



**400 Bedford Street aka 'Morgan
Self-Storage Bldg.'
- South Entrance -
Manchester, NH 03101**

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Welcome to Manchester's 1st Community Acupuncture clinic

Please take a few minutes to slowly read this introduction to our clinic and community. We are happy that you have an interest in joining us.

Manchester Acupuncture Studio (MAS) is different from almost all acupuncture clinics in the United States in two important ways.

Most acupuncture clinics use a style of acupuncture where needles are inserted directly into the area of pain. The problem with this approach is that it can feel pretty uncomfortable, and one runs the risk of aggravating any pain. We are practitioners of different styles and traditions of acupuncture. These methods are time-tested and derived from the I Ching, one of the oldest books in the world. The effects can also be surprisingly fast.

The acupuncture points chosen may be on the scalp and ears, from the elbows to the fingers – and from the knees to the toes. Consequently, you'll just have to roll your sleeves and pant legs up, in order to get ready for your treatment. Our treatments are efficient, comfortable and extremely effective. Pain relief can occur in seconds with long lasting relief of chronic pain resulting over a series of treatments.

MAS is also one of the first acupuncture clinics established in the country as part of the Community Acupuncture Network (CAN) whose mission is to make acupuncture affordable for everyone, maintaining health care should not cost an arm and a leg, nor be given as charity – but shared as a human right. In our clinic this is achieved primarily by offering one of the world's oldest and most effective medical treatments – acupuncture - in a comfortable group setting. By doing this we can engender a warm community atmosphere and lower cost per treatment, thereby making treatments available to people of all means, and ultimately providing an opportunity for more frequent use of acupuncture, with great outcomes. If you'd like more information about community acupuncture, visit www.communityacupuncturenetwork.org.

In addition we also offer a resource library with reading area and Tea Spot within our cozy mill home. We hope you'll find yourself comfortable here – and we encourage you to enjoy your time while playing an important part in changing the way high quality health care is delivered in our city – and country.

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Community acupuncture practices are grown through the efforts of the acupuncturists and patients, who naturally rely on each other for success moving forward. Opportunities are available for those interested in bartering services, skills or time for the benefit of our community practice. If you would like to directly support our mission of helping to bring social justice to health care, please talk to our front desk staff regarding opportunities with our clinic.

The Beauty of the Sliding Scale

Acupuncture is undeniably most effective for current health concerns when it is done frequently and regularly. We've found this to be especially true at the beginning of a course of treatment, when we are getting the ball rolling with respect to healthy changes. Twice a week is usually the minimum required to make progress with a health issue – though more frequent visits are common. The purpose of the sliding scale is ultimately to separate the issues of money and treatment. When this is done, acupuncture can be available as often as needed, affording quicker and more lasting results.

\$15-35 each visit

You decide what you can afford. No questions asked.

Please do keep in mind the number of times each week we'll suggest for you to come as part of your treatment plan so that you can budget accordingly.

The bottom line is you should choose a rate you feel you can budget for at each visit. We understand that everyone's financial situation differ greatly – even week to week! Remember, our goal is to be able to provide acupuncture to you as often as is needed for improvement of your health issues.

Because we offer a sliding scale, we cannot accept insurance billing (that's the insurance companies' rule, not ours). If you have insurance that covers acupuncture, we'll be happy to give you a payment receipt, and you can submit it for reimbursement; that's OK with the insurance companies. We also offer simple cash receipts for your own records as well.

Our clinic does not receive grants, state or federal money, or insurance reimbursement. It exists because patients pay for their treatments – in a sustainable community business model.

The Community Setting

Most acupuncture treatments in the United States take place on a table in a room by oneself.

