New Patient Questionnaire
Long Life Acupuncture & Herbs

Complete this questionnaire on your computer, print and bring to your appointment.

First, click the below SAVE button to keep a copy on your computer.
Remember where, on your computer, you saved *NewPtQuestionnaire.PDF*.
After saving, open (double-click the file name) the
saved document on your computer to complete off line.
Place the cursor in each field or click check boxes where appropriate.
Hint: Pressing the TAB Key will move the cursor forward to the *next* field.
Hold SHIFT while pressing TAB key to move the cursor to *previous* field.
Save and print when done.

After printing, please review for accuracy.
To correct errors open the saved document, make corrections then save and print.

Remember to sign & date Consent!

This document is *Personal & Confidential.*
Please take necessary precautions to protect your privacy.
Do not email!

Thank you.

Dr. Jianxin Huang, L. Ac. MD (PRC)
Long Life Acupuncture & Herbs

Next Page

Click to Save to Your Computer Then Back to Web

Date:_____ Last _____First _____

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answer will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not on this form, please note it in the comments section. Thank you.

NAME _____ PHONE: Hm: _____ Wrk: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ PLACE OF BIRTH _____ ETHNIC _____

HEIGHT _____ WEIGHT _____ MARITAL STATUS _____ SOCIAL SECURITY# _____

EMPLOYER NAME_____ OCCUPATION _____

FAMILY PHYSICIAN_____ REFERRED BY _____

IN EMERGENCY, NOTIFY _____ PHONE _____

INSURANCE: Name _____ Policy No. _____ Goup No._____

Main problem(s) you would like us to help you with: _____

_____

How long ago did this problem begin (be specific): _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, sex):

_____

_____

Have you been given a diagnosis for this problem? If so, what?

_____

What kinds of treatment have you tried?: _____

_____

Past medical history (please include date): Cancer_____ Diabetes_____ Hepatitis _____
High blood pressure_____ Heart Disease_____ _____ Rheumatic Fever_____
Thyroid disease_____ Seizures_____ Venereal disease_____
Other_____

Surgeries (type and date): _____

_____

Significant trauma (auto accidents. falls etc.): _____

_____

Significant dental work (type and date of): _____

Birth history (prolonged labor, forceps delivery, etc.) _____

Allergies (drugs. chemicals. foods): _____

Family medical history(check): Diabetes☐ Cancer☐ High blood pressure☐ Heart disease☐
Stroke☐ Seizures☐ Asthma☐ Allergies☐

Other: _____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.):

_____

_____

Previous Page | Next Page

Email: _____

Last _____First _____

Occupational Stress(chemical . physical. psychological. etc.): _____

_____

_____

Do you have a regular exercise program? Yes☐ No☐ Please describe _____

Have you ever been on a restricted diet? Yes☐ No☐ What Kind _____

PLEASE DESCRIBE YOUR AVERAGE DAILY DIET:

Morning: _____

Noon _____

Evening _____

How many cigarettes do you smoke per day _____

How much coffee, tea or cola do you drink per week _____

How much alcohol do you drink per week _____

Please describe any use of drugs for non-medical purpose _____

——————PLEASE CHECK ANY YOU HAVE HAD IN THE LAST THREE MONTHS——————

GENERAL

☐ Chills
☐ Fever
☐ Sweat easily
☐ Night sweats
☐ Localized weakness
☐ Bleed or bruise easily
☐ Peculiar tastes or smells
☐ Strong thirst (cold or hot)
☐ Thirst .no desire to drink
☐ Fatigue
☐ Sudden energy drop
Time of day?_____
☐ Edema
Where____
☐ Poor sleeping
☐ Tremors
☐ Poor balance
☐ Cravings
☐ Change in appetite
☐ Poor appetite
☐ Weight gain
☐ Weight loss

SKIN AND HAIR

☐ Rashes
☐ Itching
☐ Change in hair or skin
☐ Ulcerations
☐ Eczema
☐ Oozing on skin lesion
☐ Hives
☐ Pimples
☐ Recent moles
☐ Loss of hair
☐ Dandruff
☐ Contusion (break in skin)
☐ Other hair or skin problems

HEAD, EYES EARS, NOSE AND THROAT

☐ Dizzinss
☐ Concussion
☐ Migraines
☐ Headaches
When_____
Where_____
☐ Facial pain
☐ Glasses
☐ Poor vision
☐ Night blindness
☐ Blurry vision
☐ Color blindness
☐ Blind field
☐ Spots in front of eyes
☐ Eye pain
☐ Eye strain
☐ Cataracts
☐ Eye dryness
☐ Excessive tear
☐ Discharge from eyes
☐ Poor hearing
☐ Ringing in ears
☐ Earaches
☐ Discharge from ear
☐ Nose bleeds
☐ Sinus congestion
☐ Nasal drainage
☐ Grinding teeth
☐ Jaw clicks
☐ Recurrent sore throats
☐ Hoarseness
☐ Sores on lips or tongue
Other head or neck problems:
_____

