Sustainable Health Acupuncture

Welcome! The following are some guidelines for your first treatment, followed by directions.

Please eat a little something before your treatment - a light meal that includes some protein is best.

Wear loose, comfortable clothing.

Please try not to brush your tongue the day of your treatment - observing your tongue coat is an important part of diagnosis in Traditional Chinese Medicine (TCM).

Please have your paperwork filled out before your visit.

We understand that life happens. If you are running late, please call to let us know! If you arrive late with no call, please understand that your practitioner may not be able to see you. If you need to cancel or reschedule an appointment, please give us 24 hours' notice. Giving us as much advance notice as possible allows us to fill your spot & help someone else! Missed appointments, or those canceled with less than 24 hours' notice will be subject to a fee of 1/2 the full appointment cost.

DIRECTIONS to 640 Merrimon Ave, Suite 204, Asheville, NC 28804

From 240 East or West
Take exit 5A (Merrimon Ave).
Turn Right off the exit onto US-25/Merrimon Ave.
Drive 1.5 miles and make a left into the Merrimon Square Plaza.
(The plaza is just past CVS and Edgewood Rd. on your left.)

We are located on the second floor, between Zen Sushi and Urban Burrito. There is an elevator in the middle of the plaza for your convenience.

I look forward to meeting you,
Liz

Sustainable Health Acupuncture

History of Chief Concern:

In your own words, please use the space below to describe your chief concern or the reason for your visit.

Note any diagnoses made, tests, done to confirm the diagnosis, treatments, and your response to those treatments.

Include therapies and medications tried and your reactions to each, positive or negative.

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PATIENT GENERAL INFORMATION Today's Date: ______________________

Patient Name: __________________________________ Age: __________

Birth Date: ____________ Circle: Single Partnered Married Divorced Widowed

Home Address: ____

City, State, Zip: ____

Mailing Address, if different: ____

Home Phone: ____________________ Work Phone: __________________________

Cell Phone: ______________________ Email: ________________________________

Which is the best way to reach you during the day? ___________________________________

Employer: _______________________________ Occupation: _____________________

Legal Guardian: ____

Name of Significant Other: ____________________________________ Age: ______________

Employer ________________________________ Occupation: ______________________

Who Should We Contact in Case of Emergency? ____

Relationship: ________________________ Phone: ____________________________

Referred By: (please check)

Our website ___ Other website ___ Friend ___ Yellow Pages___ Other____

Specifically: ____

Is this your first time to an acupuncture clinic? Yes No

If No, when was your last acupuncture treatment? ________ Where? _________________________

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AGREEMENTS

I promise to inform Liz Roseman, L.Ac., of any change in my supplements or medications, including additions, subtractions, or changes in dosage.

I understand that if I do not show up for my appointment, or if I cancel with less than 24 hours' notice, I may be subject to a fee of 1/2 the appointment charge.

I promise to take an active role in my own healing process by making positive lifestyle changes that empower me toward my fullest expression of life. These lifestyle changes may include dietary changes, exercise, meditation/quiet time, journaling, taking Chinese herbs, or any other activity that you and I discuss and will help you toward healing.

____
Signature

____
Date

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Patient Name: ______________________________________Date: _____________

Please review the following symptoms and 'X' the boxes that apply to you.

Mark 'Now' if your symptoms are current and 'Past' if any are significant from your past.

	Now	Past
Cough	_	_
Phlegm	_	_
Wheezing	_	_
Short of breath	_	_
Easily fatigued	_	_
Hoarseness	_	_
Sneezing	_	_
Loss of smell	_	_
Nasal congestion	_	_
Nasal discharge	_	_
Asthma	_	_
Allergies	_	_

What are you allergic to?___________
____
____
____

	Now	Past
Hay fever	_	_
Itchy eyes	_	_
Eczema	_	_
Sinus headaches	_	_
Acne	_	_
Perspire easily	_	_
Itchy skin	_	_
Swollen glands	_	_
Sore throats	_	_
Smoker	_	_
Catch colds easily	_	_
Melancholy/Sadness	_	_

List known food allergies: __________
____
____

	Now	Past
Prolapsed Uterus	_	_
Prolapsed stomach	_	_
Gums bleed easily	_	_
Nose bleeds	_	_
Big appetite	_	_
Small appetite	_	_
Diarrhea	_	_
Loose stool	_	_
Constipation	_	_
Heartburn	_	_
Stomach ulcers	_	_
Stomach pain	_	_
Gas	_	_
Bad breath	_	_
Inability to concentrate	_	_
Loss of taste	_	_
Crave sweets	_	_
Bruise easily	_	_
Slow wound healing	_	_
Poor digestion	_	_
Abdominal bloating	_	_
Fatigue after eating	_	_
Discomfort after meals	_	_
Nausea	_	_
Vomiting	_	_
Hiccups	_	_
Mouth sores	_	_
Belching or burping	_	_
Hemorrhoids	_	_
Hernia	_	_

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	_ **Now**	_ **Past**
Headache	_	_
Location on head: ___________________		
Migraine	_	_
Constricted chest	_	_
Anger easily	_	_
High blood pressure	_	_
Vertigo	_	_
Spots before eyes	_	_
Blurred vision	_	_
Eyes tired	_	_
Eyes sensitive	_	_
Irritable	_	_
Lower rib pain	_	_
Bitter taste in mouth	_	_
Depression	_	_
Frustration	_	_
PMS	_	_
Describe PMS symptoms: _____________		
___________________________________		
___________________________________		
Dizziness	_	_
High cholesterol	_	_
High triglycerides	_	_
History of hepatitis	_	_
Palpitations	_	_
Delirium	_	_
Jittery	_	_
Night sweats	_	_
Hot flashes	_	_
Insomnia	_	_
Pale skin	_	_
Sense impending doom	_	_
Heart racing	_	_
Dry mouth	_	_
Chest pain	_	_
Restlessness	_	_
Numb hands	_	_
Heart murmur	_	_

