HEALTH HISTORY FORM

Jade & Jasmine Healing Arts, LLC

Name____ Birthday_____________ Age_______ Gender___________

Address____ City_______________________ State_______ Zip__________

Home Phone______________________ Cell Phone________________________ Work Phone________________________

Email____ Height_____________ Weight_________________

Married Single Partner Divorced Widowed   Children (Age & Gender)____

Family Physician___________________________ Phone______________________ Referred by______________________

Emergency Contact___________________________ Phone____________________ Relationship______________________

Goals: What health concerns would you like to address through treatment?

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Nutrition

Please describe any special diet or food restrictions to which you adhere (e.g. Gluten-free, Vegan, Low Carb, etc.)

____

What do you eat on a "typical" day?

Breakfast____ Lunch____

Dinner____ Snacks ____

Foods Cravings:______________________________ Preferred Beverage Temperature: ☐Hot ☐Room Temp. ☐Cold

Medications / Supplements

Please include prescription medicine, vitamin, supplement, herbal, hormone, laxative, homeopathic, and over the counter medicine you take on a regular basis, along with dosage and brand, if known.

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

Allergies (environmental, animal, medication, chemical, food):____

Lifestyle

What is your occupation?_______________________________________ How many hours do you work weekly?_________

How many servings per day (or week/month) do you use of the following?

Coffee_______ tea________ soft drinks________ alcohol_________ water__________ cigarettes/tobacco_____________

Please describe your current exercise regimen:

Hours per week: ______ Activities: ____ ☐No Exercise

Do you have a known history of any exposure to toxic substances? ☐Yes ☐No

Have you traveled internationally? ☐Yes ☐No   Treated for: ☐Parasites ☐Malaria ☐Dysentery ☐Dengue Fever

Hospitalizations and Surgical History Please list dates of hospitalizations and describe the treatment or procedure.

____Date ________

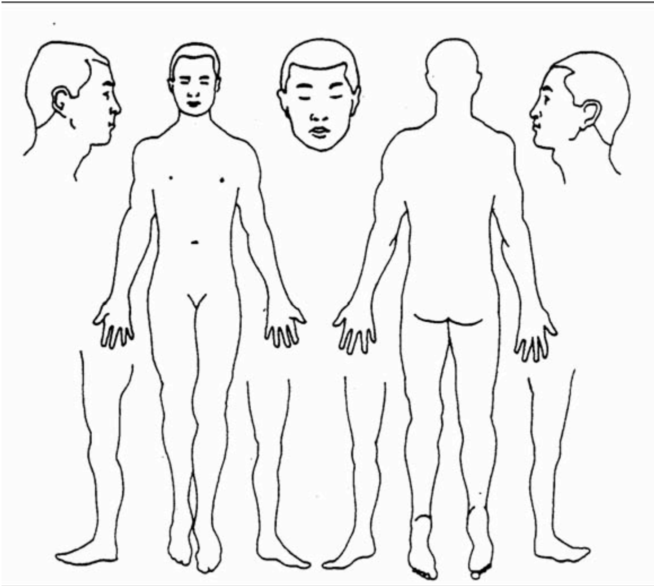
____Date________

____Date________

____Date________

____Date________

Muscular-Skeletal Pain



Do you experience pain or discomfort in any area of your body? ▫Yes ▫No

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

Do you have any difficulty with:
▫Walking ▫Sitting ▫Standing ▫Driving

Please list any accidents, injuries, broken bones or scars: ________________________________
____

For Women: Please indicate the dates for:
Last Pap Smear ____ Last Mammogram _____ Tubal Ligation _____ Hysterectomy ______Ectopic Pregnancy______
Are you currently pregnant or trying to conceive? ▫Yes ▫No ▫Unsure Date of Last Menses: _______________
Indicate number of occurrences: Live Births ______ Pregnancies_________ Miscarriages ________ C-Sections______

Medical History Part I

Condition	Self (date diagnosed)	Mother	Father	Sibling	Grandparent (maternal/paternal)	Spouse	Child
Heart disease							
Stroke							
Cancer							
Asthma							
Thyroid Disease							
Age Deceased	NA						
Depression or Mental Illness							
Seizures							
Substance abuse							
Arthritis							
Diabetes							

Medical History Part II

CHECK ALL THAT APPLY

GENERAL

Past	*Current*	*Condition*
[ ]	[ ]	Change in appetite
[ ]	[ ]	High/Low appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Strong Thirst
[ ]	[ ]	Bleed/ bruise easily
[ ]	[ ]	Decreased Libido

CARDIOVASCULAR

Past	*Current*	*Condition*
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Pacemaker
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _________________

FEMALE

Past	*Current*	*Condition*
[ ]	[ ]	Bladder/ urinary tract infections
[ ]	[ ]	Yeast or bacterial vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Ovarian Cysts
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Endometriosis
[ ]	[ ]	Uterine Fibroids
[ ]	[ ]	Vaginal Dryness
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps/ tenderness

