



CASCADe
ACUPUNCTURE &
HERBAL MEDICINE

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Patient Information

Name:			Date:		
Address:		City:		State:	Zip:
Home Phone: ()		Work Phone: ()		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Age:		Date of Birth:		City of Birth:	State of Birth:
Height:		Weight:		Employer Name:	
Occupation:		Family Physician:		Referred by:	
Emergency Contact (Name):		Emergency Contact Phone: ()		Have you been treated by acupuncture or oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Insurance Information

Insurance Company:			Name of Subscriber:		
Relation of Subscriber to Patient:		Subscriber's Birth Date:		Social Security Number:	
Address: (if different from Patient's address)			City:		State: Zip:
Insurance Company Telephone Number: ()		Subscriber Number:		Group Number:	
Is this a Personal Injury Auto Insurance Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No				If YES, what is the date of the injury?	
Claim Number:		Claim Adjuster's Name:		Claim Adjuster's Phone Number: ()	

Health Information

What is/are the main problem(s) you would like us to help you with? _____ _____ _____
How long ago did this problem begin (be specific)? _____ _____ _____
To what extent does this problem interfere with your daily activities (work, sleep, sex)? _____ _____ _____
What kinds of treatment have you tried? _____ _____ _____

Past Medical Information

Please check all that apply, and include the date.

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Thyroid Disease _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Venereal disease _____

Surgeries (Type and Date)? _____

Significant Trauma (Auto Accidents, Falls, etc.)? _____

Significant Dental Work (Type and Date)? _____

Birth History (Prolonged Labor, Forceps Delivery, etc.)? _____

Allergies (Drugs, Chemicals, Foods/Result)? _____

Family Medical History – Please check all that apply.

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Allergies
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____

Medicines taken within the last two months (Vitamins, Drugs, Herbs, etc.): _____

Occupational Stress (Chemical, Physical, 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? _____

Please Describe Your Average Daily Diet:

Morning _____

Afternoon: _____

Evening: _____

How many packs of cigarettes do you smoke per day? _____

How much alcohol to you drink per week? _____

How much coffee, tea or cola do you drink per week? _____

Please describe any use of drugs for non-medical purposes: _____

Please Check Any Symptoms You Have Had in the Last Three Months

General

- Chills
- Fevers
- Sweat Easily
- Night Sweats
- Localized Weakness
- Bleed or Bruise Easily
- Peculiar tastes or smells
- Strong thirst
- Thirst, no desire to drink
- Fatigue
- Sudden Energy Drop
Time of day _____
- Edema
Where _____
- Poor Sleeping
- Tremors
- Poor Balance
- Cravings
- Change in Appetite
- Weight Gain
- Weight loss

Skin and Hair

- Rashes
- Itching
- Change in Hair or Skin
- Ulcerations
- Eczema
- Oozing on skin/ lesion
- Hives
- Pimples
- Recent Moles
- Loss of Hair
- Dandruff

Other hair or skin problems

Head, Eyes, Ears, Nose And Throat

- Dizziness
- Migraines
- Headaches
When: _____
Where: _____
- Facial Pain
- Glasses
- Poor Vision
- Night Blindness
- Blurry Vision
- Color Blindness
- Blind field
- Spots in front of eyes
- Eye Pain
- Eye strain
- Cataracts
- Eye Dryness

- Excessive tear
 - Discharge from eyes
 - Poor Hearing
 - Ringing in ears
 - Earaches
 - Discharge from ear
 - Nose Bleeds
 - Sinus Congestion
 - Nasal Drainage
 - Grinding Teeth
 - Teeth Problems
 - Jaw Clicks
 - Concussions
 - Recurrent sore throats
 - Hoarseness
 - Sores on lips or tongue
- Other head or neck problems:*

Cardiovascular

- High blood pressure
 - Low blood pressure
 - Chest discomfort or pain
 - Heart palpitations
 - Cold hands or feet
 - Swelling of hands
 - Swelling of feet
 - Blood clots
 - Fainting
 - Difficulty in breathing
- Other heart or blood vessel problems:*

Respiratory

- Cough
 - Asthma/ wheezing
 - Pain with a deep breath
 - Difficulty in breathing when lying down
 - Production of phlegm.
What color: _____
 - Coughing blood
 - Pneumonia
 - Bronchitis
- Other lung problems:*

Gastrointestinal

- Bad Breath
- Nausea
- Vomiting
- Heartburn
- Belching
- Indigestion

- Diarrhea
 - Constipation
 - Chronic Laxative use
 - Blood in Stools
 - Black Stools
 - Abdominal pain or cramps
 - Gas
 - Rectal Pain
 - Hemorrhoids
- Other Stomach or intestinal problems:*

Genito-Urinary

- Pain on urination
 - Urgency to urinate
 - Frequent urination
 - Blood in Urine
 - Dribbling
 - Kidney Stones
 - Impotency
 - Change of sexual drive
 - Sores on genitals
- Do you wake up to urinate?*
Yes No
How often?

