Don F. Gates, L.Ac. Date _____

Health History Questionnaire

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire thoroughly. This information is held in strict confidentiality. If you have any questions, please ask. If there is anything you wish to bring to my attention that isn't asked on this form, please note it in the *Comments* section. Thank you for your help.

Name _____ Date of Birth _____ Age _____
Address _____ Height _____ Weight _____ Sex _____
_____ Employer _____
_____ Occupation _____
Phone # (H) _____ (W) _____ Marital Status ☐ S ☐ M ☐ D ☐ W ☐ P
(C) _____ Spouse / Partner's Name _____
E-mail Address _____ Emergency Contact _____
Referred By _____ Relationship _____ Phone _____

Have you ever received acupuncture before? For what reason? _____
What is the chief health issue you'd like to have treated? _____
When did the problem begin? _____
To what extent does it interfere with your daily life? _____
Have you been given a diagnosis for the problem? If so, what? _____
What treatment have you been using for relief of this issue? _____
What other therapies are you currently using? _____

Past Medical History—please elaborate, as appropriate

☐ Allergies _____	☐ Heart Disease _____	☐ Seizures _____
☐ Asthma _____	☐ Hepatitis _____	☐ Stroke _____
☐ Cancer _____	☐ High Blood Pressure _____	☐ Thyroid Disease _____
☐ Diabetes _____	☐ HIV/AIDS _____	☐ Other _____

Surgeries & Hospitalizations (type & dates) _____
_____
Significant Traumas _____
_____
Known allergies (drugs, chemicals, foods, etc.) _____
_____
Occupational Stress (chemical, physical, psychological) _____
_____
Birth History (prolonged labor, forceps, premature, etc.) _____
What medications / vitamins / supplements are you taking? _____
Have you undergone any courses of antibiotics recently? ☐ Many ☐ Moderate ☐ Few ☐ None

Family Medical History—please elaborate, as appropriate, and note which family member(s)

☐ Allergies _____	☐ Drug/Alcohol Abuse _____	☐ Seizures _____
☐ Asthma _____	☐ Heart Disease _____	☐ Stroke _____
☐ Cancer _____	☐ Hepatitis _____	☐ Thyroid Disease _____
☐ Diabetes _____	☐ High Blood Pressure _____	☐ Other _____

Habits & Lifestyle
Do you exercise regularly? Please describe: _____
Do you eat fast food? ☐ None ☐ Some ☐ Often ☐ Daily
Do you drink soda or eat "junk food"? ☐ None ☐ Some ☐ Often ☐ Daily

Please describe the type of foods you eat daily:
Morning _____
Midday _____
Afternoon _____
Evening _____

Please check any of the habits below that apply to you, now or in the past, and indicate your usage per day or week:

☐ Tobacco _____ per _____ Age started ____ Age quit _____
☐ Alcohol _____ per _____ Age started ____ Age quit _____
☐ Coffee _____ per _____ Age started ____ Age quit _____
☐ Marijuana _____ per _____ Age started ____ Age quit _____
☐ Cocaine _____ per _____ Age started ____ Age quit _____
☐ Heroin _____ per _____ Age started ____ Age quit _____
☐ Other _____ per _____ Age started ____ Age quit _____

Do you suffer from any of the following conditions?

please check all that apply

General

Past Current

☐ ☐ Catch cold easily
☐ ☐ Recurrent infections
☐ ☐ Night sweats
☐ ☐ Sweat easily
☐ ☐ Bleed or bruise easily
☐ ☐ Strong thirst (☐ hot ☐ cold)
☐ ☐ Thirst, no desire to drink
☐ ☐ Fatigue / low energy
☐ ☐ Sudden energy drops
Time of day _____
☐ ☐ Sudden change in weight

Sleep

Past Current

☐ ☐ Difficult to fall asleep
☐ ☐ Wake up easily during night
Times per night? _____
☐ ☐ Wake too early in morning
What time? _____
☐ ☐ Nightmares
☐ ☐ Vivid dreams
☐ ☐ Grinding teeth
☐ ☐ Talking in sleep
☐ ☐ Sleepwalking
☐ ☐ Snoring
☐ ☐ Sleep apnea
☐ ☐ Other _____

