

Dr. Jeremiah Carlson
Acupuncturist/Chiropractic Physician
Acupuncture and Herbal Medicine

Some advice to get the most benefit from your acupuncture treatments and to avoid side effects.

Before you come for your acupuncture visit:

- Bring a list of all medications and supplements you are taking
- Wear no make-up or perfume, especially on your first visit.
- Loose clothing is more convenient. We ask the patient to undress if the painful area is difficult to access otherwise.
- Do not drink coffee at least 5 hours prior to your visit.
- Have a light meal or snack before the visit. Heavy meals can cause nausea. Empty stomach can be the cause of dizziness after the treatment.
- Drink enough water on the day of the treatment
- Do not eat or drink food that changes the color of your tongue.
- Do not drink alcohol.

After your acupuncture visit:

- Do not drink alcohol
- Do not eat greasy or spicy food
- Rest is preferable. Make the day as easy as possible.
- Do not exercise
- Do not shower

Consent to Treatment

I, _____, hereby authorize Dr. Jeremiah Carlson, to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatment using the herb *Arthemisa vulgaris* (moxibustion, “moxa”) or a conventional heat lamp may be placed on or near any part of my body. For indirect moxibustion treatments, the moxa is placed on the head of the needle or barrier (such as a slice of ginger or salt) which rests on the skin. When direct moxa is used, the moxa is placed directly on the skin. The heat generated from moxa treatments may involve slight discomfort or leave a small blister or scar on the skin. With any type of heat, there is a risk of burn.
3. A massage technique called “gwa sha” may produce redness on the skin which remains for 1-5 days. A slight bruising or tenderness may persist following the treatment.
4. Cupping may be used to promote the circulation of Qi (energy) through the meridians. Cups may produce a red/purple color on the area cupped which may remain for 1-5 days.
5. Electrical stimulation may be used which produces a vibration/tapping sensation on the needles. Ion pumping cords may be attached to the needles. I have been informed that I have a right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved with this treatment, and was given an opportunity to ask questions pertaining to my treatment. I also understand there is always a possibility of unexpected complications and I understand that no guarantee can be made concerning the results of the treatment.

Signature of patient: _____

Printed Name: _____

Date: _____

Practitioner Signature: _____

Health History Questionnaire

Information for your Acupuncturist

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

All information is strictly confidential.

I. General Patient Information

Date: ___/___/___ Name: _____

Address: _____ City: _____

State _____ Zip _____

Home Phone: (____) _____ Work Phone: (____) _____

Age: _____ Date of Birth: ___/___/___ Place of Birth: _____

Guardian (if under 18): _____

Gender: [] M [] F Height: ___' ___" Weight: _____ lbs.

Social Security Number: _____ - _____ - _____

Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____

State _____ Zip _____

Does anything limit you from care? [] Y [] N If yes, explain: _____

How did you hear about our office? _____

Other physicians/therapists seen for this condition. _____

Medications (if any): _____

Prescribed by: _____

Treatment: _____

Results: _____

Supplements (if any vitamins, herbs, minerals, etc.): _____

Major Complaint(s), in order of significance to you:

	Severe	Moderate	Slight	Normal	
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<hr/>					
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

How do these conditions impair your daily activities? _____

II. Patient Medical History

How was your childhood health? _____
Hospital Visits/Stays: _____

Recent tests: (please indicate test results and date below)

<input type="checkbox"/> Physical	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Prostate	<input type="checkbox"/> Blood (which?)
<input type="checkbox"/> HIV/STD	<input type="checkbox"/> Pap smear	<input type="checkbox"/> Mammography	
<input type="checkbox"/> Other: _____			

Test Results and Date: _____

Check any you have had in the past:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> CVA (stroke) | <input type="checkbox"/> Vein condition | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Nervous disorder |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Polio | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraines | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> other lung illnesses | <input type="checkbox"/> other liver illnesses | <input type="checkbox"/> other heart illnesses | <input type="checkbox"/> other kidney illnesses |
| <input type="checkbox"/> other spleen illnesses | | <input type="checkbox"/> other stomach illnesses | |
| <input type="checkbox"/> other: _____ | | | |

