Dr. Peter Dracher DACM; LAc
Health History Questionnaire and Intake Form

Welcome! Please take a moment to fill out this form as completely as possible. All information and communication is confidential and not shared without written consent.

Name_____ Date of Birth_____

Address_____ City_____

State_____ Zip_____ Occupation_____

Phone_____ Email_____
This information helps me communicate with you by text or email related to treatments and appointments.
I also email newsletters from time to time. If you prefer, opt out of only the newsletter by checking here. □

Emergency Contact Name_____ Phone _____

Check if you have you ever received Acupuncture □ or Massage Therapy □
For what condition(s) were you treated?
_____

Are you currently taking any medications? □ No □Yes
If yes, please list names, duration and dosage _____
_____
_____

Are you currently seeing any other healthcare professional(s)? □ No □Yes
If yes, please list names and reason/treatment _____
_____
Current Physician _____ Phone _____

Is there a family history of:
Diabetes ___ Cardio-Vascular Disease____ Allergies_____ Asthma____ Cancer____

Check if you have taken frequent:
____ Antibiotics ____ Antihistamines ____ Sedatives ____ Hormones
____ Birth Control Pills ____ Bronchial Inhalers ____ Cortisone ____ Nose Drops or Sprays
____ Skin Ointments ____ Antidepressants
____ Herbs, Homeopathic remedies, Vitamins, Drugs (Please List):
_____

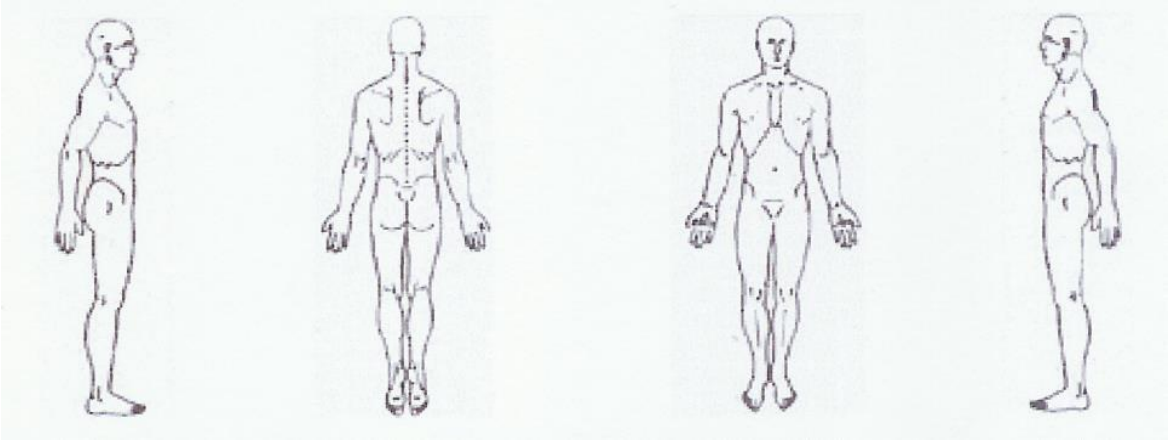
Are you allergic to any foods or medications? If so, which? _____

Have you ever been hospitalized for a:
Medical problem □No □Yes Surgeries □No □Yes Psychiatric reason □No □Yes
If yes, list reasons for hospitalization, treatment & date of stay:
_____
_____

What are your 3 main health concerns?

_____
_____
_____

Please indicate with an X where you are feeling pain or discomfort:



Please describe the nature of the pain/discomfort:
□dull □aching □sharp □shooting □burning □throbbing □deep □nagging □other _____
Does the pain radiate and if so where? _____

Severity of pain: 0 1 2 3 4 5 6 7 8 9 10

What makes the pain /discomfort worse? _____
_____

What alleviates the pain/discomfort? _____
_____

Please check all of the following that have affected your health currently or in the past

___ muscle strain/sprain	___ broken/dislocated bones	___ back problems
___ arthritis	___ whiplash	___ chronic pain
___ pain/numbness/weakness	___ scoliosis	___ TMJ
___ diabetes	___ blood clots	___ cancer
___ constipation	___ diarrhea	___ skin conditions
___ dizziness	___ seizures	___ fainting
___ cold hands/feet	___ chemical dependency	___ smoking or alcohol use
___ heart conditions/disease	___ stroke	___ high blood pressure
___ auto-immune conditions	___ depression	___ hepatitis A, B, C, D, E
___ HIV/AIDS	___ STD	___ infectious diseases

Please provide any details you feel necessary _____
_____
_____

Body Systems Review (please circle all that apply):

0 = never 1 = rarely 2 = occasionally 3 = frequently 4 = always

0 1 2 3 4 low appetite	0 1 2 3 4 ravenous appetite
0 1 2 3 4 loose stools	0 1 2 3 4 heartburn/acid reflux
0 1 2 3 4 mouth sores	0 1 2 3 4 fatigue after eating
0 1 2 3 4 abdominal gas/bloating after food	0 1 2 3 4 bruise easily
0 1 2 3 4 gums (bleeding/swollen)	0 1 2 3 4 thirst
0 1 2 3 4 organ prolapsed (diagnosed)	0 1 2 3 4 belching or vomiting
0 1 2 3 4 breath odor	0 1 2 3 4 unusual taste in mouth