SKIN & HAIR

Past	*Current*	*Condition*
[ ]	[ ]	Hair Loss
[ ]	[ ]	Weak/Brittle Nails
[ ]	[ ]	Dandruff
[ ]	[ ]	Rashes /Hives
[ ]	[ ]	Fungal Infections
[ ]	[ ]	Itching
[ ]	[ ]	Eczema/Psoriasis
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HEAD & NECK

Past	*Current*	*Condition*
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Migraines
[ ]	[ ]	Facial Pain
[ ]	[ ]	Other: ______________

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____________

EYES

Past	*Current*	*Condition*
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots /Floaters
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye dryness/ itching
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Glaucoma

NOSE, THROAT, MOUTH

Past	*Current*	*Condition*
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Mouth/Tongue Sores
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	TMJ
[ ]	[ ]	Difficulty swallowing

RESPIRATORY

Past	*Current*	*Condition*
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	COPD
[ ]	[ ]	Shortness of Breath
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: ______________

GASTRO-INTESTINAL

Past	*Current*	*Condition*
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Loose Stools
[ ]	[ ]	Bloating/Distension
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Intestinal pain or cramps
[ ]	[ ]	Indigestion/ Reflux
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas /Flatulence
[ ]	[ ]	Other: _____________

GENITO-URINARY

Past	*Current*	*Condition*
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain on urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Incontinence
[ ]	[ ]	Dribbling/Leaking
[ ]	[ ]	Other: _________

MALE

Past	*Current*	*Condition*
[ ]	[ ]	Nocturnal Emissions
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Erectile Dysfunction
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Prostate Issue
[ ]	[ ]	Other: ___________

NEUROLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Vertigo
[ ]	[ ]	Confusion
[ ]	[ ]	Poor Memory
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Loss of balance/coordination
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: __________________

PSYCHOLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability / short temper
[ ]	[ ]	Treated for emotional or Psychological problems
[ ]	[ ]	Compulsive Behavior
[ ]	[ ]	Suicidal Thoughts

INFECTION SCREENING

Past	*Current*	*Condition*
[ ]	[ ]	HIV or AIDS
[ ]	[ ]	TB (Tuberculosis)
[ ]	[ ]	Hepatitis
[ ]	[ ]	Mononucleosis
[ ]	[ ]	STD______________________
[ ]	[ ]	Blood Transfusion
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral (cold sores)
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	*Current*	*Condition*
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Osteoarthritis
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain
[ ]	[ ]	Rheumatoid arthritis

Do you have any additional concerns you would like to discuss?

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____

Signature:____Date: ____________________

Voluntary Consent Form

I hereby request and consent to be treated with acupuncture and other procedures within the scope of practice of acupuncture by Beth Burke Farrar, L.Ac., a licensed acupuncturist in the states of Maryland and Virginia. I understand that treatment methods may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), far infrared heat, Chinese herbal medicine and nutritional counseling.

Acupuncture: I understand that acupuncture involves the insertion of needles. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects. Side effects could include, but are not limited to, local bruising, slight bleeding, dizziness, fainting, pain and discomfort, numbness or tingling near the needling sites that may last a few days, and temporary aggravation of symptoms existing prior to treatment. 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 spontaneous miscarriage, nerve damage and organ puncture, including lung puncture. 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.

Chinese Herbs: I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that are recommended to me are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. The herbs may have an unpleasant smell or taste. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify my practitioner of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I understand that some herbs and acupuncture treatment methods may be inappropriate during pregnancy. I will notify my practitioner if I am or become pregnant, or if it is possible that I may be pregnant.

I understand that acupuncture serves individuals with a wide range of complaints, including both acute and chronic healthcare issues. No guarantees concerning its use and effect are given to me. I understand that if there is an emergency, or a worsening of my health condition, or if a new ailment or condition arises, that I should consult a licensed physician.

By voluntarily signing below, I show that I have read carefully, or have had read to me, this consent to treatment form. I acknowledge that the purpose, procedures, potential risks and benefits of acupuncture treatment have been explained to me. I am free to ask questions regarding this form and the proposed services at any time. 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. I understand that I am free to refuse specific therapies or discontinue services at any time.

Payment & Cancellation Policy

In an effort to provide you with professional and personalized holistic healthcare, I reserve your appointment time exclusively for you. If you need to cancel or reschedule your session, kindly contact me by noon the day prior to your appointment or else you will be charged the full fee for the missed session. Illness and family emergency are exempt. If you are not feeling well the day of your session, please call me ahead of time to discuss whether it would be appropriate to receive treatment that day. The charge for a returned check is $30.

______________________________	______________________________	____________
Printed Name	Signature	Date