Patient Health History

Name: ____ Date: ______/______/______
(first) (middle) (last)

Date of Birth: _______/_______/_______ Age: _______ Gender: M/F Marital status: S M D W

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? ____

For what reason? ____

2. Please identify the health concerns that have brought you to Water's Way Clinic in order of importance below:

Condition **Past Treatment**

a. ______________________________ ____

How does this condition affect you? ____

b. ______________________________ ____

How does this condition affect you? ____

c. ______________________________ ____

How does this condition affect you? ____

d. ______________________________ ____

How does this condition affect you? ____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

____

____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

____

____

____

5. Do you have any reason to believe you may be pregnant? Y N

If so, how far along are you? ____

6. Do you have any infectious diseases? Y N If yes, please identify: ____________________________

7. **Family History:**

Check those applicable:

	Father	Mother	Sibling(s)	Self	Partner/Spouse	Children
Age (if living)	_______	_______	_______	_______	_______	_______
Health (G=Good, P=Poor)	_______	_______	_______	_______	_______	_______
Cancer	_______	_______	_______	_______	_______	_______
Diabetes	_______	_______	_______	_______	_______	_______
Heart Disease	_______	_______	_______	_______	_______	_______
High Blood Pressure	_______	_______	_______	_______	_______	_______
Stroke	_______	_______	_______	_______	_______	_______
Mental Illness	_______	_______	_______	_______	_______	_______
Asthma/Hay fever/Hives	_______	_______	_______	_______	_______	_______
Kidney Disease	_______	_______	_______	_______	_______	_______
Age (at death)	_______	_______	_______	_______	_______	_______
Cause of Death	_______	_______	_______	_______	_______	_______

8. **Height:** __________ **Weight:** Currently: __________ Past Maximum: ________ When? ________

9. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

10. **Childhood Illness** (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

11. **Immunizations** (please circle any that you have had):

Polio Tetanus Measels/Mumps/Rubella Pertussis Diphtheria Hib Hepatitis B

Others: ____

12. **Hospitalizations and Surgeries:**

Reason	When	Reason	When

13. **X-Rays/CAT Scans/MRI's/NMR's/Special Studies:**

Reason	When	Reason	When

14. **Emotional** (please **circle** any that you experience **now** and underline any that you have experienced in the past):

Mood Swings   Nervousness   Mental Tension

15. **Energy and Immunity** (please **circle** any that you experience **now** and underline any that you have experienced in the past):

Fatigue   Insomnia   Slow Wound Healing   Chronic Infections   Chronic Fatigue Syndrome

16. **Head, Eye, Ear, Nose, and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision   Eye Pain/Strain   Glaucoma   Glasses/Contacts   Tearing/Dryness

Impaired Hearing   Ear Ringing   Earaches   Headaches   Sinus Problems

Nose Bleeds   Frequent Sore Throats   Teeth Grinding   TMJ/Jaw Problems   Hay Fever

17. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia   Frequent Common Colds   Difficulty Breathing   Emphysema

Persistent Cough   Pleurisy   Asthma   Tuberculosis

Shortness of Breath   Other Respiratory Problems: ____

18. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease   Chest Pain   Swelling of Ankles   High Blood Pressure

Palpitations/Fluttering   Stroke   Heart Murmurs   Rheumatic Fever   Varicose Veins

19. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers   Changes in Appetite   Nausea/Vomiting   Epigastric Pain   Passing Gas   Heartburn

Belching   Gall Bladder Disease   Liver Disease   Hepatitis B or C   Hemorrhoids   Abdominal Pain

20. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease   Painful Urination   Frequent UTI   Frequent Urination   Heavy Flow

Kidney Stones   Impaired Urination   Blood in Urine   Frequent Urination at Night

21. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles   Breast Lumps/Tenderness   Nipple Discharge   Heavy Flow

Vaginal Discharge   Premenstrual Problems   Clotting   Bleeding Between Cycles

Menopausal Symptoms   Difficulty Conceiving   Painful Periods

22. **Menstrual/Birthing History:**

1. Age of First Menses: _______   4. Birth Control Type: ________   7. # of Abortions: ________

2. # of Days of Menses: _______   5. # of Pregnancies: ________   8. # of Live Births: ________

