HEALTH INFORMATION FORM – Dr. Eichelberger's Patients

Name _____ **Date** _____
Address _____**City** _____**Zip** _____
Date of Birth _____ **Your Age** _____**Occupation** _____
Home Phone _____ **Business Phone** _____ **Cell Phone** _____
Best Number to Reach You _____ **Best Day & Time to Reach You** _____
Email Address_____
Driver's License # _____ **State**_____
Spouse's Name _____ **Spouse Age** _____ **# of Children** ____ **Ages** _____
Emergency Contact _____ **Contact's Phone #** _____
Referred By _____

Part I: History and Lifestyle

Family History: Check any problems you or your relatives have been diagnosed as having. Please indicate who was diagnosed:

- Arthritis _____
- Asthma _____
- Cancer _____
- Diabetes _____
- Epilepsy _____
- Glaucoma _____
- Gout _____
- Heart Problem _____
- High Blood Pressure _____
- Low Thyroid _____
- Kidney Trouble _____
- Nervous Breakdown _____
- Stomach Ulcer _____
- Stroke _____
- Tuberculosis _____

Personal History: Circle any other problems you have experienced:

- Anemia
- Bronchitis
- Chicken pox
- Diverticulosis
- Eczema
- Emphysema
- Eye disease
- Gall stones
- Hemorrhoids
- Hepatitis
- Hernia
- Herpes
- Jaundice
- Liver disease
- Malaria
- Measles
- Mononucleosis
- Mumps
- Pancreatitis
- Polio
- Rheumatic fever
- Sexual Abuse
- Venereal disease
- Other_____

Circle any of the following medications you are taking:

- Antacids
- Antibiotic/Anti-fungal
- Antidepressants
- Anti-diabetic/Insulin
- Aspirin/Tylenol
- Chemotherapy
- Cortisone
- Diuretics
- Heart Medications
- High Blood Pressure
- Hormones
- Laxatives
- Lithium
- Oral Contraceptives
- Radiation
- Relaxants/Sleeping Pills
- Recreational Drugs Specify_____
- Thyroid Medication
- Ulcer Medications
- Other _____

Circle if you eat, drink or use:

- Alcohol
- Candy
- Carbonated Beverages
- Cigarettes
- Coffee
- Distilled Water
- Fluoridated Water
- Fast Foods
- Fried Foods
- Refined Flour Products (pasta, bread, pastry, etc.)
- Luncheon Meats
- Margarine
- Refined Sugar
- Milk Products
- Artificial Sweeteners
- Non-Herbal Teas
- Chewing Tobacco
- Vitamins & Minerals

Circle if you:

- Diet often
- Salt food without tasting
- Exercise less than 3 times weekly
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarettes

Part 2: Symptom Review

Please list your major health concerns in order of importance:

1. _____

2. _____

3. _____

4. _____

5. _____

Directions: Circle any of the following symptoms that have bothered you in the past six months, even if they seem irrelevant to the reason you are coming in. Please comment in the space provided about how frequent, when they last occurred, how long they lasted, how severe they were, anything you suspect might have triggered them, etc.

SYMPTOMS		COMMENTS
Head:		
Headaches	Sore scalp/dandruff	
Dizziness	Hair loss	
Eyes:		
Dry eyes	Excessive tearing	
Red eyes	Double vision	
Blurred vision	Other vision problems	
Ears:		
Poor hearing	Ear ringing	
Earaches	Deafness	
Ear discharge	Other ear problems	
Nose:		
Poor sense of smell	Frequent colds	
Nasal obstruction	Sinus pain	
Frequent bloody noses	Post-nasal drip	
Mouth:		
Bleeding gums	Cold sores	
Sore tongue	Ulcerations	
Dry lips	Dry mouth	
Dental cavities	Other dental problems	
Throat:		
Sore throats	Difficulty swallowing	
Tonsillitis	Spitting up mucus often	
Hoarseness		
Respiratory:		
Cough	Bloody sputum	
Thick sputum	Pain with breathing	
Wheezing	Short of Breath	
Heart:		
Chest pain or pressure	Ankle swelling	
Heart palpitations	Intolerant of exercise	
Difficulty lying flat		
Blood:		
Bruise or bleed easily	Cold limbs	

Skin:

Rash	Pigment changes
Dryness	Changing moles or lumps
Itching	Abnormal sweating

Stomach:

Poor appetite	Pain with eating
Excessive appetite	Intestinal gas
Poor digestion	Nausea
Heartburn	Belching
Vomiting	Sleepy after eating
Food allergies	Ulcers

Intestines:

Diarrhea	Dry (hard) stool
Constipation	Loose or watery stool
Hemorrhoids	Undigested food in stool
Blood in stool	Abnormal stool color
Mucus in stool	Stool painful to pass

How often do you have bowel eliminations?