This is not how most of the world has traditionally received treatment, where acupuncture usually occurs in a community setting. We all know the value of power in numbers, right? Would you prefer to eat in an empty restaurant, or one that is full of people and bustling? How about an empty movie theater? Us neither! A healthy group setting creates a dynamic that can be used for all of our benefit in an acupuncture clinic. Receiving treatment in a community setting has other tangible benefits, as well: it's easier for friends and family to come in together and many patients find it a relief to not be isolated during their treatment. In addition, our practice allows patients to keep their needles in as long as they want, as we observe the 'right' amount of time varies from person to person. Most people learn after a few treatments when they feel 'done' or 'cooked'. This can take anywhere from twenty minutes to a couple of hours. You can stay as long as you feel comfortable doing so – or until we close for the day! If you want to be finished at a specific time, ask your acupuncturist. We'll make sure you're out on time. Otherwise, we prefer you forget about time altogether. When you are feeling as though you are ready to end your visit, or need to get our attention, just open your eyes and give us 'a meaningful look', and we will remove your points or be available otherwise.

Our Commitment to You...

Our goal is to make it possible for you to receive acupuncture regularly enough and long enough to get better and stay better.

We want our community to be welcoming to all different kinds of people. We want to give you tools to take care of your own health so that you need not only rely on an all-too-often impersonal and inefficient medical system offering costly, high-tech interventions.

We will provide you with skilled practitioners who continue to sharpen clinical skills through ceaseless education, in order to provide you with the absolute best quality acupuncture treatments. We will provide a safe environment free of judgment. We will always be available to listen to any advice and/or feedback you may have about MAS.

Your Responsibilities...

MAS does not provide primary care medicine. Acupuncture is a wonderful complement to Western medicine, but it is not a substitute for it. If you have, or think you may have a potentially serious condition such as an infection, unexplained weight loss or gain, heart conditions, a suspected fracture or dislocation, severe abdominal pain, unexplained bleeding, respiratory distress etc. or if you want a doctor to go over the details of your medical history, you should either visit your primary care physician or go to the local emergency room, as appropriate. We'd be happy to provide referrals for very capable doctors in the Manchester area. Please do not expect us to diagnose and treat something life threatening. We can provide care for a *multitude* of conditions very effectively. However, acupuncture is not primary care medicine.

Flexibility. The community setting does require some flexibility from you. For instance, some patients have a favorite recliner. When we are busy, someone may be in your favorite chair. Similarly, we have a few patients who may snore. Patients who dislike snoring can bring earplugs to their treatments. Be creative. We are grateful for this! If you want, you can bring a favorite clean pillow or blankets from home for your treatment. Basically, ***we need you to make yourself comfortable in the Big Room before we arrive to treat you.*** So grab a blanket, kick off your shoes and make yourself at home.

Commitment. Acupuncture is most often a process. It is unrealistic to expect long-standing health issues to resolve after three or four visits. A typical course of treatment for long-standing conditions in China is acupuncture every other day for three months! Thankfully, most folks do not need such an intense regimen. However, almost all people will require some course of treatment varying in length and frequency, depending on their individual needs. Part of the reason that we are able to keep our prices so low is because of the extraordinary amount of marketing our patients do on our behalf – we do very little advertising otherwise. We are so grateful for this. In fact, truth be told if it were not for happy and vocal patients, MAS would cease to be. Our patients are such effective marketers because they have first-hand experience of how well acupuncture works. **Almost all of our satisfied patients basically made a commitment to a course of treatment.**

On your first visit, your acupuncturist will suggest a course of treatment, which can be anything from “*we’d like to see you once a week for six weeks*” to “*we’d really like to see you every day for the next three days*”. This suggestion is based on our experience with treating different kinds of conditions. If you don’t come in often enough or long enough, acupuncture probably won’t work for you. **The purpose of our sliding scale is to help you make that commitment.** If you have questions about how long it will take to see results, please ask us, or if you think you need to adjust your treatment plan, please let us know. We need you to commit to the process of treatment in order to get the results we both want for you.

Finally, a word about the treatment room ...

The treatment room is intended to remain a quiet space for you and others to rest, sleep and sort it all out. Its atmosphere exists through our patients relaxing together. We appreciate everyone’s presence! We find this kind of collective stillness is a rare and valuable thing in our rushed and isolating society. Maintaining this reservoir of calm requires that no one talk very much in the clinic space – including us. We ask that any speaking be done in a whisper or very low tone of voice. If you would like to speak to your acupuncturist one-on-one at any length, please let us know. We can arrange for time in the office.