3. Length of Cycle: _______   6. # of Miscarriages: ________

23. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties   Prostrate Problems   Testicular Pain/Swelling   Penile Discharge

24. **Musculoskeletal & Pain** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain   Muscle Spasms/Cramps   Arm Pain   Upper Back Pain   Mid Back Pain

Low Back Pain   Leg Pain   Joint Pain (if so, where?): ____________________

25. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness   Paralysis   Numbness/Tingling   Loss of Balance   Seizures/Epilepsy

26. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid   Hypoglycemia   Hyperthyroid   Diabetes Mellitus   Night Sweats   Feeling Hot or Cold

27. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet

Is there anything else we should know? ____________________

____

28. **Lifestyle:**

a. Do you typically eat at least three meals per day?   Y   N   If no, how many? __________

b. Exercise routine: ____________________

c. Spiritual practice: ____________________

d. How many hours per night do you sleep? ________   Do you wake rested?   Y   N

e. Level of education completed: High School   Bachelors   Masters   Doctorate   Other

f. Occupation: ____________________   Employer: ____________________   Hours/Week: _______

Do you enjoy work?   Y/N   Why/Why not? ____________________

g. Nicotine/Alcohol/Caffeine Use: ____________________

h. Have you experienced any major traumas?   Y   N   Explain: ____________________

____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day? _____

j. Television habits: ____________________   Reading habits: ____________________

k. Interests and hobbies: ____________________

How did you hear about us? ____________________

Would you like to receive our email newsletter? ____________________

Water's Way

Confidential Patient Information

Name:

Address:

Home Phone: Other Phone:

May we Leave a Message? May we Leave a Message?

E-mail:

Date of Birth: Age:

Emergency Contact:

DISCLOSURE STATEMENT

WATER'S WAY ACUPUNCTURE

Eliza Worth McEmrys, MSOM L. Ac.
124 E Arrellaga Street Phone: 805-452-3193
Santa Barbara, CA 93101

Education and Experience:

Eliza McEmrys earned her Master of Science degree in Oriental Medicine (MSOM) from National College of Naturopathic Medicine in Portland, Oregon in September 2004. The four-year Classical Chinese Medicine program consists of 3,768 hours of education both in the classroom and in various clinical settings. She was certified as a Diplomate in Acupuncture by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in 2004. This includes certification in Clean Needle Technique. Eliza has studied Mandarin Chinese, and spent over four months studying Qi Gong and Herbalism with teachers in China's Sichuan province between 2001 and 2003. After graduating in 2004, Eliza practiced in Chicago until 2006, and then moved to Denver where she practiced from 2006-2008.

Eliza's training includes adjunctive therapies such as Chinese herbalism, moxibustion, cupping, shiatsu, medical qi gong, acupressure, auriculotherapy, acu-detox protocols and dietary and lifestyle recommendations.

Eliza is a past member of the Association of Acupuncture and Oriental Medicine (AAOM), the Acupuncture Association of Colorado (AAC) and the Illinois Association of Acupuncture and Oriental Medicine (ILAAOM). She is licensed to practice acupuncture in the State of California. She has been a licensed acupuncturist in Colorado, Illinois, and Oregon. None of these licenses have ever been suspended or revoked.

This clinic complies with the rules and regulations promulgated by the State of California, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule
Initial consultation and treatment (90 minutes): $ 135
Follow-up treatment (50 minutes): $ 95

The practice of acupuncture in California regulated by State Acupuncture Board. For more information check their website, http://www.acupuncture.ca.gov/.

Water's Way
Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Water's Way, a Chinese Medical Clinic.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, 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 the Chinese Medical Clinic as soon as possible.*

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: ____ **Date:** ____________________

Printed Name: ____________________________________ **Date of Birth:** ______________

Address: ____

City: ____________________ **State:** __________ **Zip Code:** ___________ **Phone:** _____________

SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*____________________________________ *X*____

Patient's Signature Date — Explained by me and signed in my presence Date