Skin / Hair / Nails

Past Current

☐ ☐ Dry skin / scalp / hair
☐ ☐ Thin / brittle nails
☐ ☐ Rashes / hives
☐ ☐ Itching
☐ ☐ Eczema
☐ ☐ Warts
☐ ☐ Acne
☐ ☐ Change in moles
☐ ☐ Hair loss / thinning hair
☐ ☐ Other _____

Head/Eyes/Ears/Nose/Throat

Past Current

☐ ☐ Headaches
Where _____
When _____
☐ ☐ Migraines
☐ ☐ Dizziness / vertigo
☐ ☐ Earache
☐ ☐ Discharge from ear
☐ ☐ Change in hearing
☐ ☐ Ringing in ears
☐ ☐ Blurry vision
☐ ☐ Night blindness
☐ ☐ Color blindness
☐ ☐ Spots before eyes
☐ ☐ Sore eyes
☐ ☐ Eye pain
☐ ☐ Excessive tearing
☐ ☐ Glasses / contacts
☐ ☐ Facial pain
☐ ☐ Facial paralysis
☐ ☐ Nosebleeds
☐ ☐ Nasal discharge
☐ ☐ Recurrent sinus infection
☐ ☐ TMJ
☐ ☐ Teeth / gum problems
☐ ☐ Recurrent sore throat
☐ ☐ Hoarseness / loss of voice
☐ ☐ Tonsillitis / swollen glands
☐ ☐ Sores on lips / mouth / gums
☐ ☐ Other _____

Respiratory

Past Current

☐ ☐ Pain with breathing
☐ ☐ Difficulty breathing
☐ ☐ Shallow breathing
☐ ☐ Shortness of breath
☐ ☐ Production of phlegm
☐ ☐ Recurrent / chronic cough
☐ ☐ Coughing blood
☐ ☐ Asthma / wheezing

Respiratory cont.

Past Current

☐ ☐ Bronchitis
☐ ☐ Emphysema
☐ ☐ Pneumonia
☐ ☐ Other _____

Cardiovascular

Past Current

☐ ☐ Pacemaker
☐ ☐ High blood pressure
☐ ☐ Low blood pressure
☐ ☐ Chest discomfort / pain
☐ ☐ Heart palpitations
☐ ☐ Arrhythmia
☐ ☐ Cold hands or feet
☐ ☐ Swelling of hands or feet
☐ ☐ Blood clots
☐ ☐ Spider veins
☐ ☐ Fainting
☐ ☐ Other _____

Genito-urinary

Past Current

☐ ☐ Pain on urination
☐ ☐ Urgent urination
☐ ☐ Frequent urination
☐ ☐ Blood in urine
☐ ☐ Cloudy urine
☐ ☐ Change in urinary flow
☐ ☐ Urinary incontinence
☐ ☐ Incontinence at night
☐ ☐ Dribbling urination
☐ ☐ Wake to urinate? # times? ___
☐ ☐ Recurrent bladder infections
☐ ☐ Recurrent yeast infections
☐ ☐ Kidney stones
☐ ☐ Prostate problems
☐ ☐ Change in sexual drive
☐ ☐ Impotence
☐ ☐ Rashes / itching
☐ ☐ Other _____

Gynecological
Past Current
☐ ☐ Irregular periods
☐ ☐ Painful periods
☐ ☐ Premenstrual syndrome
☐ ☐ Menopausal syndrome
☐ ☐ Abnormal PAP smear
☐ ☐ Pain with intercourse
☐ ☐ Postcoital bleeding
☐ ☐ Clots
☐ ☐ Fibroids
☐ ☐ Endometriosis
☐ ☐ Infertility
☐ ☐ Vaginal dryness
☐ ☐ Vaginal discharge
☐ ☐ Vaginal sores
☐ ☐ Breast lumps
☐ ☐ Nipple discharge
☐ ☐ Other

Are you now pregnant?
☐ yes ☐ no
Do you practice birth control?
☐ yes ☐ no
what type & how long?_____

