ANCIENT ENERGETICS
Integrative Energy Medicine
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HEALTH HISTORY FORM

Please take the time to fill out this questionnaire carefully before you arrive for your first appointment. The information you provide will assist me in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Referred by: _____ Your Occupation: _____

Physician: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

In Emergency Notify: _____ Phone: _____

Main Complaint (symptoms, diagnosis, duration, etc.)

What are your goals for our work together?

Significant Trauma (physical or emotional)

Birth History- your own birth (prolonged labor, forceps delivery, complications, etc.)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise
Days per week Length of workout Type of Activity

What makes your condition better? (Rest, movement, heat, cold, fresh air, eating, crying, etc.)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.)

Please give the following information about your immediate family's health:

Relationship	Age if living	Age at death	State of health or cause of death
Mother			
Father			
Brothers and sisters			
Spouse			
Children			

Have any of your blood relatives had any of the illnesses listed below?
If so, indicate the relationship (father, sister etc.

Illness	**Family members**
Asthma	
Tuberculosis	
High blood pressure	
Heart disease	
Stroke	
Diabetes	
Cancer	
Blood diseases	
Glaucoma	
Rheumatoid arthritis	
Gout	
Rheumatic fever	
Epilepsy	
Mental/emotional problems	
Suicide	
Alcoholism/drug addiction	

Do you:	**Rarely/never**	**Sometimes**	**Often**
Become bored easily?			
Feel depressed?			
Feel bored?			
Have trouble making decisions?			
Worry a lot?			
Feel nervous?			
Have trouble relaxing?			
Become angry easily?			
Have sexual problems?			
Ever feel like committing suicide?			
Use marijuana?			
Use hard drugs?			
Do you often feel tired?			
Ever feel like fainting?			
Have difficulty sleeping?			

Do you:	Rarely/never	Sometimes	Often
Get cold hands and feet easily?			
Sleep restlessly?			
Ever shake or tremble?			
Bruise easily?			
Any problems with coordination?			
Have dry skin?			
Have brittle fingernails?			
Any other skin problems?			
Have double vision?			
Blurry vision?			
Watery or itchy eyes?			
Have dry eyes?			
See colored rings around lights?			
Have difficulty hearing?			
Have headaches?			
Have neck pains?			
Have chest colds?			
Have head colds?			
Have sneezing spells?			
Have nose bleeds?			

Any other symptoms not listed?

Classic Indications:

Preference	Most liked	Least Liked
Season		
Taste		
Climate		
Time of Day		
Mood		

Do you drink coffee? _____Yes _____ No If yes, how many cups per day? _____

Per day I drink _____ beers _____glasses of wine _____drinks of hard liquor.

Has anyone ever told you have a problem with alcohol? _____Yes _____No

How many meals per day do you eat? _____How many are hot meals?

Do you eat breakfast? _____Yes _____No

Do you diet frequently? _____Yes _____No Are you dieting now? _____Yes _____ No

Do you consider your weight _____ just right _____underweight _____overweight

Do you snack _____rarely _____daily _____more than once daily?

Usual snack food? _____

Check the frequency you eat the following foods	More than once daily	Daily	3 times weekly	Once weekly	Rarely or never
Whole grain cereal or bread					
White bread, pastas, other starches					
Sugar, desserts					
Dairy products					
Eggs					
Meat, poultry, fish					
Smoked or processed meat					
Beans, peas					
Nuts and seeds					
Citrus fruit or juice					
Dark green vegetables					
Orange/yellow or other vegetables					
Vinegar, pickled food					
Salad greens					

List the foods you ate yesterday:

Breakfast:	Mid-morning:	Lunch:	Mid-afternoon:	Supper:	Evening:

List any foods you crave from time to time:

Is there a time of day or type of situation in which you have these cravings?

List any foods to which you have an aversion:

Personal History: Please check any conditions or symptoms you have now.

- ☐ Arthritis
- ☐ High/Low Blood Pressure
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Gastritis/Pancreatitis
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Seizures
- ☐ Anemia
- ☐ Lyme Disease
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Food Allergies/Intolerance
- ☐ Hepatitis
- ☐ Thyroid Imbalance
- ☐ Chronic Pain Condition
- ☐ Infertility
- ☐ Heart Disease
- ☐ Elevated Blood Cholesterol
- ☐ Diverticulitis/IBS
- ☐ Raynaud's Disease
- ☐ Respiratory Allergies
- ☐ Impotence
- ☐ Emphysema

Please check if you have had any of these items listed below in the last year
Put a star on the box if you had this in the past but do not any longer.

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Cravings
- ☐ Bleed/Bruise easily
- ☐ Muscle weakness/fatigue
- ☐ Poor Sleeping
- ☐ Night Sweats
- ☐ Localized Weakness
- ☐ Weight loss/gain
- ☐ Sudden energy drop
- ☐ Fatigue
- ☐ Sweats Easily
- ☐ Poor Balance
- ☐ Peculiar tastes/smells
- ☐ Strong thirst (hot or cold drinks)
- ☐ Fevers
- ☐ Tremors
- ☐ Change in appetite
- ☐ Dental/gum problems

Skin and Hair

- ☐ Rashes
- ☐ Eczema/Psoriasis
- ☐ Skin discoloration
- ☐ Dermatitis
- ☐ Ulcerations
- ☐ Dandruff
- ☐ Acne
- ☐ Warts
- ☐ Hives/Allergic Dermatitis
- ☐ Loss of hair
- ☐ Change in skin/hair texture
- ☐ Fungal Infection
- ☐ Itching
- ☐ Recent moles
- ☐ Face flushing
- ☐ Weak or ridged nails

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color Blindness
- ