109 Hinton Ave. #10 Wilmington, NC 28403

Patient Name ____ Age_______ Male/Female

Date of Birth _____/_____/_______ Height ___________ Weight ____________

S. S. # _______ - ______ - ___________ Marital Status __________________________

Phone (H) (_______) _______ - _________ Phone (W) (_______) _______ - _________

Address ____

City ____ State ________ Zip ______________

E-Mail ______________________________________ Cell Phone (_______) _______ - _________

Employer ____________________________________ Occupation _______________________________

Spouse's Name ____ Date of Birth _____/_____/_______

Contact Number (_______) _______ - _________ Employer _________________________________

Primary Care Physician ________________________________ Phone (W) (_______) _______ - _________

Referred By _____ ________________________________ Phone (_______) _______ - _________

Emergency Information

Please indicate who to notify in case of emergency

Name ____ Phone (H) (_______) _______ - _________

Relationship ____ Phone (W) (_______) _______ - _________

Phone (C) (_______) _______ - _________

Patient Name ____ **Date** _____/_____/_______

Chief Complaint(s) (please indicate how long you've had the condition(s)).

Other Complaint(s) (please indicate how long you've had the condition(s)).

What kinds of treatment have you received?

List any Hospitalizations & Surgeries **Date (mm/dd/yyyy)** **Place**

____
____
____
____
____
____
____
____

List Medications being taken (include dose)

____
____
____
____
____
____
____
____

Confidential Patient Health History

Name: ____**Date:**_____/_____/_____

Please check if you have had (in the past three months);

General

[ ] Anemia
[ ] Fatigue
[ ] Fever
[ ] Weight Loss
[ ] Sweats
[ ] Chills
[ ] Drug Addiction
[ ] Poor Appetite
[ ] Localized Weakness
[ ] Bleed or Bruise Easily
[ ] Peculiar Tastes or Smells
[ ] Strong Thirst (hot or cold drinks)
[ ] Sudden Energy Drop
[ ] Poor Sleep Habits
[ ] Tremors
[ ] Poor Balance
[ ] Cravings
[ ] Weight Gain
[ ] Alcoholism
[ ] Tetanus Shot
[ ] Frequent cold/flu

Skin and Hair

[ ] Rashes
[ ] Itching
[ ] Dandruff
[ ] Change in hair/skin texture
[ ] Ulcerations
[ ] Eczema
[ ] Open sore
[ ] Acne
[ ] Corns
[ ] Warts
[ ] Psoriasis
[ ] Recent moles
[ ] Loss of Hair
[ ] Hives
[ ] Nail Problems
[ ] Dry skin

Head, Eyes, Ears, Nose and Throat

[ ] Dizziness/Vertigo
[ ] Poor Vision
[ ] Cataracts
[ ] Ringing in ears
[ ] Sinus Problems
[ ] Grinding Teeth
[ ] Nasal Congestion
[ ] Headaches
[ ] Concussions
[ ] Eye Strain
[ ] Night Blindness
[ ] Blurry Vision
[ ] Poor Hearing
[ ] Nose Bleeds
[ ] Hoarseness
[ ] Migraines
[ ] Eye Pain
[ ]Color Blindness
[ ] Earaches
[ ] Spots in front of eyes
[ ] Recurrent Sore Throats
[ ] Facial Pain

Cardiovascular

[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Palpitations
[ ] Irregular Heartbeat
[ ] Mitral Stenosis
[ ] Mitral Prolapse
[ ] Myocarditis
[ ] Pneumatic Heart Disease
[ ] Chest Pain
[ ] Varicose Veins
[ ] Swelling of Hands/Feet
[ ] Fainting
[ ] Coronary Heart Disease
[ ] Difficulty in Breathing
[ ] Hardening of Arteries
[ ] Phlebitis
[ ] Blood Clots
[ ] Cold hands/feet

Respiratory

[ ] Cough
[ ] Bronchitis
[ ] Difficulty breathing lying down
[ ] Emphysema
[ ] Coughing Blood
[ ] Pneumonia
[ ] Asthma
[ ] Pain w/ Deep Breath
[ ] Production of Phlegm
[ ] Pleurisy

Gastrointestinal

[ ] Nausea
[ ] Constipation
[ ] Diarrhea
[ ] Vomiting
[ ] Gas
[ ] Belching
[ ] Bad Breath
[ ] Blood in Stools
[ ] Black Stools
[ ] Abdominal Pain or Cramps
[ ] Rectal Pain
[ ] Hemmorrhoids
[ ] Indigestion
[ ] Chronic Laxative Use
[ ] Acid Reflux
[ ] Ulcer
[ ] Colitis

Genitourinary

[ ] Bed Wetting
[ ] Blood in Urine
[ ] Frequent Urination
[ ] Kidney Infections / Stones
[ ] Painful Urination
[ ] Bladder Infections
[ ] Genital Herpes
[ ] Venereal Disease
[ ] Prostate Problems
[ ] Cystitis
[ ] Incontinence