# of pregnancies _____
births _____
premature births _____
miscarriages _____
abortions _____
Age of first menses _____
days between menses _____
Duration of bleeding _____
1st day of last menses _____
Age of menopause _____
Date of last PAP _____

Digestive
Past Current
☐ ☐ Little appetite
☐ ☐ Strong appetite
☐ ☐ Hunger, no desire to eat
☐ ☐ Bad breath
☐ ☐ Belching

Digestive, cont.
Past Current
☐ ☐ Nausea
☐ ☐ Vomiting
☐ ☐ Heartburn
☐ ☐ Indigestion
☐ ☐ Abdominal pain
☐ ☐ Weight gain
☐ ☐ Weight loss
☐ ☐ Loose stools / diarrhea
☐ ☐ Dysentery
☐ ☐ Strong smelling stools
☐ ☐ Bloody stools
☐ ☐ Pale stools
☐ ☐ Black, tarry stools
☐ ☐ Constipation
☐ dry stools
☐ not daily
☐ with difficulty
☐ ☐ Pain with passing stools
☐ ☐ Gas / flatulence
☐ ☐ Gall bladder problems
☐ ☐ Appendicitis
☐ ☐ Hernia
☐ ☐ Rectal pain
☐ ☐ Hemorrhoids
☐ ☐ Anorexia nervosa
☐ ☐ Bulimia
☐ ☐ Other _____

Musculoskeletal
Past Current
☐ ☐ Neck pain
☐ ☐ Shoulder pain
☐ ☐ Back pain
☐ ☐ Hand / wrist pain
☐ ☐ Knee pain
☐ ☐ Foot / ankle pain
☐ ☐ Joint / bone problems
☐ ☐ Muscle wasting / weakness
☐ ☐ Osteopenia / osteoporosis
☐ ☐ Herniated disc
☐ ☐ Sciatica
☐ ☐ Other _____

Neurological / Mental
Past Current
☐ ☐ Seizures
☐ ☐ Paralysis
☐ ☐ Tremors
☐ ☐ Stroke
☐ ☐ Concussion
☐ ☐ Nerve damage
☐ ☐ Numbness / tingling
☐ ☐ Lack of coordination
☐ ☐ Loss of balance
☐ ☐ Poor memory
☐ ☐ Difficulty concentrating
☐ ☐ Other _____

Psychological / Behavioral
Past Current
☐ ☐ Depression
☐ ☐ Fearfulness
☐ ☐ Manic Behavior
☐ ☐ Anxiety / nervousness
☐ ☐ Panic attacks
☐ ☐ Often stressed
☐ ☐ Easily angered
☐ ☐ Aggressive behavior
☐ ☐ Lose control of emotions
☐ ☐ Substance abuse
☐ ☐ Other _____

Have you ever been treated for emotional problems?
☐ yes ☐ no
Have you ever considered or attempted suicide?
☐ yes ☐ no

Infection Screening
Have you ever tested positive? When?
☐ HIV _____
☐ Tuberculosis _____
☐ Hepatitis _____
☐ Gonorrhea _____
☐ Syphilis _____
☐ Herpes (oral / genital) _____
☐ Other _____

Please note the degree of severity of your chief complaint today:
No Problem ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Worst Imaginable
1 2 3 4 5 6 7 8 9 10

Please note the greatest degree of severity of your chief complaint to date:
No Problem ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Worst Imaginable
1 2 3 4 5 6 7 8 9 10

Comments: _____

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Mandatory Disclosure of Information & Informed Consent to Treatment

Please read this document carefully and sign where indicated on the reverse side.

You are the most important person on your health-care team and, as such, are entitled to receive clear and comprehensive information about the modalities, techniques, and duration of your therapy. Becoming informed and understanding what to expect from your treatment from the beginning will help make your experience more comfortable and, I believe, more effective overall. If you have questions about your health, your treatment, or any aspect of traditional Chinese medicine (TCM), please feel free to contact me.

Purpose and Benefit of Treatment
Acupuncture and herbal medicine have been used to treat disease for thousands of years. The World Health Organization cites dozens of conditions that can be effectively treated by Chinese medical methods. These include musculoskeletal injuries, digestive disorders, respiratory diseases, women's health issues, and many more.