Immunizations: _____

Surgeries: _____

III. Family History

Family member	Alive	Deceased	Present health or cause of death
Father	<input type="checkbox"/>	<input type="checkbox"/>	

Mother	<input type="checkbox"/>	<input type="checkbox"/>	

Spouse	<input type="checkbox"/>	<input type="checkbox"/>	

Children	<input type="checkbox"/>	<input type="checkbox"/>	

Brother	<input type="checkbox"/>	<input type="checkbox"/>	

Brother	<input type="checkbox"/>	<input type="checkbox"/>	

Brother	<input type="checkbox"/>	<input type="checkbox"/>	

Sister	<input type="checkbox"/>	<input type="checkbox"/>	

Sister	<input type="checkbox"/>	<input type="checkbox"/>	

Sister	<input type="checkbox"/>	<input type="checkbox"/>	

Where are you in the birth order? first last middle only
Check the following that have occurred in your blood relatives:

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ | | |

IV. Patient Profile

Please clearly mark any areas of pain and any scars (please indicate which of the areas are scars):

Is the pain:

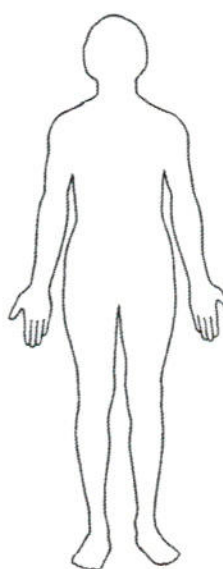
- | | | |
|-----------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Dull | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |

Do the following lessen the pain?

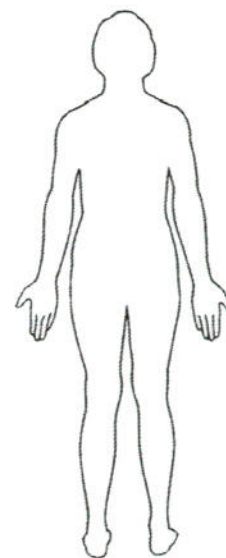
- | | | |
|-----------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Other: _____ | |

Do the following worsen the pain?

- | | | |
|---------------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Pressure | <input type="checkbox"/> Cold | <input type="checkbox"/> Heat |
| <input type="checkbox"/> Other: _____ | | |



Front



Back

Please check the following that pertain to you:

Overall Temperature (Kidney function):

- Cold hands
- Cold feet
- Sweaty hands
- Sweaty feet
- Hot body temperature (sensation)
- Cold body temperature (sensation)
- Afternoon flushes
- Night sweats
- Heat in the hands, feet, and chest
- Hot flashes any time of the day
- Thirsty
- Perspire easily
- Lack of perspiration

- Take water to bed
- Difficulty keeping eyes open in the daytime

Overall Energy (Lung, Kidney function):

- Shortness of breath
- Difficulty keeping eyes open in the daytime
- General weakness
- Easily catch colds
- Low energy
- Feel worse after exercise

Blood (Liver, Spleen, Heart function):

- Dizziness
- See floating black spots

Heart function:

- Palpitations
- Anxiety
- Sores on the tip of the tongue
- Restlessness
- Mental confusion
- Chest pain traveling to shoulder
- Frequent dreams
- Wake unrefreshed
- Drink coffee (# of cups per week: _____)

Lung function:

- Nasal Discharge (Color: _____)
- Cough
- Nose Bleeds
- Sinus Congestion
- Dry mouth
- Dry throat
- Dry Nose
- Dry Skin
- Allergies (To what? _____)
- Alternating fever and chills
- Sneezing
- Headache (Location: _____)

