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 are confidential and not shared without written consent.

Name_____ Date of Birth_____

Address_____ City_____

State_____ Zip_____ Most Recent 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? ___No ___Yes

Are you currently seeing any other healthcare professional(s)? ___No ___Yes
If yes, please list names and reason/treatment _____
_____

Current Physician _____ Phone _____

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

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

Are you currently taking any Herbs, Homeopathic remedies, Vitamins, Drugs? ___ No ___Yes
If yes, please list names, duration and dosage _____
_____
_____

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 list Symptom and Duration/Onset

_____

_____

_____

What are your current treatment goals?

_____

Please list major physical, mental, emotional, or birth traumas you have experienced and when

_____

_____

Do you have a regular exercise routine? If so, please describe in brief

_____

What are your average eating habits?

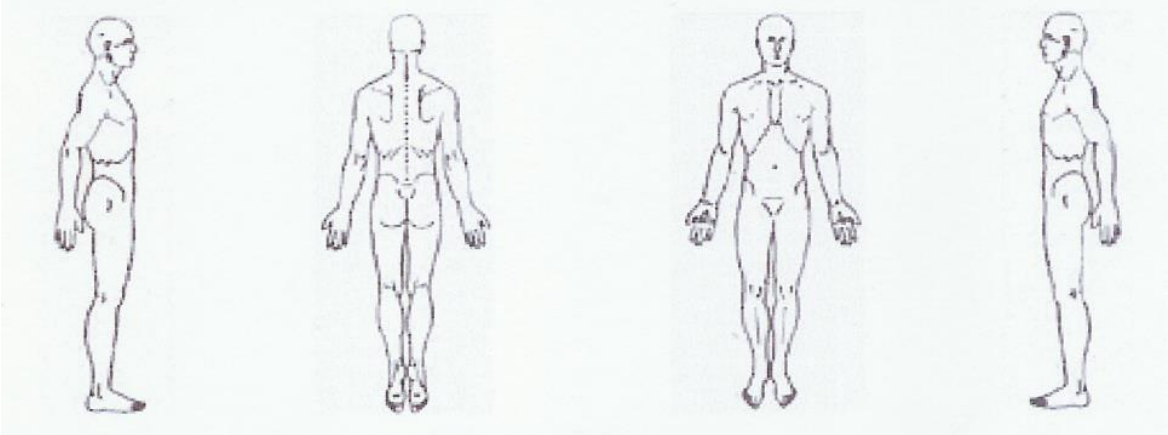
Morning: _____

Afternoon: _____

Evening: _____

Do you have a regular meditation practice? ____ Yes _____No

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



Please describe the nature of any pain/discomfort if applicable:
□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? _____
_____

Notes:

Review of Systems Please check all that apply or occurred in the past

General

___ Edema/Swelling
___ Overweight
___ Underweight
___ Insomnia
___ Restless Sleep
___ Fatigue
___ Sudden Energy Drops
___ Strong Thirst
___ Thirst Without Wanting to Drink
__ Immune Compromised
___ Auto-immune
___ Type: _____
___ Cancer
___ Type/Location: _____
___ Diabetes
___ Frequent Antibiotics
___ HIV/AIDS
___ Hepatitis _____
___ Infectious Disease
___ Feel Cold

Head/EENT

___ Hair loss
___ Scalp Itching
___ Dizziness
___ Headaches
___ Location
___ Migraines
___ with Aura
___ with Nausea
___ Flush Face
___ Blurry Vision
___ Eye Floaters/Spots
___ Eye Pain/Pressure
___ Dry Eyes
___ Floaters/Spots in Eyes
___ Red Eyes
___ Excess Tearing
___ Glasses/Contacts
___ Glaucoma or Cataracts
___ Loss of Vision
___ Night Blindness
___ Ear Discharge
___ Ear Ringing/Tinnitus
___ Loss of Hearing
___ Poor Hearing
___ Nasal Discharge
___ Nose Bleeds
___ Post Nasal Drip
___ Sinus Congestion
___ Sinus Pressure
___ Snoring
___ Loss of Voice
___ Mouth Sores
___ Recurrent Sore Throat
___ Strep Throat
___ Swollen Glands
___ Teeth Grinding
___ TMJ/Jaw Pain

Muskuloskeletal

___ Muscle Pain or Weakness
___ Implants (screws, joints, etc)
___ Joint Pain
___ Arthritis
___ Broken Bones
___ Neck Pain
___ Whiplash
___ Shoulder Pain
___ Arm Pain
___ Elbow/Forearm Pain
___ Numbness/Tingling in Hands
___ Wrist/Hand/Finger Pain
___ Rib Pain
___ Abdominal Pain
___ Back Pain
___ Hernia
___ Hip Pain
___ Thigh Pain
___ Knee Pain
___ Leg Pain
___ Ankle/Foot/Toe Pain
___ Numbness/Tingling in Feet
___ Muscle Spasms/Twitching
___ Loss of Muscle Strength
___ Loss of Muscle Function
___ Scoliosis
___ Cold Hands or Feet
___ Other Injuries

