ Throbbing
- ☐ Stabbing
- ☐ Spreading / Radiating
- ☐ Better with cold
- ☐ Worse with cold

Other: _____

Skin and Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Hives
- ☐ Acne
- ☐ Face flushing
- ☐ Itching
- ☐ Dandruff
- ☐ Hair loss
- ☐ Ulcerations / Furuncles
- ☐ Fungal infection
- ☐ Moles / warts
- ☐ Changes in hair or skin texture

Any other hair or skin problems?_____

Oral Health

- ☐ Periodontitis
- ☐ Bleeding gums
- ☐ Dental abscesses
- ☐ Stomatitis
- ☐ Canker sores
- ☐ Frequent cavities
- ☐ Tooth sensitivity
- ☐ Teeth clenching or grinding
- ☐ Pain or clicking of the jaw

Any other oral problems? _____

Head, Eyes, Nose and Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Headaches (where? when?)
- ☐ Facial pain
- ☐ Eye pain
- ☐ Eye strain
- ☐ Poor Vision
- ☐ Blurry visit
- ☐ Night blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Floaters
- ☐ Ear pain
- ☐ Recurrent ear infections
- ☐ Itching in the ear
- ☐ Deafness
- ☐ Tinnitus (ringing in the ears)
- ☐ Poor hearing
- ☐ Deviated septum
- ☐ Sinus problems
- ☐ Nasal congestion
- ☐ Post nasal drip
- ☐ Recurrent sore throats
- ☐ Dry throat
- ☐ Itchy throat

Any other head or neck problems?_____

Respiratory

- ☐ Cough / Wheezing
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Difficult inhalation / exhalation
- ☐ Pain on inhalation
- ☐ Difficulty breathing when lying down
- ☐ Excessive phlegm (color?)_____

Any other respiratory problems? _____

Cardiovascular

- ☐ Fast pulse (over 100 beats/min.)
- ☐ Slow pulse (under 60 beats/min.)
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Chest pain
- ☐ Feeling of pressure in the chest
- ☐ Difficulty breathing
- ☐ High / low blood pressure
- ☐ Migraines with nausea
- ☐ Dizziness
- ☐ Fainting
- ☐ Anemia
- ☐ Raynaud's disease
- ☐ Cold hands / feet
- ☐ Swollen hands / feet
- ☐ Varicose / Spider veins
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Spontaneous sweating
- ☐ Feeling dizzy or faint when getting up quickly or standing for a long time

Any other heart or blood vessel problems: _____

Endocrine

- ☐ Overactive thyroid
- ☐ Underactive thyroid
- ☐ Hyperparathyroidism
- ☐ Hypoparathyroidism
- ☐ Parathyroid tumor
- ☐ Cushing's syndrome
- ☐ Addison's disease
- ☐ Diabetes
- ☐ Pituitary disorder
- ☐ Hypoglycemia
- ☐ Other_____

Any other hormonal problems?_____

Gastrointestinal

- ☐ Lack of appetite
- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Belching
- ☐ Hiccoughs
- ☐ Acid reflux / GERD
- ☐ Insufficient stomach acid
- ☐ Indigestion
- ☐ Diarrhea / loose stools
- ☐ Constipation/hard or difficult to pass stools
- ☐ Feeling incomplete after elimination
- ☐ Intestinal gas
- ☐ Abdominal pain or cramps
- ☐ Gastritis
- ☐ Pancreatitis
- ☐ Peritonitis
- ☐ Peptic or duodenal ulcers
- ☐ Irritable bowel syndrome
- ☐ IBS / Crohn's disease
- ☐ GI tumors
- ☐ Polyps
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Blood in stool
- ☐ Rectal pain or itching
- ☐ Ileocecal valve spasm
- ☐ Hernia

Any other gastrointestinal problems?_____

Genitourinary

- ☐ Pain or burning on urination
- ☐ Difficult urination
- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Scanty flow
- ☐ Dribbling urination
- ☐ Incontinence
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Urinary tract infections
- ☐ Prostate gland problems
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Pain in testicles
- ☐ Warts or sores on genitals
- ☐ Genital herpes
- ☐ HPV
- ☐ Vasectomy
- ☐ Decreased libido
- ☐ Erectile dysfunction
- ☐ Impotence

Do you wake up at night to urinate?_____ If so, how often?_____

Any other genital or urinary problems?_____

Gynecological

- ☐ Irregular period
- ☐ Lack of periods
- ☐ Heavy periods
- ☐ Scanty periods
- ☐ Painful periods
- ☐ Bleeding between periods
- ☐ PMS
- ☐ Menopause
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Tubal ligation
- ☐ Recurrent yeast infections
- ☐ Vaginal itch
- ☐ Vaginal pain or soreness
- ☐ Excessive discharge
- ☐ Vaginal dryness
- ☐ Painful intercourse
- ☐ Ovarian cysts
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ PCOS
- ☐ Infertility
- ☐ Fibrocystic breast tissue

Age at first menses_____ Age at menopause (if applicable) _____ Number of children _____

Number of pregnancies _____ Ectopic pregnancies _____Miscarriages _____ Abortions _____ Premature births _____

Could you be pregnant now? _____ Date of last PAP / Pelvic exam: _____

Time between cycles _____ First day of last menses _____ Average duration of flow _____

Color of the flow: ☐ Pale red ☐ Bright red ☐ Dark red ☐ Wine ☐ Rust ☐ Purple ☐ Brown

Do you experience any of the following symptoms before or during your period?

- ☐ Nausea
- ☐ Vomiting
- ☐ Food cravings
- ☐ Tension headaches
- ☐ Migraines
- ☐ Anxiety
- ☐ Depression
- ☐ Irritability
- ☐ Mood swings
- ☐ Water retention
- ☐ Menstrual cramps
- ☐ Clots in the flow
- ☐ Breast tenderness / Swelling
- ☐ Back pain

Do you practice birth control? _____ If so, what type? _____ _____For how long?_____

Any other gynecological problems?_____

Neuropsychological

- ☐ Seizures
- ☐ Vertigo / Dizziness
- ☐ Loss of balance
- ☐ Lack of coordination
- ☐ Areas of numbness
- ☐ Concussion
- ☐ Poor memory
- ☐ ADD / ADHD
- ☐ Irritability
- ☐ Easily susceptible to stress
- ☐ Nervousness
- ☐ Anxiety / Panic Attacks
- ☐ Depression
- ☐ Seasonal affective disorder
- ☐ Substance abuse

Please describe any traumatic experiences you have had:

Age: _____ Event _____

Age: _____ Event _____

Age: _____ Event _____

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide?_____

Any other neurological or psychological problems? _____

Autoimmune and Inflammatory Conditions

- ☐ Hashimoto's disease
- ☐ Systemic lupus erythematosus
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease
- ☐ Rheumatoid arthritis
- ☐ Osteoarthritis
- ☐ Temporal arteritis
- ☐ Polymialgia rheumatica
- ☐ Myofacial pain syndrome
- ☐ Fibromyalgia
- ☐ Bursitis
- ☐ Tendinitis
- ☐ Capsulitis
- ☐ Tendosynovitis
- ☐ Plantar fasciitis
- ☐ Glomerulonephritis
- ☐ Streptococci infections
- ☐ Staphylococci infections
- ☐ Ear infections
- ☐ Sore throat
- ☐ Swollen glands
- ☐ Swollen lymph nodes
- ☐ Respiratory / seasonal allergies
- ☐ Food allergies / sensitivities
- ☐ Atopic dermatitis
- ☐ Neurodermatitis
- ☐ Cellulitis
- ☐ Alopecia
- ☐ Vulvitis
- ☐ Low immunity

Any other autoimmune / inflammatory problems?_____

Please list any other problems you would like to discuss: _____

_____

_____

_____

Informed Consent for Acupuncture and Oriental Medicine Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including, but not limited to, acupuncture, acupressure, electrical stimulation, moxibustion, cupping & gua sha, tui-na, herbal therapy, nutritional and lifestyle counseling on me (or the patient named below, for whom I am legally responsible) by Victoria Segal, L.Ac.

Acupuncture and Oriental medicine have the effect of normalizing physiological functions, modifying the perception of pain, and treating certain diseases or dysfunctions of the body, but they **are not a substitute for conventional medical diagnoses or treatment.** Consequently, it is recommended that you consult a physician regarding any condition or conditions for which you are seeking acupuncture or herbal treatment.