Unfortunately, we can’t explain what every point does, or how acupuncture works, while we are treating you - these are very large topics! This is why our lending library exists. Or, if you have questions about acupuncture and how it works, you can go to our website and look for the 'links' section, which will bring you lots of informative websites. If you have questions, we’ll happily give you plenty to read!

Part of our success is that our patients learn the “routine” and take on a lot of responsibilities for the appointments. Re-scheduling and making payment happens at the front desk **before** each treatment, so you can relax and enjoy treatment without concern for details afterwards (the exception is today – your first visit). Please take all personal belongings (bags, shoes, etc.) with you back into the treatment room where there will be a plastic crate available behind/next to your recliner for your stuff. We cannot be responsible for items left in the clinic after your visit. And of course, *please turn off your cell phone or pager before coming into the treatment room, please.*

Last but not least – enjoy your time here. This is what we are all here for. We hope that MAS can be a valuable part of your community and health.

Andy, Tracy and the whole MAS staff and family

A note about parking

Do not pay to park. Most of us will park in the lot right in front of the 'Morgan' building just off of Bedford Street – at no charge. Parking is also available right next to the entrance of our clinic, against the building, for those who have a harder time walking and getting around.

Manchester Acupuncture Studio, LLC

Health History & Registration

Date: ___ / ___ / ___

Name:				Sex:		Age:	
Address:			City:		State:		Zip Code:
Home Phone #:		Other Phone #: Work Cell Other		Email:			
Date of Birth:		Time of Birth: AM / PM		City of Birth:		State of Birth:	
Height:	Weight:	Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living w/partner <input type="checkbox"/> Other : _____					
Employer:			Occupation:				
Physician:				Physician's Phone #:			
How did you hear of our clinic?:				Have you been treated by Acupuncture or Oriental Medicine Before? <input type="checkbox"/> No <input type="checkbox"/> Yes ___ / ___ / ___			

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

2

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

3

When did this start? _____ ago

Heat makes it: better no change worse

Cold makes it: better no change worse

Damp weather: better no change worse

Exercise / Activity: better no change worse

1 |-----| 10

HEALTH HISTORY

Circle the † if you have / had the condition and note the year it started.
Circle the ††† if there is a family history of the condition.

	YOU	Year	FAMILY		YOU	Year	FAMILY
Cancer type(s)?	†	_____	†††	Osteoporosis	†	_____	†††
Diabetes	†	_____	†††	Herpes	†	_____	†††
Hepatitis	†	_____	†††	AIDS / HIV	†	_____	†††
High Blood Pressure	†	_____	†††	Other STD	†	_____	†††
Heart Disease	†	_____	†††	Rheumatic Fever	†	_____	†††
Stroke	†	_____	†††	Alcoholism	†	_____	†††
Seizure Disorder	†	_____	†††	Allergies type(s)?	†	_____	†††
Thyroid Disease	†	_____	†††	Mental Illness	†	_____	†††
Asthma	†	_____	†††	Kidney Disease	†	_____	†††
Pacemaker	†	_____	†††	Anemia	†	_____	†††

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? Yes No

If so, what and how often:

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

INJURIES & SURGURIES

Please note what happened to what body area and when it occurred (incl. dental)



Revised Payment Policy – November 2008

Payment is expected at the time of your visit. ***We cannot accept payment for treatments ahead of the date of your visit.*** We do accept checks, cash, Visa & Mastercard. We make every attempt to make acupuncture available to as many people as possible at the most affordable rates. This is our mission.

All of us at MAS are grateful for our community's warm embrace of our acupuncture clinic. As such, our "first come, first serve" appointment scheduling has become tight as we try to accommodate everyone who would like to come in for treatment.

In consideration of other folks who may be on a waiting list for appointments, we ask that you give us at least 24 hours notice in advance of an appointment that will not be kept.

All appointments that are canceled with less than 24 hours notice, or are missed altogether without notifying our office, will be charged a \$10.00 fee payable at the next visit.

This will be strictly enforced.