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0 1 2 3 4 spontaneous sweat	0 1 2 3 4 fatigue
0 1 2 3 4 allergies	0 1 2 3 4 catch colds easily
0 1 2 3 4 asthma	0 1 2 3 4 shortness of breath
0 1 2 3 4 general weakness	0 1 2 3 4 cough
0 1 2 3 4 dry nose/mouth/skin/throat	0 1 2 3 4 nasal discharge
0 1 2 3 4 feel worse after exercise	0 1 2 3 4 sinus congestion

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0 1 2 3 4 sore, cold or weak knees	0 1 2 3 4 feel cold
0 1 2 3 4 low back pain	0 1 2 3 4 edema
0 1 2 3 4 frequent urination	0 1 2 3 4 urinary incontinence
0 1 2 3 4 early morning diarrhea	0 1 2 3 4 ear problems
yes no impaired memory	yes no hair loss
yes no infertility	high normal low libido

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0 1 2 3 4 muscle spasms/twitches	0 1 2 3 4 irritable
0 1 2 3 4 feel better after exercise	0 1 2 3 4 numb extremities
0 1 2 3 4 tight feeling in chest	0 1 2 3 4 dry eyes
0 1 2 3 4 alternating diarrhea/constipation	0 1 2 3 4 ear ringing
0 1 2 3 4 symptoms worse with stress	0 1 2 3 4 anger easily
0 1 2 3 4 neck/shoulder tension	0 1 2 3 4 red eyes

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0 1 2 3 4 feel heart beating	0 1 2 3 4 chest pain
0 1 2 3 4 insomnia	0 1 2 3 4 disturbing dreams
0 1 2 3 4 sores on tip of tongue	0 1 2 3 4 headaches
0 1 2 3 4 anxiety	0 1 2 3 4 restlessness
0 1 2 3 4 chest pain traveling to shoulder	0 1 2 3 4 obsessive thinking
high normal low overall body temperature	high normal low overall energy level

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0 1 2 3 4 see floaters in eyes	0 1 2 3 4 foggy thinking
0 1 2 3 4 heat in palms or soles	0 1 2 3 4 dizzy upon standing
0 1 2 3 4 feeling of heaviness	0 1 2 3 4 nausea
0 1 2 3 4 afternoon fever	0 1 2 3 4 night sweats
0 1 2 3 4 enlarged lymph nodes	0 1 2 3 4 cloudy urine
0 1 2 3 4 face flushes	

Patient Information & Treatment Consent Form

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for whom I am legally responsible) by Peter Dracher LAc, LMT and/or his designated employee or those contracted by him to perform such services. I understand that methods or treatments may include but are not limited to acupuncture, massage therapy, moxibustion, cupping, bloodletting, electrical stimulation, Tui Na, Gua Sha, tai chi, yoga, qi gong exercise, Chinese or Western herbal medicine, and nutritional counseling. I have been informed that acupuncture is considered a safe method of treatment, but that it may have side effects including bruising, numbness or tingling near the needle site, which may last a few days. Minor, transient discomfort can occur as the pins penetrate the skin.

It is extremely rare for a serious medical incident to result from acupuncture. The most common untoward effects of the treatment include, but are not limited to, these: occasionally, the acupoint will bleed slightly when the needle is withdrawn; bruising from minor bleeding under the skin is infrequent, but does happen; transient lightheadedness can occur. An unusual risk of acupuncture includes spontaneous miscarriage, nerve damage and organ puncture. Infection is a possible risk, however since this practice uses only sterilized, single-use, disposable needles while maintaining a clean and safe environment, this is unlikely. Burns and scarring are potential risks of moxibustion. Petechiae is a common effect of cupping and gua sha.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. I agree to prepare and consume the herbs according to the instructions of my acupuncturist. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist *immediately.* I understand that the fees for herbs/supplements are additional to the cost of treatment.

_____**initials** I have been informed that I have a right to refuse any form of treatment and all rights regarding patient privacy and records. I have read, or have had read to me the above consent and HIPAA regulations. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I understand that healing is not always a direct path and that symptoms may occasionally worsen before improving or require more than one course of treatment. 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.

_____**initials** I understand it may be necessary for my practitioner to contact another one of my health care providers to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records and to obtain my medical records from my other practitioners for the reasons listed above.

I agree to let the practitioner know if I am ever pregnant, or trying to get pregnant, as this will influence the placement of the needles.

My signature or that of my designated representative below is my acknowledgement that I have read or have had read or explained to me the above and consent to treatment. I further acknowledge that I have had the opportunity to ask questions prior to treatment, and I intend this consent to cover the entire course of treatment for my present and any future conditions for which I seek treatment. My signature below also constitutes consent to bill my insurance for treatment pursuant to any plan my provider may choose to accept or be in contract with, if any, and that I may choose to use.

Cancellation policy: If it is necessary for you to cancel, please give 24 HOURS NOTICE. If you cancel with less notice, you will be charged a full visit fee. Your full cooperation is appreciated.

_____ _____

Signature of patient or authorized representative Date

_____

Print Patient Name or authorized representative