Urinary:

Frequent urination	Dribbling urine after urination
Frequent bladder infections	Urination with cough or sneeze
Painful or burning urination	Hesitancy with urination
Change in quantity of urine	Color of urine:
Loss of force of urine stream	How often do you urinate each day?
Need to urinate at night	

Neurological:

Nervousness	Numbness or tingling in hands/feet
Tremors or shaking	Convulsions
Lack of coordination	Paralysis
Nerve pain (neuralgia)	

Reproduction:

Decreased sexual desire	Genital herpes
Excessive sexual desire	Sexually transmitted disease

Endocrine:

Neck enlarged	Hair or nail changes
Hot flashes	Intolerance to heat or cold

Musculo-skeletal:

Arthritis	Muscular weakness
Joint pain	Muscular cramps
Back pain	Swelling of joints
Deformity	Stiff neck
Jaw pain (TMJ)	Feet hurt

Thermal Sensitivities – Check those that most apply, if any:

Prefer:	Hot Drinks ____	Cold Drinks ___
	Hot Weather ___	Cold Weather ___
General:	Often Feel Cold:	Hands ___ Feet ___ All Over ___
	Often Feel Hot:	Hands ___ Feet ___ All Over ___

Fluids:

Frequently Thirsty — Almost Never Thirsty

Amount of water you drink daily _____

Amount of liquid you drink daily (other than water) _____

Sleep

Insomnia	Wake up often at night
Wake up tired	Hard to fall asleep
Nightmares	Number of hours sleep per night_____

Cognitive

Difficulty focusing	"Fuzzy" thinking
Forgetful	Lack of interest in general

Emotions:

Frequent stress	Often feel irritable
Frequent Anxiety	Often feel depressed or overwhelmed
Mood swings	Often feel happy
Often feel angry	Often feel guilty
Often feel lonely	Often feel overworked
Often feel sad	Often feel unmotivated
Tend to worry	

General:

Abnormal weight gain	Unexplained fever or chills
Abnormal weight loss	Loss of feeling of well-being
Fatigue	Overweight / underweight

** Symptoms Worse: Morning ___ Afternoon ___ Evening ___ Night ___

<u>Men</u>:

Premature ejaculation	Discharge from penis
Impotence	Low sperm count
Seminal emission	Difficulty keeping erection
Prostate problems	Pain/coldness in genital area

<u>Women</u>:

Vaginal pain	Cannot get pregnant
Vaginal dryness	Vaginal bumps or sores
Vaginal itching	Painful intercourse
Vaginal discharge	Discharge from nipples
Breast lumps/tenderness	

Menses:

Heavy blood flow	Premenstrual emotional problems
Light blood flow	Premenstrual bloating/swelling
Irregular periods	No menstrual period
Menstrual cramps	Spotting between periods

Are you or might you be pregnant?

How many days apart are your periods?

Length of period:

Number of pregnancies:

Number of abortions:

Number of miscarriages:

Number of live births:

Frequency of intercourse:

Method of preventing conception:

Use this diagram to show where and how much discomfort you may be experiencing. Mark the appropriate letter or number on the diagram below.

For this complaint:

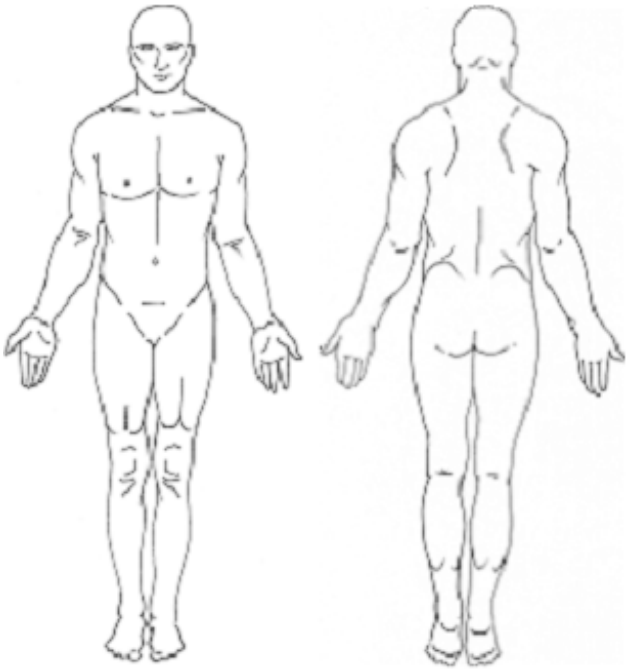
C – Constant: 100% of the day
I – Intermittent: 75% of the day
F – Frequent: 50% of the day
Oc – Occasional: 25% or less
N – Nighttime

