Case History Information

Name: _____ Birthdate: _____ Age: _____

Address: _____ Social Security #: _____ - _____ - _____

City: _____ Occupation: _____

State: _____ ZIP: _____ Employer: _____

Phone (Day): _____ Employment Address: _____

Phone (Evening): _____ City: _____

Your Doctor's Name: _____ State: _____

Specialty: _____ Work Phone: _____

Your Doctor's Phone: _____

Diagnosis by Your Doctor: _____

Present Complaints: _____

Referred by: _____ My Pain Now Is: ☐ Minimal ☐ Slight ☐ Moderate ☐ Severe

Please Answer the Following Questions:

1	**Do you have a tendency to faint?**	☐ Yes ☐ No	13	**Do you have excessive thirst?**	☐ Yes ☐ No
2	**Do you bruise or discolor easily?**	☐ Yes ☐ No	14	**Are you taking any therapies at this time?**	☐ Yes ☐ No
3	**Do you bleed easily?**	☐ Yes ☐ No	15	**Are you taking any medications/drugs/herbs?** *(if so, list on the other side)*	☐ Yes ☐ No
4	**Do you have or ever had hepatitis?**	☐ Yes ☐ No	16	**Have you had any surgeries or operations?** *(if so, list on the other side)*	☐ Yes ☐ No
5	**Do you have high blood pressure?**	☐ Yes ☐ No	17	**Are you hungry at the present time?**	☐ Yes ☐ No
6	**Do you have heart problems?**	☐ Yes ☐ No	18	**Are you exhausted at the present time?**	☐ Yes ☐ No
7	**Do you have respiratory problems?**	☐ Yes ☐ No	19	**Are you nervous at the present time?**	☐ Yes ☐ No
8	**Do you have digestive problems?**	☐ Yes ☐ No	20	**Are you allergic to anything?**	☐ Yes ☐ No
9	**Do you have bowel problems?**	☐ Yes ☐ No			
10	**Do you have kidney or bladder trouble?**	☐ Yes ☐ No		(Below for Females Only)	
11	**Do you sweat a lot?**	☐ Yes ☐ No	21	**Are you pregnant at this time?**	☐ Yes ☐ No
12	**Do you have headaches?**	☐ Yes ☐ No	22	**Last monthly period?**	

Please Indicate Your Preferred Payment Method:

☐ **Cash** ☐ **Check** ☐ **Visa** ☐ **Master Charge** ☐ **Health Insurance:** ☐ **Worker's Compensation** ☐ **Personal Injury Case**

CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I, the undersigned, do hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures. The methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western Herbal Medicine, and nutritional counseling.

I have been Informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There may be some bruising after cupping. The herbs and nutritional supplements which may be recommended are traditionally considered safe in the practice of Chinese Medicine.

I Wish to rely on the acupuncturist to exercise, judgement during the course of the treatment, which the acupuncturist feels at the time, is In my best Interests.

By signing below I agree to the above named procedures. I Intend this consent to cover the entire course of treatment for my present condition(s)

Patient's Signature:_____ Date:_____

Case History Information

Name: _____ Birthdate: _____ Age: _____

Address: _____ Social Security #: _____ - _____ - _____

City: _____ Occupation: _____

State: _____ ZIP: _____ Employer: _____

Phone (Day): _____ Employment Address: _____

Phone (Evening): _____ City: _____

Your Doctor's Name: _____ State: _____

Specialty: _____ Work Phone: _____

Your Doctor's Phone: _____

Diagnosis by Your Doctor: _____

Present Complaints: _____

CONSENT FOR HOMEOPATHIC TREATMENT AND CARE

I, the undersigned do hereby request and consent for the homeopathic treatment. I have been informed that homeopathic remedies are safe, but occasionally there may be aggravation of the symptoms Just for few hours.

I wish to rely on the homeopathic practitioner to exercise judgment during the course of the treatment which the homeopath feels at the time, is in my best interests.
By signing below I agree to the above named therapy. I intend this consent to cover the entire course of treatment for my present condition(s).

Patient's Signature: _____ Date: _____

Case History Information

Name: _____ **Date:**_____

*Be brief in your answers below. A check '✓' '**yes**' '**no**' or **one** to **two** words is enough.*
Dr. Shah will go into greater detail with you during the interview.

Please List Current Medications:

_____

_____

_____

_____

_____

_____

Family Diseases:

Mother:

_____

Father:

_____

Mother's Mother:

_____

Mother's Father:

_____

Father's Mother:

_____

Father's Father:

_____

Surgeries: (What Year & Kind?)

_____

_____

_____

_____

Trauma: (✓ if you have had)

_____ Motor Vehicle Accident
_____ Loss of Consciousness
_____ Bums
_____ Fractures
_____ Head Injury
_____ Sprains (recurrent)
_____ Heat / Sun Stroke

Cardiovascular: (✓ if you have had)

_____ Blood Pressure (High)
_____ Heart Problems
_____ Clots / Phlebitis
_____ Varicose Veins
_____ Anemia

Lungs: (✓ if you have had)

_____ Shortness of Breath
_____ Asthma
_____ Bronchitis
_____ Pneumonia
_____ Other Lung Problem(s)

Hormonal Problems:
(✓ if you have had)

_____ Diabetes Mellitus
_____ Thyroid Problems
_____ Other

Infectious Diseases / Parasites
(✓ if you have had)

_____ Infections
(Ear, Nose, Throat, or Sinus Infections)
Are They Recurrent? ☐ Yes ☐ No
_____ Malaria
_____ Mononucleosis
_____ AIDS / HIV
_____ Tuberculosis
_____ Lyme Disease
_____ Worms (parasites)
_____ Other

Joint or Muscle Problems?
☐ Yes ☐ No

Urinary Problems:
(✓ if you have had)

_____ Bladder or Kidney Infections
Are They Recurrent? ☐ Yes ☐ No
_____ Kidney Stones

Liver:
(✓ if you have had)

_____ Hepatitis
_____ Gallbladder Stones

Allergies:
(✓ if you have had)

_____ Airborn (pollens. etc.)
_____ Food(s)

Skin:

Name of Condition _____

Cancer: (Year & Diagnosis Type)

Year: _____

Diagnosis Type: _____

Substance Abuse:

_____ Alcohol
_____ Marijuana
_____ Cocaine
_____ Other (Please List)

_____

_____

Venereal Diseases:
(Please List)

_____

_____

_____

Exposure to Chemicals / Toxins
(Please List)

_____

_____

_____

Bad Reaction to Any Drug or Vaccination?
☐ Yes ☐ No

If yes, what?

_____

_____

_____

Warts Now or Ever? ☐ Yes ☐ No

Headaches or Migraines? ☐ Yes ☐ No

Vertigo or Dizziness? ☐ Yes ☐ No

Memory of Concentration Issues? ☐ Yes ☐ No

Jerking or Trembling? ☐ Yes ☐ No

Numbness or Tingling? ☐ Yes ☐ No

Sleep Problem? ☐ Yes ☐ No

Dental Problems? ☐ Yes ☐ No

Mental or Emotional Issues:
(Please List)

_____

_____

_____