CARDIOVASCULAR

☐ High blood pressure
☐ Low blood pressure
☐ Chest discomfort/pain
☐ Heart palpitations
☐ Cold hands or feet
☐ Swelling of hands
☐ Swelling of feet
☐ Blood clots
☐ Fainting
Other heart or blood vessel problems
_____

Last _____First _____

RESPIRATORY

☐ Cough
☐ Asthma/wheezing
☐ Pain with a deep breath
☐ Difficulty in breathing when lying down
☐ Production of phlegm
Color?_____
☐ Coughing blood
☐ Pneumonia
☐ Bronchitis
Other lung problems:_____

GASTROINTESTINAL

☐ Bad breath
☐ Nausea
☐ Vomiting
☐ Heartburn
☐ Belching
☐ Indigestion
☐ Diarrhea
☐ Constipation
☐ Chronic laxative use
☐ Blood in stools
☐ Abdominal pain or cramps
☐ Gas
☐ Rectal Pain
☐ Hemorrhoids
Other stomach or intestinal problems:_____

GENITO_URINARY

☐ Pain on urination
☐ Urgency to urination
☐ Frequent urination
☐ Blood in urine
☐ Decrease in flow
☐ Unable to hold urine
☐ Dribbling
☐ Kidney stones
☐ Impotency
☐ Change of sexual drive
☐ Sores on genitals
Other genital or urinary system problems:_____
How often do you wake up to urinate_____
Any particular color to your urine
_____

PREGNANCY AND GYNECOLOGY

☐ Number of pregnancies
☐ Number of births
☐ Premature births
☐ Miscarriages
☐ Abortions
☐ Age at first menses
☐ Period between menses
☐ Duration
☐ First date of the last menses
☐ Unusal character(heavy or light)
☐ Painful periods
☐ Irregular periods
☐ Premenstrual symptoms
☐ Clots
☐ Menopause: Age_____yr.
☐ Vaginal discharge
☐ Postcoital bleeding
☐ Vaginal sores
☐ Last Papsmear
☐ Breast lumps
☐ Nipple discharge
Do you practice birth control?
Yes ☐ No ☐
What type and for how long?
_____

MUSCULOSKELETAL

☐ Neck pain
☐ Shoulder pain
☐ Back pain
☐ Elbow pain
☐ Hand/wrist pains
☐ Hip pain
☐ Knee pain
☐ Foot/ankle pains
☐ Muscle pains
☐ Muscle weakness

NEUROPSYCHOLOGICAL

☐ Seizures
☐ Areas of numbness/tingling
☐ Weakness
☐ Sleep disorder
☐ Concussion
☐ Bad temper
☐ Loss of control/violence potential
☐ Vertigo
☐ Lack of coordination
☐ Depression
☐ Easily susceptible to stress
☐ Loss of balance
☐ Poor memory
☐ Anxiety
☐ Substance abuse
Other neuro /psychological problems:_____
Have you ever been treated for emotional problems?
Yes ☐ No ☐
Have you ever considered or attempted suicide?
Yes ☐ No ☐

Consent Form

For Acupuncture and Associated Traditional Therapies

I, the undersigned, hereby authorize Dr. Jianxin Huang, Washington State-licensed acupuncturist and nationally-certified herbologist, to perform the following specific procedures:

Acupuncture— Special, sterilized needles inserted at specific points on the skin, into the underlying tissues.
Cupping— putting glass, bamboo, or other cups on the skin, with a vacuum created by heat or other means.
Gua Sha— the technique of rubbing an area of the body with a blunt, round instrument.
Moxa —indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.
Tuina— an ancient massage technique used to treat a wide variety of common disharmonies.
Herbal Consultation— as dietary advice- based on Traditional Chinese Medical theory.

I recognize the potential risks and benefits of these procedures as described below:

Potential risk: discomfort, pain, infection, and blistering at the site of procedure, temporary discoloration of the skin, and even an aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies which may lead to elimination of the presenting health problems, and prevention of other problems.

Understanding the above, I voluntarily consent to the above procedures. I agree that neither Dr. Jianxin Huang, nor his colleagues or employees, have given me any guarantees regarding cure or improvement of my condition.

I hereby release Dr. Jianxin Huang from any and all liability relating to the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw consent and to discontinue participation in these procedures at any time.

I accept full and direct responsibility for paying all bills for Dr. Huang's services to me; I agree to this solely for Dr. Huang's additional protection, and in consideration of his awaiting payment. My responsibility to pay Dr. Huang for his services does not depend on my success or failure in any attempt to recover said fees from insurance companies, through the courts, or from other third parties.

I understand there will be a 1.5% monthly fee for outstanding bills over 30 days and bills more than 90 days past due will be turned over for collection.

I understand that if I miss an appointment without 24 hours advance notification, I will be charged in full.

_____ _____
Signature of Patient Date

or _____ _____
Signature of person authorized to consent Date

Patient

Previous Page First Page