Intensity of Complaint:

1 – Mild (does not interrupt activities)
2 – Mild to Moderate (does not interrupt, but does distract)
3 – Moderate (interrupts some activities)
4 – Moderate to Severe (interrupts most activities)
5 – Severe (most activities interrupted)
6 – Very Severe (total interruption of activities)

Type of Pain:

X Aching
O Sharp
+ Grabbing
/ Stabbing
Throbbing
Radiating to another body area
S Stiffness



None Unbearable

Pain Now

None Unbearable

Pain Over the Past Week

None Unbearable

Pain At Best

None Unbearable

Pain At Worst

If applicable, please mark if you have any of the experiences below and the specific areas where they occur:

Heat makes it better	Ache
Cold makes it better	Pain that moves
Pressure makes it better	Constant pain
Pressure makes it worse	Pain only occurs sometimes
Sharp pain	Pain worse with activity
Dull pain	Pain worse after resting

Changes To This Notice

We reserve the right to change our policies and practices concerning the privacy of your medical information and this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will always post a copy of the current notice in the following locations _____ [describe generally, .i.e. "near main patient entrances".] The notice will contain on the first page, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services. To file a complaint with the Provider, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer

The Provider's Privacy Officer is: Bruce Eichelberger, 85 Washington Street, Reno, NV 89503

Acknowledgement

I hereby acknowledge that I have received a copy of the Privacy Practices Notice,

Signature: _____ Date: _____

Print Name: _____

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices Notice.

Date: _____

Name of Patient: _____

Reason for refusal/failure: _____

_____

_____

Signature of Provider Employee: _____

File Signed Copy of this Page with Patient's Record

INFORMED CONSENT

Practitioner Information

Dr. Bruce Eichelberger is a Doctor of Oriental Medicine in the State of Nevada, license #101, acquisition date February 23, 2002. He was nationally certified in Acupuncture and Chinese Herbology with the National Commission for Certification in Acupuncture and Oriental Medicine (NCCAOM) starting in 1991. He received his Master of Traditional Oriental Medicine degree (MTOM) from Emperor's College of Traditional Oriental Medicine in 1991. In 1996 he passed the national Doctor of Oriental Medicine examination given in China. In addition, he has extensive training in acupressure, Medical Qigong and other Oriental Medicine techniques with Master Share K. Lew since 1973. He is also a Certified Healthexcel Metabolic Typing Advisor and is certified in Neurotransmitter Assessment and Remediation through Neurogistics.

Practice Details

Oriental Medicine in the State of Nevada includes, but is not limited to Acupuncture, Herbal Medicine and other services approved by the Board. Traditionally, other services associated with Oriental Medicine include electrical, mechanical and magnetic stimulation of the body, moxibustion, acupressure, cupping, dermal friction technique (guasha), the use of infra-red devices, sonopuncture, dietary advice, point injection therapy and therapeutic exercise (qigong). Please note that Dr. Eichelberger may tape record appointments to insure accuracy and quality.

Potential Side-Effects

Acupuncture is safe and rarely uncomfortable. As with the insertion of any needle in the body, there is potential for minor, unintentional discomfort or bruising. Side effects occur very rarely. These may include, but are not limited to: 1) some residual pain or discomfort at the insertion area, 2) broken needles, 3) infection, 4) anxiety reaction, 5) minor bruising. If you experience any adverse reactions during or after an acupuncture treatment, please notify Dr. Eichelberger promptly. There may be ways to easily minimize or eliminate the problem.

Late Cancellation Policy

As a courtesy, please let us know as early as possible if you need to cancel an appointment. If you will be arriving exceptionally late (>20 minutes) to the appointment, please call ahead as it may be better to reschedule your visit. If you must cancel or reschedule, please do so at least 24 hours in advance so that someone else may have the opportunity to take your appointment. We reserve the right to bill for cancellations made less than 24 hours prior to your visit.

Special Conditions

In some medical conditions, certain acupuncture techniques are contraindicated. If any of the following applies to you, please inform Dr. Eichelberger:
1) Bleeding disorders (e.g. hemophilia), 2) Epilepsy or other seizure disorders,
3) Pacemakers/heart irregularities, 4) Pregnancy or suspected pregnancy.

I have read and understand the above, and consent to acupuncture treatment if it is indicated to help my condition:

Signed _____ Date: _____

Print Name: _____