Gastrointestinal

___ Breath Odor
___ Loss of Appetite
___ Increased Appetite
___ Food Cravings
___ Nausea
___ Vomiting
___ Heartburn/GERD
___ Indigestion
___ Belching
___ Abdominal Pain/Cramping
___ Weight Gain
___ Weight Loss
___ Bloating
___ Food Allergies
___ Fatigue After Eating
___ Loose Stool
___ Diarrhea
___ Constipation
___ Dry Stools
___ Blood or Pus in Stool
___ Green Stools
___ Black Tary stools
___ # of BM/Day _____
___ Gas
___ Hemerrhoids
___ Rectal Pain
___ Anorexia
___ Bulimia
___ Colitis
___ Diverticulosis/Diverticulitis

Dental

___ Filling Locations
_____
___ Root Canal Locations
_____
___ Crown Locations
_____
___ Braces
___ Other dental work

GYN/Women

___ Menarch _____
___ Days in cycle _____
___ Clotting
___ Cramping
___ Low Flow
___ Heavy Flow
___ Painful Periods
___ Vaginal discharge
___ Spotting
___ Date of Last Period _____
___ Menopause
___ Pregnant (current)
___ Abortions
___ # of Live Births
___ # of Miscarriages
___ # Premature Births
___ Birth Control
___ C-sections
___ Infertility
___ Endometriosis
___ PID (Pelvic Inflammatory Disease)
___ Breast Lumps
___ Breast Tenderness
___ Change in Sex Drive
___ Fibroids
___ Pain During/After Sex
___ Hormone Replacement
___ Sexually Active

Men

___ Erectile Difficulty
___ Change in Sex Drive
___ Discharge from Penis
___ Hernia
___ Genital/Testicular Pain
___ Prostate issues
___ Impotence
___ Premature Ejaculation
___ Pain During/After Sex
___ Hormone Replacement
___ Sexually Active

Emotional/Cognitive

___ Broken Heart
___ Trauma
___ Easily Angered
___ Depression
___ Anxiety
___ Panic Attacks
___ Foggy Head
___ Easily Startled
___ Racing Thoughts
___ Substance Use
___ Fear/Fright
___ Aggression
___ Suicidal Ideation/Attempt
___ Stress Management Issues
___ Antidepressants
___ Disturbing or Vivid Dreams
___ Obsessive Thinking
___ Irritability

Genitourinary

___ UTI
___ STI/STD Type_____
___ Frequent Urination
___ Painful/Burning Urination
___ Urgent Urination
___ Dribbling/Incomplete Urination
___ Blood in Urine
___ Kidney Stones
___ Incomplete Urination
___ Incontinence
___ Rashes
___ Cloudy Urine

Neurological

___ Stroke
___ Seizures
___ Tremors
___ Parkinsons
___ Balance Issues
___ Neuropathy
___ Sensitivity to Touch
___ Concussions
___ TBI
___ Vertigo
___ Memory Issues
___ Balance Issues
___ Concentration Difficulty
___ Coordination Issues
___ Loss of Dexterity
___ Nerve Damage
___ Paralysis
___ Foggy Thinking
___ Fainting

Cardiovascular

___ Average BP _____
___ Palpitations
___ Chest Pains/Tightness
___ Dizziness Apon Standing
___ Pacemaker
___ Cold Hands/Feet
___ Fainting or Dizziness
___ Edema/Swelling
___ Clotting Issues
___ Spider Veins
___ Atrial Fibrillation
___ Fast or Slow Heart Rate
___ Heart Attack

Respiratory

___ Loss of Voice
___ Shallow Breathing
___ Cough
___ Cough with Phlegm
___ Constricted Throat
___ Shortness of Breath
___ Bronchitis
___ Pneumonia
___ Asthma/Wheezing
___ Frequent Colds/Flu
___ Difficulty Breathing
___ Pain with Breathing
___ Phlegm in Throat
___ Allergies
___ Inhalers
___ Antihistamines

Skin/Body

___ Rashes
___ Skin Discoloration
___ Itching
___ Dry Skin
___ Eczema
___ Psoriasis
___ Sweat Easily or Profusely
___ Night Sweats
___ No Sweating
___ Bruise Easily
___ Recent Moles
___ Acne
___ Dry Skin
___ Cracked Skin
___ Varicose Veins
___ Fungal Infection
___ Sweaty Palms

Additional Information:

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. I understand that laser therapy is a safe procedure with proper use and avoiding direct exposure to the eyes. I acknowledge that all proper uses and safety protocols have been explained to me.

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