We do also recognize that emergencies happen, and would be happy to consider these on an individual basis, of course.

I agree to the above policy:

Print Name _____

Signature _____

Date _____

PATIENT NAME

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 1 OF 2 - PLEASE SIGN BOTH SIDES

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here _____ Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE
(Or Patient Representative)

X

(Date)

(Indicate relationship if signing for patient)

PLEASE SIGN REVERSE SIDE ALSO

ARBITRATION AGREEMENT AND INFORMED CONSENT, PAGE 2 OF 2 - PLEASE SIGN BOTH SIDES

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

PATIENT SIGNATURE X (Or Patient Representative)	Date
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(Indicate relationship if signing for patient)

OFFICE SIGNATURE	Date
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PLEASE SIGN REVERSE SIDE ALSO

Manchester Acupuncture Studio, LLC
HEALTH HISTORY FOR WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

<p align="center">COLD</p> <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	<p align="center">Thirst for cold / hot drinks</p> <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<p align="center">HOT</p> <input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats <i>When _____ am / pm</i> <i>Where on body _____</i>
		<input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

<p align="center">DRY</p> <input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<p align="center">Dry mouth</p> <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<p align="center">OILY</p> <p align="center"><small>Where on your body?:</small></p> <input type="checkbox"/> Edema / Swelling _____ <input type="checkbox"/> Rashes _____ <input type="checkbox"/> Itching _____ <input type="checkbox"/> Dandruff
		<input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss

DIGESTION

<p align="center">DIARRHEA</p> <p>BM: How often? _____ x / every _____ days</p> <p>Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger
		<p align="center">CONSTIPATION</p> <input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools

ENERGY

<p align="center">LOW</p> <input type="checkbox"/> Sudden energy drop <i>Time of day: _____ am / pm</i> <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy
		<p align="center">HIGH</p> <input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week

SLEEP

hours per night _____

 Difficulty falling asleep
 Wake _____ x / night @ _____ am / pm
 Wake to urinate *How often?* _____
 Disturbing dreams
 Restless sleep
 Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

<input type="checkbox"/> Anger	<input type="checkbox"/> Grief
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Joy
<input type="checkbox"/> Worry	<input type="checkbox"/> Fear
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Sadness	<input type="checkbox"/> Indecision

EYES, EARS NOSE THROAT

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Phlegm (color _____)	<input type="checkbox"/> Cough

MENSES

Age at first menses: _____

Length of full cycle: _____ days

Length of menses: _____ days

Last menses start date: _____ / _____

of pregnancies: _____

of births: _____ premature _____

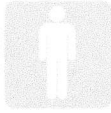
of abortions / miscarriages: _____

MENOPAUSE

Age at last menses : _____ Hot flashes _____ x / day Vaginal dryness

Year changes began: _____ Night sweats _____ x / week Loss of sex drive

<input type="checkbox"/> Heavy periods	<input type="checkbox"/> Cramps	<input type="checkbox"/> Mood changes
<input type="checkbox"/> Light periods	<input type="checkbox"/> Before bleeding	<input type="checkbox"/> Fatigue w/ menses
<input type="checkbox"/> Painful periods	<input type="checkbox"/> First day	<input type="checkbox"/> Digestive changes w/ menses
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> During period	<input type="checkbox"/> Midcycle spotting
<input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS)	<input type="checkbox"/> Clots	<input type="checkbox"/> Yeast infections
	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Birth control pill (hormonal)



Manchester Acupuncture Studio, LLC

HEALTH HISTORY FOR MEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

HOT

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cold hands or feet
<input type="checkbox"/> Chills
<input type="checkbox"/> Cold "in the bones"
<input type="checkbox"/> Areas of numbness | Thirst for cold / hot drinks
<input type="checkbox"/> Thirst, no desire to drink
<input type="checkbox"/> Absence of thirst
<input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Night sweats
<input type="checkbox"/> Unusual sweats
When _____ am / pm
Where on body _____ | <input type="checkbox"/> Hot hands, feet, chest
<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Hot in afternoon
<input type="checkbox"/> Hot at night |
|--|--|---|---|