Acupuncture is a safe method of treatment, but it may occasionally have side effects, including bruising, numbness, or tingling near the needling sites lasting a few days. Unusual risks of acupuncture include dizziness, fainting, infection or scarring. There have been extremely rare instances reported of spontaneous miscarriage, nerve damage and pneumothorax. Bruising is a common side effect of cupping and gua sha. Burns and/or scarring are a potential risk of heat therapy and moxibustion.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. Chinese herbs and nutritional supplements derived from plant, animal and mineral sources are traditionally considered an important and safe in the practice of Chinese medicine. Infrequently, one may experience possible side effects such as nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that if I experience any adverse reaction related to the use of herbs or nutritional supplements, I should stop the herbs and inform the acupuncturist of my symptoms.

I understand that some herbs may be inappropriate during pregnancy and breastfeeding and accept full responsibility to notify the acupuncturist if I am or become pregnant, or if I am a nursing mother.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interest. I also understand there is always a possibility of an unexpected complication, and I understand that no guarantee can be made concerning the results of the treatments on me by Victoria Segal, L. Ac.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content and by voluntarily signing below I agree to the above-named procedures. 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.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an 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 Name (print)	Patient Signature	Date
Patient Representative Name (if applicable)	Patient Representative Signature	Date
Victoria Segal, L.Ac. Practitioner Name	Practitioner Signature	Date

Office Policies Notice

Welcome to Jade and Cinnabar Acupuncture and Oriental Medicine, and congratulations on taking this step towards health and wellness!

An acupuncture appointment at our clinic is viewed as a commitment between the acupuncturist and patient. We respect your time and ask you to do the same for ours.

While we understand that unanticipated events and scheduling conflicts come up for everyone, since we don't double-book the schedule and see one patient at a time, last minute cancellations and missed appointments greatly impact our ability to run the practice smoothly.

We request and appreciate as much of an advance notice as possible given for any scheduling changes so that other patients can take an advantage of available appointment times.

Cancellation Policy:

Due to the nature and size of our business we require a minimum of a 24 hour notice for all appointment changes. Late cancellations, i.e. appointments broken, rescheduled or cancelled less than 24 hours in advance of the scheduled visit time, will incur a forfeiture charge in the full amount of the scheduled appointment fee.

Initial appointments require a minimum 48 hour advance notice for any scheduling changes.

As a courtesy, late cancellations can be rescheduled for an available appointment slot within a 7 day timeframe without charge. Extenuating circumstances such as true emergencies will be given a consideration.

Late Arrivals Policy:

Appointment times are reserved specifically for you. We will try our best to accommodate you, but if you arrive late your session may be shortened as not to penalize patients whose appointments follow yours. Depending upon how late you arrive, I will then determine if there is enough time remaining to start a treatment, or we need to reschedule. Out of respect and consideration to the practitioner and other patients, please plan accordingly and be on time.

Thank you for your understanding and cooperation.

I, _____ (please print name), have read the above policies and acknowledge that I am responsible for payment of the full fee of my scheduled appointment if I fail to show up, or cancel or reschedule my appointment with less than 24 hour notice.

Patient Name (print)	Patient Signature	Date
Patient Representative Name (if applicable)	Patient Representative Signature	Date

Notice of Privacy Policies

This office is dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

Personal information and health information is gathered in several ways:

- Information we receive from you
- Information we receive from other healthcare providers
- Information we receive from third party payers

This information is used for treatment, payment, and healthcare operations. You should be aware that during the course of our relationship we will likely use and disclose health information about you for your treatment, payment, and healthcare operations.

You may specifically authorize us to use Protected Health Information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures of your Protected Health Information will be made to any personal representation of your choice.

Marketing

This office will not use your health information for marketing communications without your written authorization. This office may send birthday cards, newsletters and appointment reminders by phone, postcard, email or letter.

Disclosure

This office may use or disclose your Protected Health Information when required by law.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information. This request must be in writing.
5. You have a right to receive all notices in writing.

If you have any questions, complaints or would like more information please contact this office.

Contact: Victoria Segal, L.Ac. - Jade and Cinnabar Acupuncture and Oriental Medicine
Address: 17 Hanover Road, suite 230, Florham Park, NJ 07932
Phone: 973. 476.2865
E-mail: vicsegal@gmail.com

If desired, you may send a written complaint to the US Department of Health and Human Services at:
DHHS (Office of Civil Rights)
200 Independence Avenue S.W. Room 509 F HHH Building, Washington, DC 20201

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____ have read, reviewed, understand and agree to the statement of the Privacy Policy for healthcare services in this office.

Patient's Signature _____ Date _____