	_ **Now**	_ **Past**
Scanty yellow urine	_	_
Urinary infections	_	_
Kidney infections	_	_
Cold feet	_	_
Cold hands	_	_
Urine color: dark___ light___ clear___		
Frequent urination	_	_
How many times per day? _____		
Night urination	_	_
How many times do you wake to urinate? ___		
Decreased stream	_	_
Urgent urination	_	_
Painful urination	_	_
Difficult urination	_	_
Prostate problem	_	_
Ear ringing	_	_
Pitch: High___ Low___		
Hearing loss:	_	_
Weak/sore knees	_	_
Rheumatoid arthritis	_	_
Hair loss	_	_
Impotence	_	_
Stiff joints	_	_
Painful joints	_	_
Sex drive: High___ Low___ Normal___		
Incontinence	_	_
Swollen ankles	_	_
Puffy beneath eyes	_	_
Lower back pain	_	_
Loose teeth	_	_
Osteoarthritis	_	_
Infertility	_	_
Spermatorrhea	_	_
Seminal emission	_	_
Abnormal thirst	_	_
Craves salt	_	_
History of Kidney stones	_	_
Phobias	_	_
Memory loss	_	_

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Are you under excessive stress? Why?____

Do you get regular exercise? How? ____

Please circle those that apply to you:

Diet often
Salt foods automatically before tasting
Exposure to chemicals
Work at a computer

Please circle any those that apply to you currently or are significant in your past:

Alcoholism
Anemia
Appendicitis
Asthma
Cancer
Congested Heart Failure
Diabetes
Eating disorders
Epilepsy
Goiter
Herpes
Heart attack
Heart disease
HIV
Jaundice
Hepatitis
Infertility
Influenza
Malaria
Measles
Meningitis
Mental disorders
Mumps
Obesity
Pleurisy
Pneumonia
Rheumatic fever
Scarlet fever
Small pox
TIA
Tonsillectomy
Tuberculosis
Typhoid fever
Venereal infection
Whooping cough

Anything else you would like us to be aware of: __________________________________
____

Surgical History: Please list procedures and dates.
____
____
____
____

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Family History: Please circle those that apply to your family and list who:

Alzheimer's	Gallbladder Disease	Neurologic Disease
Cancer	Heart Disease	Stroke
Diabetes	Mental Disorders	Thyroid Disease

Please mark how you feel about the following aspects of your life:

	Great	**Good**	**Fair**	**Poor**
Sex life	_	_	_	_
Family	_	_	_	_
Friends	_	_	_	_
Relationship	_	_	_	_
Spirituality	_	_	_	_
Job	_	_	_	_

Please circle diagnostic tests done and list dates and results:

Blood work When?__________ Results____

X-Ray When?__________ Results____

MRI When?__________ Results____

CT Scan When?__________ Results____

EMG When?__________ Results____

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Please complete this section if you are currently experiencing pain:

Describe location of pain:____

Circle the words that best define your pain:

dull sharp stabbing sore sudden cramping throbbing burning constant
radiating fixed moves about severe moderate chronic ache

Pain radiates to:____

Describe the onset of the pain: ____

Circle if any help pain: ice heat rest movement dampness dry
Circle if any aggravate pain: ice heat rest movement dampness dry

Are there any movements that aggravate the pain? ______________________________

How does exercise affect your pain? ______________________________

Do any medications help your pain? ______________________________

List other treatments you've had for the pain: ______________________________
____

Please circle any that you eat, drink or use:

Alcohol	Coffee	Decaf Coffee
Hot Tea	Iced Tea	Sweet Tea
Candy	Cigarettes	Carbonated Beverages
Diet Sodas	Fried Foods	Fast foods, regularly
Refined sugars	Red meat, regularly	Margarine

Vitamins: ____
Minerals: ____
Herbs:____
Homeopathics: ____

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Please circle those medications that currently apply to you and list your dose:

Antacids

Antidepressants

Antibiotics

Antifungal

Aspirin

Birth control pill

Blood pressure prescriptions

Chemotherapy

Contraceptives

Glucose regulators

Heart medications

Hormones

Ibuprofen

Laxatives

Muscle relaxers

NSAIDs

Pain control prescriptions

Radiation treatments

Recreational drugs

Sleeping pills

Thyroid prescriptions

Tylenol

Ulcer medications

Other: ____

____

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WOMEN ONLY

Age at first menses: _____ Age at menopause: ______

Date of last menstrual period: ____________________ Do you cycle every 28 days? Yes No

If not, how many days is your cycle? ____________________

If no longer menstruating, did you used to cycle every 28 days? Yes No

How many days is/was your flow? _____

What is the color of your flow? (e.g.: brown, dark red, bright red, etc…) ___________________________

Do you experience the following:	**Now**	**Past**
Clots	_	_
Cramps	_	_
PMS	_	_
Vaginal Pain	_	_
Abortion or D&C	_	_
Sexually transmitted disease	_	_
Painful breasts	_	_
Irregular PAP smear	_	_
Breast distension	_	_
Fibroid tumors	_	_
Fibrocystic breasts or ovaries	_	_
Infertility	_	_
Pregnancy	_	_
Miscarriage	_	_
Hormonal imbalance	_	_
Vaginal discharge	_	_
Regular breast mammogram	_	_
Are you pregnant now?	Yes	No

How many pregnancies have you experienced? ___

How many children do you have? ___