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

OILY

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Dry skin
<input type="checkbox"/> Dry hair
<input type="checkbox"/> Dry eyes
<input type="checkbox"/> Dry brittle nails | <input type="checkbox"/> Dry mouth
<input type="checkbox"/> Dry lips
<input type="checkbox"/> Dry throat
<input type="checkbox"/> Dry nose / Nosebleeds | Where on your body?:
<input type="checkbox"/> Edema / Swelling _____
<input type="checkbox"/> Rashes _____
<input type="checkbox"/> Itching _____
<input type="checkbox"/> Dandruff | <input type="checkbox"/> Oily skin
<input type="checkbox"/> Oily hair
<input type="checkbox"/> Pimples
<input type="checkbox"/> Weight gain / loss |
|---|--|---|---|

DIGESTION

DIARRHEA

CONSTIPATION

- | | | | |
|--|--|--|---|
| BM: How often? _____ x / every _____ days
Stools keep shape? <input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Alternating diarrhea & constipation (IBS)
<input type="checkbox"/> Indigestion | <input type="checkbox"/> Gas
<input type="checkbox"/> Bloating
<input type="checkbox"/> Belching
<input type="checkbox"/> Poor appetite | <input type="checkbox"/> Nausea / Vomiting
<input type="checkbox"/> Bad breath
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Dry Stools
<input type="checkbox"/> Difficult to pass
<input type="checkbox"/> Tired after BM
<input type="checkbox"/> Foul smelling stools |
|--|--|--|---|

ENERGY

LOW

HIGH

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Sudden energy drop
<i>Time of day: _____ am / pm</i>
<input type="checkbox"/> Energy drop after eating
<input type="checkbox"/> Fatigue | <input type="checkbox"/> Dependence on caffeine / stimulants
<input type="checkbox"/> Wired / ungrounded feeling
<input type="checkbox"/> Body / Limbs feel heavy
<input type="checkbox"/> Body / Limbs feel weak | <input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Blood pressure High / Low
<input type="checkbox"/> Bleed / Bruise easy | <input type="checkbox"/> Hard to concentrate
<input type="checkbox"/> Poor memory
<input type="checkbox"/> Dizziness / lightheaded
<input type="checkbox"/> Headaches _____ x / week |
|---|--|---|---|

SLEEP

- # hours per night _____
- Difficulty falling asleep
 - Wake _____ x / night @ _____ am / pm
 - Wake to urinate *How often?* _____
 - Disturbing dreams
 - Restless sleep
 - Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- | | |
|--|---|
| <input type="checkbox"/> Anger
<input type="checkbox"/> Irritability
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Worry
<input type="checkbox"/> Obsessive thinking
<input type="checkbox"/> Sadness | <input type="checkbox"/> Grief
<input type="checkbox"/> Depression
<input type="checkbox"/> Joy
<input type="checkbox"/> Fear
<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Indecision |
|--|---|

EYES, EARS NOSE THROAT

- | | |
|---|---|
| <input type="checkbox"/> Poor vision
<input type="checkbox"/> Night blindness
<input type="checkbox"/> Red eyes
<input type="checkbox"/> Itchy eyes
<input type="checkbox"/> Spots in front of eyes
<input type="checkbox"/> Sinus congestion
<input type="checkbox"/> Phlegm (<i>color</i> _____) | <input type="checkbox"/> Poor hearing
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Sore throat
<input type="checkbox"/> Dental problems
<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Cough |
|---|---|

URINARY

- Fluid in = fluid out? Y N
- Decrease in flow
 - Dribbling
 - Difficulty starting / stopping
 - Incontinence
 - Kidney stones
 - Urgency to urinate
 - Frequent urination
 - Pain on urination
 - Burning sensation
 - Cloudy urine
 - Blood in urine

REPRODUCTIVE

- Are you sexually active? Y N
- Change of sexual drive: ↑ ↓
- Erectile dysfunction
 - Premature ejaculation
 - Sores on genitals
 - Discharge
 - Prostate disease
 - Genital Pain
 - Jock Itch
 - Vasectomy
 - Hernia
 - Hemorrhoids