- Overall achy feeling in the body
- Stiff neck
- Stiff shoulders
- Sore throat
- Difficulty breathing
- Smoke cigarettes (# of cigarettes per day: _____)
- Sadness
- Melancholy

Spleen function:

- Low appetite
- Abrupt weight gain
- Abrupt weight loss
- Abdominal bloating
- Abdominal gas
- Gurgling noise in the stomach
- Fatigue after eating
- Prolapsed organs (previously diagnosed, which organ? _____)
- Easily bruised
- Hemorrhoids
- Pensive
- Over-thinking
- Worry

Spleen, Stomach, Large Intestine, Small Intestine function:

- Loose
- Constipated
- Incomplete
- Diarrhea
- Blood in stools
- Mucous in stools
- Undigested food in stools

Dampness trapped in the body:

- General sensation of heaviness in the body
- Mental heaviness
- Mental sluggishness
- Mental fogginess

- Swollen hands
- Swollen feet
- Swollen joints
- Chest congestion
- Nausea
- Snoring

Stomach function:

- Burning sensation after eating
- Large appetite
- Bad breath
- Mouth (canker) sores
- Bleeding, swollen or painful gums
- Heartburn
- Acid regurgitation
- Ulcer (diagnosed)
- Belching
- Hiccoughs
- Stomach pain
- Vomiting

Liver, Gall Bladder function:

- Alternating diarrhea and constipation
- Chest pain
- Tight sensation in the chest
- Bitter taste in the mouth
- Anger easily
- Frustration
- Depression
- Irritability
- Frequently unable to adapt to stress (What causes the stress?
_____)

- Skin rashes
- Headache at the top of the head
- Tingling sensation
- Numbness
- Muscle spasms
- Muscle twitching
- Muscle cramping
- Seizures

- Convulsions
- Lump in the throat
- Neck tension
- Limited Range-of-Motion, Neck
- Shoulder tension
- Limited Range-of-Motion, Shoulder
- Drink alcohol
- Recreational drugs (Which?
_____, How much per
week? _____)
- High-pitched ringing in the ears
- Gall stones (history or current)
- Sexually transmitted disease (Which?
_____)

Eyes (Liver function):

- Itchy
- Bloodshot
- Hot
- Dry
- Watery
- Gritty
- Blurry vision
- Decreased night vision
- Near-sighted
- Far-sighted

Kidney, Urinary Bladder function:

- Frequent cavities
- Easily broken bones
- Sore knees
- Weak knees
- Cold sensation in the knees
- Low back pain
- Memory problems
- Excessive hair loss
- Low-pitched ringing in the ears
- Kidney stones
- Bladder infections
- Wake during the night twice or more to urinate

- Lack of bladder control
- Fear
- Easily startled

Urination:

- Normal color
- Dark yellow
- Clear
- Reddish
- Cloudy
- Scanty
- Profuse
- Strong odor
- Burning
- Painful

- Discharge
- Difficult
- Painful
- Urgent
- Frequent

Libido:

- Normal
- High
- Low

Other symptoms: _____

Women only:

Regular menstrual cycle? Y N

Pregnant? Y N

Number of children: _____

Number of pregnancies: _____

Age of first menstruation: _____

Age of menopause (if applicable): _____

Average number of days of flow: _____
cycle: _____

Average number of days of entire cycle: _____

	Severe	Moderate	Slight	Normal
Vaginal discharge:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you experience any of the following pre-menstrual syndromes?

- nausea
- food cravings
- depression
- vomiting
- headaches
- irritability
- water retention
- migraines
- anxiety
- breast swelling
- breast tenderness
- other emotions: _____
- dull pain, where? _____
- sharp pain, where? _____
- Other: _____

Please Fill in the Following Menstrual Chart

(Optional)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Men only:

	Severe	Moderate	Slight	Normal
<input type="checkbox"/> Swollen testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Feeling of coldness or numbness in external genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

All please fill out:

Other Comments: _____

Patient Signature: _____

Acupuncturist Signature: _____