About the Clinic
In my practice, I comply with all rules and regulations with respect to the practice of acupuncture, including those related to the proper sterilization and maintenance of equipment and the sanitization of acupuncture clinics. To prevent cross-contamination and infection, I use only sterile, single-use, disposable needles in my practice.

Before Your Treatment
To facilitate your treatment, please wear loose, comfortable clothing that can be pulled high enough to expose your elbows and knees. It's a good idea to have a light meal before acupuncture, but don't arrive uncomfortably full. Avoid consuming alcohol before and immediately after your visit; likewise with strenuous exercise.

Please do not brush or scrape your tongue before coming in for treatment—the tongue's natural coating is one of our primary diagnostic tools and, once brushed off, is lost to us for the day. Coffee, cigarettes, and artificially colored foods, while not advisable under most circumstances, can also stain your tongue coat and are best avoided in the hours before a treatment.

Please try to arrive a few minutes before your treatment is scheduled to begin so as to be relaxed and receptive at the appropriate time.

After Your Treatment
Though most people feel extremely relaxed after acupuncture, some report feeling a bit lightheaded. If this happens to you, please rest awhile in the waiting room. It will pass in short order.

Some patients occasionally experience a worsening of their symptoms after an acupuncture treatment. This can be a part of the healing process and is usually soon followed by a marked improvement in overall wellbeing. Please contact our office if you have any concerns or feel any unpleasant effects after your visit.

Herbal prescriptions and herbal patent medicines are intended solely for the person for whom they are dispensed. Please do not share your prescriptions with others, as even identical symptoms may stem from very different root causes. As with pharmaceuticals, Chinese herbs constitute a powerful medicine, and as such it's unwise to self-diagnose, especially without proper background training.

Cancellation & Late Arrival
If you need to cancel or reschedule your appointment, please give me at least twenty-four hours' notice. Without such notice, and except in emergency situations, I reserve the right to charge for missed appointments. Please also be aware that the clinic allots a specific amount of time for each treatment and that if you arrive late, the length of your treatment will be adjusted to fit that schedule.

Your Privacy
I believe absolutely in the right to privacy of my patients and will never disclose any of your personal information without your express consent, unless required to do so by law.

Informed Consent to Treatment

I, the undersigned, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of traditional Chinese medicine, including but not limited to herbology, moxibustion, cupping, electro-acupuncture, acupressure, dermal friction (gua sha), infra-red (heat lamps), and massage (tui na), on me (or on the patient named below, for whom I am legally responsible) by Don Gates and/or other licensed acupuncturists who may treat me now or in the future while working with or associated with Don Gates, or who may serve as a substitute for Don Gates.

I understand that there are some minor risks attendant to acupuncture treatment, including but not limited to slight bruising of the skin (hematoma) and/or bleeding, dizziness, nausea, and occasional aggravation of symptoms existing prior to the treatment. Bruising is a common side effect of cupping. Burns and scarring are potential risks of moxibustion. I understand that the risk of infection in acupuncture is negligible when all needles are sterile.

I understand that the herbs and nutritional supplements (which may come from plant, animal, or mineral sources) recommended in this clinic are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, indigestion, vomiting, diarrhea, headache, hives, and tingling of the tongue.

I understand that some herbs and acupuncture points may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform Don Gates. Additionally, I will inform Don Gates if I have a severe bleeding disorder or if I am wearing a pacemaker or other electronic medical device.

I have had an opportunity to discuss with Don Gates and/or with other office or clinical personnel the nature and purpose of acupuncture. I understand that results are not guaranteed. I do not expect Don Gates to be able to anticipate and explain all risks and complications, and I wish to rely on Don Gates to exercise judgment during the course of my treatment, based upon the facts then known, and to proceed in a manner that he determines is in my best interests.

I hereby release Don Gates from all liability that may occur in connection with the abovementioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

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 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.

Please sign and date below to indicate that you have read and understood this form.

_____ _____

Signature of patient
(or patient's representative, if the patient is a
minor or is physically or legally incapacitated)

Date

_____

Print name of patient (and representative, if applicable)

_____

Street address of patient (and representative, if applicable)

_____

City, state, ZIP code

_____

Telephone number

_____

Email address