- Any particular color to your urine?*

Other genital or urinary system problems:

Pregnancy & Gynecology

- Number of pregnancies: _____
- Number of births: _____
- Number of premature births: _____
- Number of miscarriages: _____
- Number of abortions: _____
- Age at first menses: _____
- Period between menses (days) _____
- Duration of menses: (days) _____
- First of date of last menses: _____
- Heavy periods
- Light periods

- Painful periods
 - Irregular periods
 - Changes in body/psyche prior to menstruation
 - Clots
 - Menopause:
Age: _____
Year: _____
 - Vaginal Discharge
 - Post-coital bleeding
 - Vaginal sores
- Date of Last Pap:* _____
- Breast lumps
 - Nipple discharge

Do you practice birth control?
 Yes No
What type and for how long? _____

Musculoskeletal

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

Neuropsychological

- Seizures
- Ares of numbness
- Weakness
- Sleep disorder
- Concussion
- Bad temper
- Loss of control/violence potential
- Vertigo
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Substance abuse

Other neurological or psychological problems:

I, _____ authorize that all of the above information is accurate and correct on this day _____ of _____, 20____.

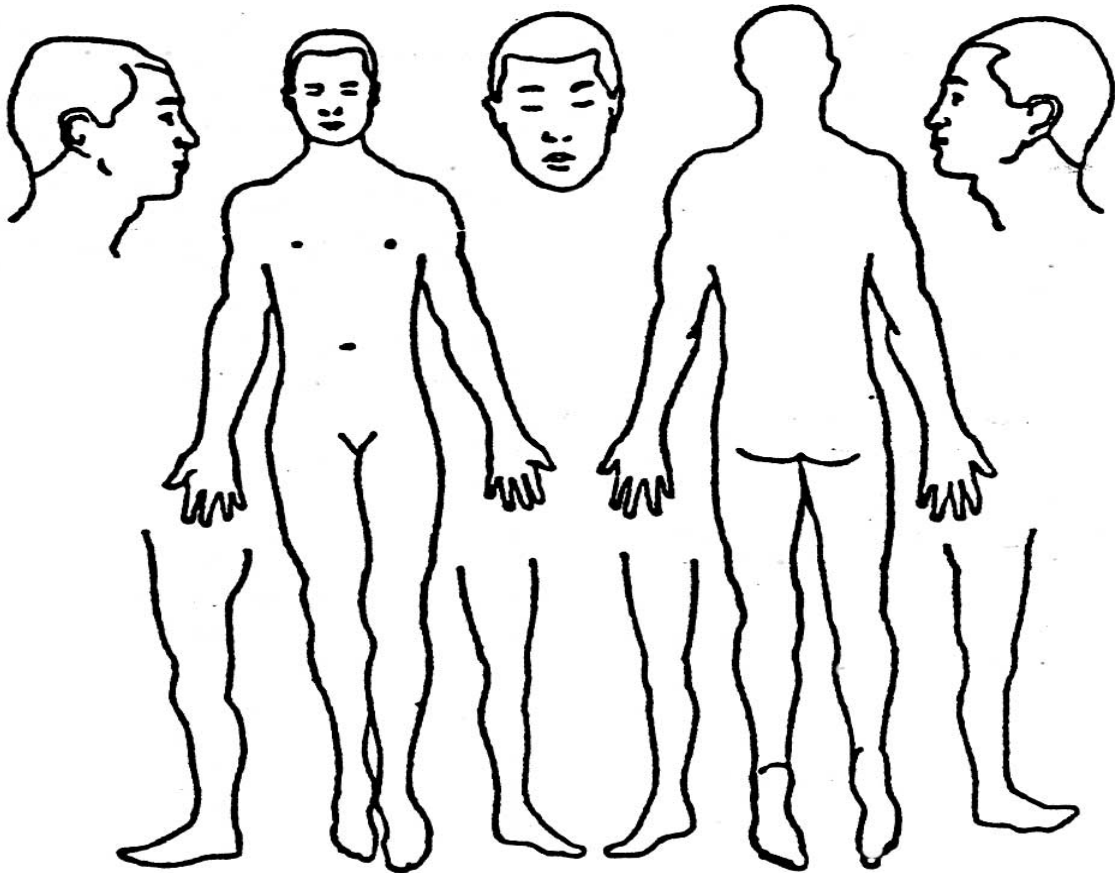
Please rate the degree of severity of your problem now:

No Problem |-----| Worst Imaginable

Please note the greatest degree of severity of your problem within the last week:

No Problem |-----| Worst Imaginable

Indicate painful or distressed areas:



