Perfect Point Acupuncture
10 Chestnut Dr. Suite F, Bedford, NH 03110
Kevin Ferst, L.Ac. & Sarah N. Ferst, L.Ac.

Confidential Patient Health History Questionnaire

Today's date M_____D_____Y_____

Name_____ Nickname_____

Phone (H) _____ (W)_____ (C)_____

Address _____

City _____ State _____ Zip _____E-mail _____

Age _____ Date of Birth M_____D_____Y_____Place of Birth_____

Height _____ Weight _____ Marital/Partnership Status _____

Profession/Occupation_____

Family Physician _____ Referred By _____

Emergency Contact _____ Phone_____

Have You Been Treated By Acupuncture or Oriental Medicine Before? Yes No

Main Problem(s) you would like help with _____

_____

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

_____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? _____

_____

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 _____
Blood Pressure High/Low _____/_____ Heart Disease _____ Rheumatic Fever_____
Thyroid Disease _____Seizures _____ STDs_____ HIV/AIDS _____
Other _____

Surgeries (type of and date)_____

_____

Significant Trauma (auto accidents, falls, etc) _____

_____

Significant Dental Work (type and date)_____

Allergies (drugs, chemicals, foods/result) _____

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)

Name of Medication/Supplement	Reason for Taking It
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Occupational Stress (physical, chemical, 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? _____

_____

Are you a smoker? Yes No Quit

If so, how many **packs of cigarettes** do you smoke per day? _____/day

How many caffeinated beverages (**coffee, cola, energy drinks**) do you drink per day? _____

How much **alcohol** do you drink per week? _____

Please describe any use of recreational drugs _____

Please check any problems you have had in the last three months:

General
- Poor appetite
- Fevers
- Sweat easily
- Localized weakness
- Bleed or bruise easily
- Peculiar tastes or smells
- Strong thirst (cold or hot)
- No desire to drink
- Sudden energy drop
  - When? _____
- Poor sleep
- Chills
- Tremors
- Poor balance
- Fatigue
- Night sweats
- Cravings
- Change in appetite
- Weight gain
- Weight loss

Skin and Hair
- Rashes
- Itching
- Dandruff
- Change in hair or skin
- Ulcerations
- Eczema
- Loss of Hair
- Hives
- Pimples
- Recent moles

Skin and Hair (continued)
- Warts
- Other hair or skin problems

_____

_____

Musculoskeletal
- Muscle pain
- Muscle weakness
- Neck pain
- Shoulder pain
- Hand/wrist pain
- Back pain
- Hip pain
- Knee pain
- Foot/ankle pain

Cardiovascular
- High blood pressure
- Irregular heartbeat
- Cold hands or feet
- Blood clots
- Low blood pressure
- Dizziness
- Swelling of hands
- Swelling of feet
- Phlebitis
- Chest pain
- Fainting
- Difficulty in breathing
- Other heart or blood vessel problems _____

_____

Head, Eyes, Ears, Nose, and Throat
- Dizziness
- Poor vision
- Cataracts
- Eye strain
- Night blindness
- Blurry vision
- Spots in front of eyes
- Eye pain
- Color blindness
- Earaches
- Ringing in ears (tinnitus)
- Poor hearing
- Sinus problems
- Grinding teeth
- Teeth problems
- Jaw clicks
- Facial pain
- Nose bleeds
- Recurrent sore throats
- Sores on lips or tongue
- Concussions
- Migraines
- Headaches - where and when _____

_____

Other head or neck problems _____

_____

Respiratory

Cough
Bronchitis
Pneumonia
Asthma
Tuberculosis
Pain with a deep breath
Difficulty in breathing when lying down
Production of phlegm
what color _____
Coughing blood
Other lung problems ____
_____
Approximately when was your last cold or flu?_____
_____

Gastrointestinal

Nausea
Constipation
Diarrhea
Chronic laxative use
Bad breath
Belching
Burning sensation
Abdominal pain or cramps
Vomiting
Gas
Indigestion
Blood in stools
Black stools
Rectal pain
Rectal burning
Anal Prolapse
Hemorrhoids
Other stomach or intestinal problems _____
_____

Pregnancy and Gynecology

Number of pregnancies ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses ____
_____
Unusual character (heavy or light)
Painful periods
Vaginal discharge
What color?_____
Changes in body/psyche prior to menstruation
Clots
Vaginal sores
Irregular periods
Last Pap _____
Breast lumps
Fibroid Cysts
Are you sexually active?__
Do you practice birth control?
Yes No N/A
What type and for how long?
_____
Other Gynecology related concerns_____
_____
_____

Genito-urinary

Pain on urination
Urgency to urinate
Frequent urination
Unable to hold urine
Urinary difficulty
Impotency
Blood in urine
Kidney stones
Sores on genitals
Other genital or urinary system problems _____
_____
Do you wake up to urinate?
Yes No
How often? _____
Any particular color to your urine? _____

Neuropsychological

Seizures
Stroke
Tremors
Fainting spells
Areas of numbness
Concussion
Poor memory
Dizziness
Vertigo
Loss of balance
Lack of coordination
Depression
Easily stressed
Bad temper
Anxiety
Difficulty concentrating
Other neurological or psychological concerns
_____
_____

Please note the severity of your main problem now:

No Problem — Worst Imaginable

Please note the severity of your main problem within the last week:

No Problem — Worst Imaginable

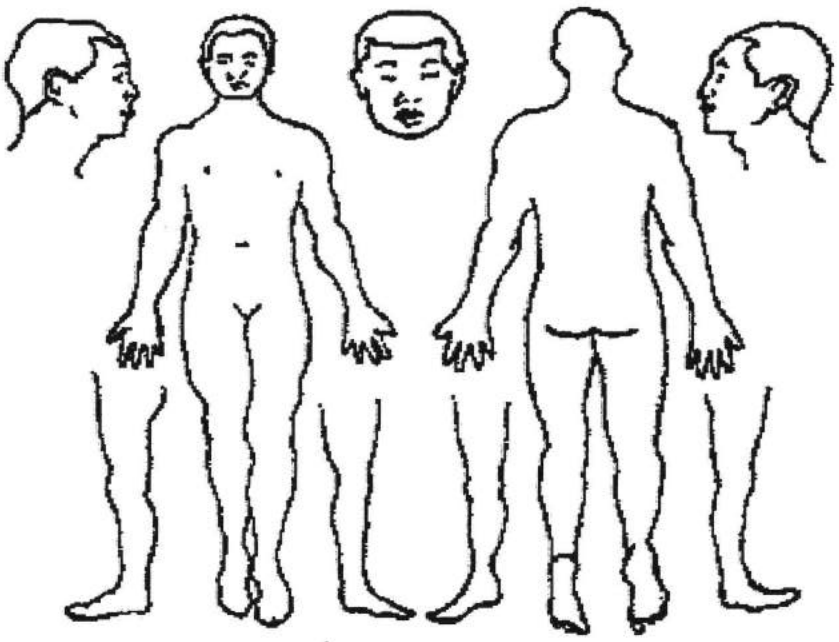
Comments (please mention any other problems or concerns you would like to discuss)

_____

_____

_____

Indicate painful or distressed areas



ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

PATIENT NAME:

ACUPUNCTURIST NAME: Sarah Ferst and Kevin Ferst

(Date)

PATIENT SIGNATURE: X

(Or Patient Representative) (Indicate relationship if signing for patient)