



7. Other illnesses, surgeries, injuries

Illnesses

Year	Illness	Treatment/ medications	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Surgeries

Year	Surgery	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Injuries/Trauma

Year	Injury /Trauma	Treatment	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Family history

- Allergies  
  Diabetes  
  Emotional Difficulties  
  Glaucoma  
  Heart Problems  
  Stroke  
 Cancer  
  Seizure Disorders  
  Thyroid Problems  
  Tuberculosis  
  Hypertension/ High BP

9. Has there been any history of abuse that you would like to discuss today? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please check any conditions or symptoms that **you presently have** or **have had in the past**:

	Now	Past		Now	Past		Now	Past
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>
Cough with blood	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting with blood	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Treatment _____		
Chronic colds	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Nasal/sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Sputum/phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Laxative use	<input type="checkbox"/>	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Lack of perspiration	<input type="checkbox"/>	<input type="checkbox"/>	Product _____		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Excessive perspiration	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Nasal polyps	<input type="checkbox"/>	<input type="checkbox"/>			

	Now	Past		Now	Past		Now	Past
Acid regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Excessive appetite	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements			Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	every _____ days			Hot tempered	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	number per day _____			Stress	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime urination	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>	Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	General chilliness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/fee	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Where _____			Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	General warmth	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (lower)	<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (middle)	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Back pain (upper)	<input type="checkbox"/>	<input type="checkbox"/>	Where _____			Poor memory	<input type="checkbox"/>	<input type="checkbox"/>
Pain goes down the legs	<input type="checkbox"/>	<input type="checkbox"/>	Eye tiredness / strain	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses	<input type="checkbox"/>	<input type="checkbox"/>	Seeing spots	<input type="checkbox"/>	<input type="checkbox"/>	Skin ulcerations	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Eye dryness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Eye redness	<input type="checkbox"/>	<input type="checkbox"/>	Problems with alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Eye itchiness	<input type="checkbox"/>	<input type="checkbox"/>	Problems with drug use	<input type="checkbox"/>	<input type="checkbox"/>
Eyes feel swollen	<input type="checkbox"/>	<input type="checkbox"/>	Eye tearing	<input type="checkbox"/>	<input type="checkbox"/>	Psychological crisis	<input type="checkbox"/>	<input type="checkbox"/>
Pressure in the eye	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Psychoactive medications	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	if yes, which ones _____		
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Sore gums	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	Emotional difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in the tongue	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mouth dryness	<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Bad taste in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Shaking/tremors	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores/ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Cysts/tumors	<input type="checkbox"/>	<input type="checkbox"/>
Changes in skin color	<input type="checkbox"/>	<input type="checkbox"/>	Skin acne	<input type="checkbox"/>	<input type="checkbox"/>	Edema/water retention	<input type="checkbox"/>	<input type="checkbox"/>
Skin bruising	<input type="checkbox"/>	<input type="checkbox"/>	Body hair changes	<input type="checkbox"/>	<input type="checkbox"/>	Night sweating	<input type="checkbox"/>	<input type="checkbox"/>
			Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>	<input type="checkbox"/>

Smoking: How much per day? \_\_\_\_\_

Alcohol: How much per day? \_\_\_\_\_

Recreational drugs: How much per day? \_\_\_\_\_

Nutrition

What do you typically eat for the following:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Exercise

What is your daily activity level related to your occupation:

Sedentary i.e mostly sitting

somewhat active

Moderately active

very active (moving around or up most of the time)

Heavy duty (lifting, moving things etc.)

What kind of physical activity level (exercise, sports) do you participate in? How often per week?

How long each time?

\_\_\_\_\_  
\_\_\_\_\_

Miscellaneous

How much water do you drink per day? \_\_\_\_\_

How many caffeine-containing products (coffee, tea, carbonated pop) do you drink per day? \_\_\_\_\_

Snacks: \_\_\_\_\_

**Male Patients** Please fill out the following section

Please check any conditions or symptoms that **you presently have** or **had in the past**:

	Now	Past		Now	Past
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Low sex drive	<input type="checkbox"/>	<input type="checkbox"/>	Urinary dribbling	<input type="checkbox"/>	<input type="checkbox"/>
Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>			

When was your last prostate exam? \_\_\_\_\_

PSA result: \_\_\_\_\_

**Female Patients** Please fill out the following section

Pregnancy: Are you presently pregnant?  Y  N  Not sure

*Please list history of pregnancy, note if full term (FT), premature (P), miscarriage (MC), abortions (A), whether vaginal (V) or Cesarean section (C). Note any difficulties you experienced during the pregnancy and/or after delivery (for example morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum etc.)*

Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_  
Year \_\_\_\_\_

**Menstruation**

Age of onset \_\_\_\_\_ Last Menstrual Period (first day of) \_\_\_\_\_

Date of last Pap exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Result \_\_\_\_\_

Length between periods \_\_\_\_\_

Regularity:  regular  irregular  usually early  usually late  varies between  
by \_\_\_\_ days by \_\_\_\_ days being early or late

How many days of menstrual flow do you usually have? \_\_\_\_\_

Flow is:  even  uneven  heavy  light

Color is:  pale  pink  light red  red  deep red  purplish  brown

Consistency is:  thin  thick  clotted

**Discomfort with period:**

lower abdominal distention  before  during  after menstruation

lower back soreness  before  during  after menstruation

cramping  before  during  after menstruation

Other \_\_\_\_\_

**Premenstrual Syndrome (PMS)**

irritability  bloating  mood swings  breast tenderness  other \_\_\_\_\_

**Vaginal Discharge**

No  Yes If yes, color and amount: \_\_\_\_\_

**Menopause**

Age of onset \_\_\_\_\_ Any difficulties / symptoms? \_\_\_\_\_

Uterine bleeding (not related to periods) Color \_\_\_\_\_ amount \_\_\_\_\_

comes on suddenly  all the time

## **Cancellation Policy**

In the event you have to cancel you appointment, please do so within 24 hours. Appointments canceled with less than 24 hours notice will be expected to pay for the treatment time scheduled.

I understand and agree to the cancellation policy.

Signature\_\_\_\_\_ Date\_\_\_\_\_

## **Patient Informed Consent**

1. I hereby voluntarily consent to be treated by acupuncture and or Chinese Herbs, and or bodywork/massage administered by Eric Rothgeb or Greg Bell, hereinafter referred to as "Practitioner".
2. I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.
3. I acknowledge that, although rare, certain side effects may result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.
4. I accept the fact that no guarantee is made concerning the use and effects of acupuncture, massage, or Chinese herbs.
5. I understand that I may stop treatment at any time.
6. I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination or diagnosis. In the course of the evaluation, there may be references to the state of various "organs", such as the heart, liver, spleen, kidneys, etc., which actually refers to the energetic channels of the same name.
7. I acknowledge the fact that Practitioner is not and does not profess to be a western-trained medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does the Practitioner give any substances by injection.
8. I acknowledge that Practitioner has completed a minimum of three years training In Acupuncture and Oriental Medicine, is a National Board Certified (NCCAOM) herbalist and acupuncturist (Dipl. OM) and a Licensed Acupuncturist (L.Ac.) in the state of Illinois.
9. The clinical data gathered in practice, without names, may be used for statistical research and teaching purposes.

Signature\_\_\_\_\_ Date\_\_\_\_\_