Comments: (please tell us any other problems you would like to discuss):

Child's Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the Comments section. Thank you

Your Child's Name:			Date of Birth:		
Place of Birth:		Height:		Weight:	
Mother's Name	Father's Name:		Sex of Child: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age of Child:	
Address:		City:	State:	Zip:	
Contact Phone: ()		Family Physician:		Referred by:	
Emergency Contact (Name):	Emergency Contact Phone: ()	Has your child been treated by acupuncture or oriental medicine before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is/are the main problem(s) you would like us to help your child with? _____ _____					
How long ago did this problem begin (be specific)? _____ _____					
To what extent does this problem interfere with your daily activities (school work, sleep, etc.)? _____ _____					
What kinds of treatment have you tried? _____ _____					
Surgeries (Types and Dates)? _____ _____					
Significant Trauma (Auto Accidents, Falls, etc.)? _____ _____					
Significant Dental Work (Type and Date)? _____ _____					
Allergies (Drugs, Chemicals, Foods/Result)? _____ _____					

Please list immunizations, with dates and any reactions you noticed:				Reactions:
DPT:	1 st	2 nd	3 rd	
APV:	1 st	2 nd	3 rd	
MMR:	1 st	2 nd	3 rd	
Others:	1 st	2 nd	3 rd	
What medication is your child taking (orthodox and complementary)? _____ _____				
Has he/she had many courses of antibiotics?: _____ _____				
Allergies? _____ _____				
Does your child wake at night? If so, How many times? _____ _____				
Would you say your child's appetite was good, medium or small?: _____ _____				
Is your child choosy over food? _____				
How much does your child have of the following each day? Cows Milk: Cheese: Cola: Juice: Oranges: Bananas:				
Does he/she take any dietary supplements: _____				

Does Your Child suffer from any of the following?

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recurrent Infections <input type="checkbox"/> Sweating <input type="checkbox"/> Sweating on head <input type="checkbox"/> Sweating after feeding <input type="checkbox"/> Strong thirst <input type="checkbox"/> Fatigue <input type="checkbox"/> Sudden Energy Drop <input type="checkbox"/> <i>Time of day</i> _____ <input type="checkbox"/> Underweight 	<p>Digestion</p> <ul style="list-style-type: none"> <input type="checkbox"/> Colic <input type="checkbox"/> Loose stools <input type="checkbox"/> Evil smelling stools <input type="checkbox"/> Green stools <input type="checkbox"/> Constipation –does not go each day <input type="checkbox"/> Painful to pass stools <input type="checkbox"/> Gas <input type="checkbox"/> Swollen tummy <input type="checkbox"/> Protruding umbilicus <input type="checkbox"/> Other digestive problems <input type="checkbox"/> Teething problems 	<p>Behavioral</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty in concentrating <input type="checkbox"/> Vacant <input type="checkbox"/> Moody <input type="checkbox"/> Aggressive <input type="checkbox"/> Temper tantrums <input type="checkbox"/> Autism <input type="checkbox"/> Other
<p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Eczema <input type="checkbox"/> Oozing on skin/ lesion <input type="checkbox"/> Pimples 	<p>Genito-Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain on urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Leakage in day <input type="checkbox"/> Wet bed <input type="checkbox"/> Rashes 	<p>What Therapies have you tried?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Acupuncture <input type="checkbox"/> Homoeopathy <input type="checkbox"/> Difficulty in concentrating <input type="checkbox"/> Herbology <input type="checkbox"/> Naturopathy <input type="checkbox"/> Other
<p>Head, Eyes, Ears, Nose And Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Earaches <input type="checkbox"/> Headaches <input type="checkbox"/> <i>When:</i> _____ <input type="checkbox"/> <i>Where:</i> _____ <input type="checkbox"/> Discharge from ear <input type="checkbox"/> Vision Problems <input type="checkbox"/> Squint <input type="checkbox"/> Spectacles <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Watering eyes <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Blocked nose <input type="checkbox"/> Snoring <input type="checkbox"/> Sore throats <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Glands 	<p>Musculoskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Wry Neck <input type="checkbox"/> Arching back <input type="checkbox"/> Clicky hips <input type="checkbox"/> Overweight <input type="checkbox"/> Hernia 	<p>Anything Else?</p>
<p>Neuropsychological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Seizures <input type="checkbox"/> Nerve damage <input type="checkbox"/> Paralysis 		
<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Phlegm <input type="checkbox"/> Recurrent cough <input type="checkbox"/> Asthma/ wheezing <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis 	<p>Developmental</p> <ul style="list-style-type: none"> <input type="checkbox"/> Small for age <input type="checkbox"/> Large for age <input type="checkbox"/> Late developer <input type="checkbox"/> Retarded 	<p>Comments?</p>