

HEALTH INFORMATION FORM – Dr. Eichelberger’s Patients

Name _____ Date _____
Address _____ City _____ Zip _____
Date of Birth _____ Your Age _____ Occupation _____
Home Phone _____ Business Phone _____
Cell Phone _____ 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 _____ | • Glaucoma _____ | • Kidney Trouble _____ |
| • Asthma _____ | • Gout _____ | • Nervous Breakdown _____ |
| • Cancer _____ | • Heart Problem _____ | • Stomach Ulcer _____ |
| • Diabetes _____ | • High Blood Pressure _____ | • Stroke _____ |
| • Epilepsy _____ | • Low Thyroid _____ | • Tuberculosis _____ |

Personal History: Circle any other problems you have experienced:

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

Circle any of the following medications you are taking:

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

Circle if you eat, drink or use:

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

Circle if you:

- | | | |
|-----------------------------|-------------------------------------|------------------------------------|
| • Diet often | • Exercise less than 3 times weekly | • Are exposed to chemicals at work |
| • Salt food without tasting | • Are under excessive stress | • 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 Dizziness	Sore scalp/dandruff Hair loss
Eyes:	Dry eyes Red eyes Blurred vision	Excessive tearing Double vision Other vision problems
Ears:	Poor hearing Earaches Ear discharge	Ear ringing Deafness Other ear problems
Nose:	Poor sense of smell Nasal obstruction Frequent bloody noses	Frequent colds Sinus pain Post-nasal drip
Mouth:	Bleeding gums Sore tongue Dry lips Dental cavities	Cold sores Ulcerations Dry mouth Other dental problems
Throat:	Sore throats Tonsillitis Hoarseness	Difficulty swallowing Spitting up mucus often
Respiratory:	Cough Thick sputum Wheezing	Bloody sputum Pain with breathing Short of Breath
Heart:	Chest pain or pressure Heart palpitations Difficulty lying flat	Ankle swelling Intolerant of exercise
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 ____	

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:

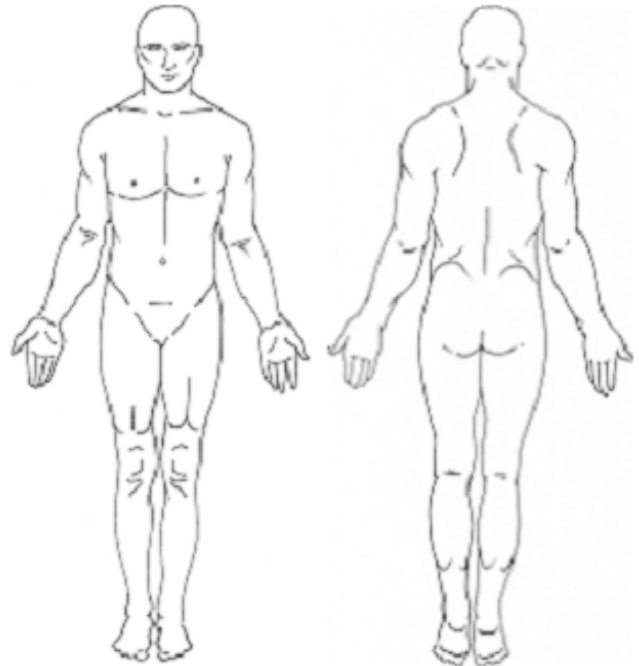
- C – Constant: 100% of the day
- I – Intermittent: 75% of the day
- F – Frequent: 50% of the day
- Oc – Occasional: 25% or less
- N – Nighttime

Intensity of Complaint:

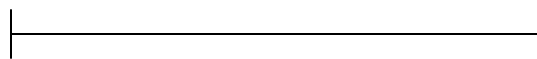
- 1 – Mild (does not interrupt activities)
- 2 – Mild to Moderate (does not interrupt, but does distract)
- 3 – Moderate (interrupts some activities)
- 4 – Moderate to Severe (interrupts most activities)
- 5 – Severe (most activities interrupted)
- 6 – Very Severe (total interruption of activities)

Type of Pain:

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

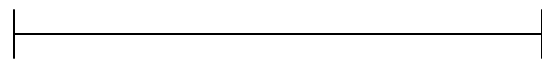


None Unbearable



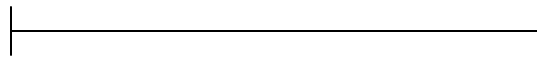
Pain Now

None Unbearable



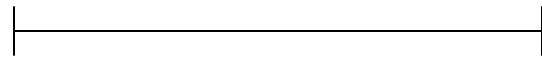
Pain Over the Past Week

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
- Cold makes it better
- Pressure makes it better
- Pressure makes it worse
- Sharp pain
- Dull pain

- Ache
- Pain that moves
- Constant pain
- Pain only occurs sometimes
- Pain worse with activity
- 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 acupuncture, 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 Neurologistics.

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, acupuncture, 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: _____