Pregnancy and Gynecology

____ Number of Pregnancies
____ Age at 1st Menstruation
[ ] Unusually heavy/light
____ Number of Abortions
____ Time between Menstruation
[ ] Vaginal Sores
____ Number of Births
____ Duration of Menstruation
[ ] Vaginal Discharge
____ Number of Miscarriages
____ First Date of Last Menstruation
[ ] Breast Lumps
[ ] Use of Birth Control
[ ] Irregular Periods
[ ] Painful Periods/Cramps
[ ] Clots
[ ] Endometriosis
[ ] Uterine Fibroids
[ ] Hot Flashes/Night Sweats
[ ] Frequent changes in emotion

Musculoskeletal

[ ] Neck Pain
[ ] Muscle Pains
[ ] Knee Pain
[ ] Back Pain
[ ] Muscle Weakness
[ ] Foot/Ankle Pain
[ ] Hand/Wrist Pain
[ ] Shoulder Pain
[ ] Hip Pain
[ ] Osteoporosis

Neuropsychological

[ ] Seizures
[ ] Dizziness
[ ] Loss of Balance
[ ] Areas of Numbness
[ ] Lack of Coordination
[ ] Poor Memory
[ ] Concussion
[ ] Depression
[ ] Anxiety
[ ] Bad Temper
[ ] Easily susceptible to stress
[ ] ADD
[ ] Difficulty Concentrating

Infection

[ ] Measles
[ ] Mumps
[ ] Whopping Cough
[ ] Rheumatic Fever
[ ] Tuberculosis
[ ] Typhoid Fever
[ ] Malaria
[ ] Chicken Pox
[ ] Scarlet Fever
[ ] Small Pox

Other

Are you allergic to any of the following? If yes, please specify
( ) Medicine
( ) Food
( ) Herbs
( ) Others

Do you have or are you any of the following?
( ) Pacemaker
( ) Electric Implants
( ) Metal Implants
( ) Severe Bleeding Disorders
( ) Pregnant
( ) HIV Positive
( ) Hepatitis A/B/C

Social History

	No	Yes	When Started	When Stopped	Amount
Coffee	____	____	____________	____________	________
Tea	____	____	____________	____________	________
Alcohol	____	____	____________	____________	________
Tobacco	____	____	____________	____________	________
Other	____	____	____________	____________	________

Family History (please include the relation)
[ ] Migraines ____________________________
[ ] Heart Disease __________________________
[ ] Asthma _______________________________
[ ] Diabetes ______________________________
[ ] High Blood Pressure ____________________
[ ] Gall Stones ____________________________
[ ] Thyroid Disease ________________________
[ ] Stroke _______________________________
[ ] Allergies ______________________________
[ ] Arthritis ______________________________
[ ] Glaucoma _____________________________
[ ] Mental Illness __________________________
[ ] Cancer _______________________________
[ ] Epilepsy ______________________________

Comments
Please tell us of any other problems you would like to discuss:
____
____
____
____
____
____
____
____
____
____

Patient Signature ____ Date ____/____/________

Bodytech Acupuncture & Sports Medicine

109 Hinton Ave. #10 – Wilmington, NC 28403 – (910) 200-8806

I, ____, herby authorize the private practitioners of Bodytech to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

Acupuncture: insertion of special disposable needles through the skin into underlying tissues at specific points on the surface of the body.

Massage: Manipulation of tissues as by rubbing, stroking, kneading, or tapping with the hand or an instrument for therapeutic purposes.

Heating Lamp or Pad: produces heat on the acupoints and meridians.

Electrical Acupuncture: use of electrical device to produce electrical stimulation on the acupuncture needles.

Herbs: may be given in the form of pills, powders, tinctures, pastes, or plasters. Herbal formulas may include shell, mineral, and animal materials.

Moxa: indirect burning on an acupoint using stick, string, or ball moxa to relieve symptoms.

Dietary Advice: based on traditional Chinese Medical Theory.

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

Potential Risks: discomfort, pain, infection, or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping; and aggravation of the symptoms prior to the acupuncture treatment.

Potential Benefits: drugless relief of present symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the present problem and the strengthening of the constitution.

Notice to Pregnant Women: We do not use labor stimulating acupuncture points unless specifically for the induction of labor. A treatment to induce labor requires a letter from the primary care provider authorizing or recommending such a treatment. All female patients must alert the practitioner if they know or suspect that they are pregnant.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Bodytech Acupuncture & Sports Medicine or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of my health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or if it is required by law. I understand that I may look at my medical record at any time and request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three years, but no more than eight years after the date of my last treatment.

____/____/______ ____

Date Signature of Patient, Patient Representative, or Guardian