LIFE MEDICINE

MEDICAL HISTORY FORM

Name _____ Age_____ Date of Birth ___/____/_____

Address _____City_____ State____ Zip_____

Home Phone _____ Cell phone_____ Email_____

Sex: ☐M ☐F Marital Status S☐ M☐ W☐ D☐ Domestic Partner ☐

Are you under the care of a physician? ☐NO ☐YES

Primary MD (Name) _____

Chief Complaint (reason for today's visit) what kind of symptoms are you having?

_____

1. Where do you have pain?

☐HEAD ☐HEADACHE ☐ NECK ☐JAW ☐SHOULDER ☐ARM ☐ELBOW ☐HAND ☐WRIST

☐ UPPER BACK ☐LOW BACK ☐TAILBONE ☐HIP ☐THIGH ☐ KNEE ☐ LEG ☐ANKLE

☐FOOT ☐CHEST ☐ABDOMEN ☐PELVIS

OTHER (explain)_____

2. Where did your pain start? _____When did it start? _____
3. How did your pain start? ☐GRADUALLY ☐SUDDENLY ☐AFTER INJURY
4. Has your pain: ☐IMPROVED ☐REMAINED THE SAME ☐WORSENED
5. Is your pain: ☐CONTINUOUS ☐INTERMITTENT
6. Describe your pain:

☐ACHY ☐DULL ☐SHARP ☐BURNING ☐SHOOTING ☐THROBBING ☐SENSITIVE

☐STABBING ☐ELECTRIC / SHOCK-LIKE

7. What other symptoms do you have with your pain?

☐WEAKNESS ☐TINGLING / NUMBNESS ☐CRAMPS / SPASMS

☐SWELLING ☐MORNING STIFFNESS ☐COLOR CHANGE

☐LOSS OF BOWEL OR BLADDER CONTROL ☐TEMPERATURE CHANGES

☐OTHER (explain) _____

_____

_____

Answer the following if you also suffer from headaches. If not, skip to # 8

* *

A. Did you ever have a head injury? ☐NO ☐YES, when _____

B. What brings on the headaches?

☐CIGARETTE SMOKE ☐ COFFEE ☐CHOCOLATE ☐ALCOHOL ☐ MENSTRUAL PERIODS

☐STRESS ☐LIGHT ☐CHEESE ☐HUNGER ☐SMELLS ☐OTHER_____

C. How often do you get headaches? _____

D. How long do they last? _____

E. Is your headache on ☐ONE SIDE OF HEAD ☐BOTH SIDES OF HEAD ☐LIKE A BAND

F. Is your headache pain: ☐THROBBING ☐ACHEY ☐PRESSURE ☐BURNING

G. What other symptoms do you have WITH YOUR HEADACHE?

☐FLASHES OF LIGHT ☐TINGLING/NUMBNESS ☐WEAKNESS ☐NAUSEA

☐VOMITING ☐FOOD CRAVINGS ☐TEMPORARY BLURRED/LOSS OF VISION

☐DIFFICULTY TOLERATING LIGHT/SMELL/SOUND

H. Does moving (example: climbing stairs) increase your headache? ☐YES ☐NO

I. Do you ever go to the emergency room for your headaches? ☐YES ☐NO

J. Do you ever receive injections for headaches in the emergency room? ☐YES ☐NO

K. Does anyone in your family have migraines? ☐ YES ☐NO

* *

8. Circle the number that best describes your general pain level during the past month:

Worst Pain: 0 1 2 3 4 5 6 7 8 9 10

Least Pain: 0 1 2 3 4 5 6 7 8 9 10

Average Pain: 0 1 2 3 4 5 6 7 8 9 10

Pain Right Now: 0 1 2 3 4 5 6 7 8 9 10

9. How often is your pain present?

☐RARE (several times per month) OCCASSIONAL ☐ (several times per week)

☐SPORADIC (several times per day) ☐FREQUENT (several times per hour) ☐CONSTANT

10. What makes your pain worse? (Lying down, standing, sleeping, etc.)

☐DRIVING ☐SITTING ☐STANDING ☐WALKING ☐COUGHING ☐SNEEZING

☐LIFTING ☐EXERCISE ☐TWISTING ☐LYING IN BED ☐BENDING ☐SQUATTING

☐KNEELING ☐CLIMBING STAIRS ☐STRAINING TO HAVE A BOWEL MOVEMENT

☐OTHER_____

11. What makes your pain better?

☐HEAT ☐COLD ☐REST ☐SLEEP ☐SITTING ☐STANDING ☐WALKING ☐EXERCISE

12. Has your pain been associated with any of the following symptoms?

☐INABILITY TO HOLD YOUR URINE (Incontinence) ☐FEVER/CHILLS ☐ABDOMINAL PAIN

☐INABILITY TO CONTROL STOOL (fecal incontinence) ☐PELVIC PAIN ☐WEIGHT LOSS

☐WEAKNESS ☐OTHER_____

14. Do you have any of the following health problems? ☐ YES (if yes check below) ☐NO

☐VISION PROBLEMS ☐SWOLLEN JOINTS ☐DIARRHEA ☐CHRONIC FATIGUE

☐LOSS OF APPETITE ☐DIZZINESS ☐EXCESSIVE THIRST/HUNGER ☐NAUSEA

☐DIFFICULTY SWALLOWING ☐URINARY PROBLEMS ☐CHEST PAIN ☐WEIGHT GAIN

☐WEIGHT LOSS ☐SHORTNESS OF BREATH ☐VOMITING ☐SKIN RASHES

☐CONSTIPATION ☐STOMACH PAIN ☐HEARING PROBLEMS ☐CHILLS ☐NIGHT SWEATS

☐PALPITATIONS ☐BLEEDING PROBLEMS ☐STOMACH ULCERS

☐ PAIN IN CALF MUSCLES WHEN WALKING

☐OTHER (specify) _____

15. Do you have any other medical problems? ☐YES (if yes, check below) ☐N

☐ALLERGIES ☐HEART DISEASE ☐CANCER ☐STROKE ☐ARTHRITIS ☐DIABETES

☐ASTHMA ☐EMPHYSEMA ☐ANEMIA ☐THYROID DISEASE ☐HIGH BLOOD PRESSURE

☐SEIZURES ☐HEAPTITIS ☐RHEUMATIC FEVER ☐VENEREAL DISEASE

☐OTHER, (explain)

_____

16. Do you have any psychiatric illnesses? ☐ YES (if yes please list psychiatrist below) ☐ NO

Psychiatrist _____

☐SCHIZOPHRENIA ☐DEPRESSION ☐PTSD ☐OTHER (specify) _____

_____

17. If you are a woman, are you pregnant at this time? ☐YES ☐NO

PAST NUMBER OF PREGNANCIES ☐1 ☐2☐3☐4☐5☐6 OTHER_____

SUCCESSFUL DELIVERIES ☐1☐2☐3☐4☐5☐6☐ OTHER_____

CESARIAN SECTION? ☐YES ☐NO

18. Have you had any surgeries? ☐YES (if yes, please list surgeries below) ☐NO

LIST TYPE OF SURGERY AND YEAR BELOW

MARK ☑YES FOR EACH PROCEDURE IF SURGERY WAS RELATED TO YOUR PAIN

_____ _____ ☐YES ☐NO

_____ _____ ☐YES ☐NO

_____ _____ ☐YES ☐NO

_____ _____ ☐YES ☐NO

_____ _____ ☐YES ☐NO

_____ _____ ☐YES ☐NO

19. Have you tried any of these treatments for pain? ☐YES (if yes, check below) ☐NO

☐TYLENOL ☐ASPIRIN ☐IBUPROPHEN ☐OTHER NSAIDS ☐OPIATES ☐TRIPTINS

☐ANTICONVULSANTS ☐SEDATIVE HYPNOTICS ☐HORMONE THERAPY

☐NERVE BLOCKS ☐LIDOCAINE ☐PHYSICAL THERAPY ☐ACUPUNCTURE

☐DRY NEEDLING ☐PROLOTHERAPY ☐OSTEOPATHY ☐CHIROPRACTIC

☐OTHER (specify) _____

20. What other practitioners have you previously seen for your pain? _____

_____

_____

21. What type of tests or diagnostic studies have you had related to your pain?

☐X-RAYS ☐MRI ☐CT/CAT SCAN ☐MYELOGRAM

☐EMG/NERVE CONDUCTION STUDY ☐OTHER (specify) _____

_____

22. Do you use any of the following IN EXCESS? ☐YES (if yes please check below) ☐NO

☐COFFEE ☐CIGARETTES/TOBACCO ☐ALCOHOL ☐OTHER_____

23. What do you do for a living? _____

24. Has your pain caused you to change jobs? ☐YES ☐NO

25. Do you have a workers compensation case pending? ☐YES ☐NO

26. What are your expectations from us?

☐PAIN REDUCTION☐IMPROVED MOOD ☐BETTER QUALITY OF LIFE

☐RETURN TO WORK ☐RENEW HOBBIES ☐DECREASE MEDICATION USE

27. Please list all medications, vitamins and/or herbal supplements that you are you currently taking:

NAME OF MEDICATION	DOSAGE	HOW OFTEN

28. Are you allergic to any medications? ☐YES (if yes, please list below) ☐NO

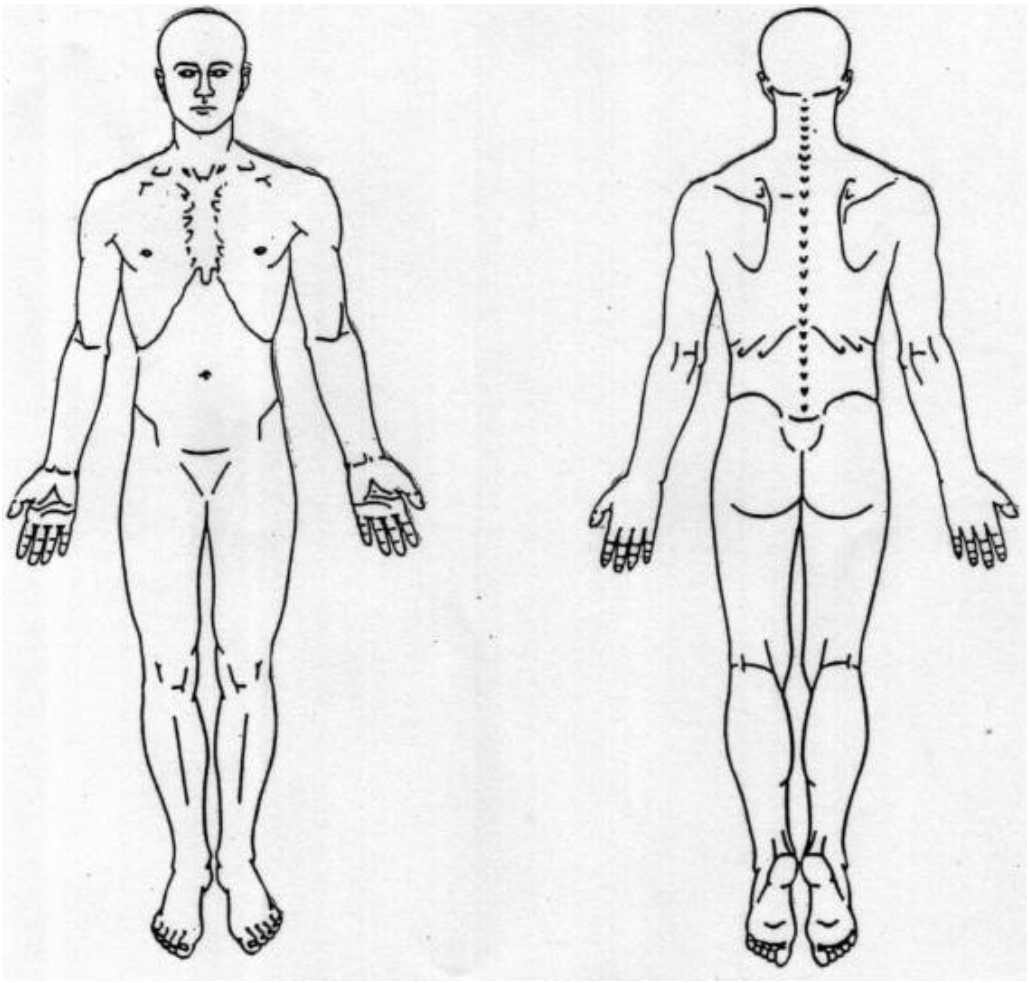
_____

_____

PAIN DIAGRAM

MARK THE LOCATION OF YOUR SYMPTOMS USING THESE SYMBOLS:

Sharp Pain	XXXXX	Numb/Tingling	++++++
Dull Pain	0000000	Other	_____



Pain Scale

Instructions: Indicate your level of pain by choosing the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Moderate Pain — Very Severe Pain

CONSENT TO EVALUATE AND TREAT

ACUPUNCTURE

Shakuju Therapy Acupuncture is considered the safest of all styles of acupuncture practiced today. Side effects are extremely rare. In Shakuju Therapy, acupuncture needles are rarely inserted, and when needle insertion is necessary, it is generally limited to a depth of 1-5 millimeters. There is no risk to internal organs. Side effects including mild discomfort, pain, bruising, or numbness at the site of procedure.

If I suspect that I am pregnant, I will immediately inform the acupuncturist.

I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure or improvement of my condition.

I understand that there may be limitations to the care provided and that in my best interest I may be referred to healthcare provider who may be more qualified to treat my condition outside of these facilities. I have read or have had read to me the above consent.

I have had the opportunity to ask questions about its content, and by signing below I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition, and for any future condition(s) for which I seek treatment.

ACUPUNCTURE MANUAL THERAPY (ANMA/SOTAI)

I hereby request and consent to the performance of acupuncture manual therapy procedures by Ted David Annenberg, LLC. L.AC.

Manual Therapy is a powerful body-mind therapy that uses skilled touch to address the relationship between energy and structures of the body. The practitioner uses pressure and gentle traction on areas of tension in the bones, joints and soft tissue to create fulcrums, or points of balance, around which the body can relax and reorganize.

Manual Therapy focuses primarily on key joints of our skeleton that conduct and balance forces of gravity, posture and movement. By addressing the deepest and densest tissues of the body along with soft tissue and energy fields, Manual Therapy helps to clear blocks in the body's energy flow, amplify vitality and contribute to better postural alignment.

JAPANESE HERBAL THERAPY

I understand that pharmaceutically standardized Japanese herbal formula/s (Kampo) may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent the perception of pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them.

I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call my practitioner as soon as possible.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health. I further understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third party payers.*
- *Conduct normal healthcare operations such as quality assessments and physicians certifications.*

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Patient or Guardian Signature: _____

Date: _____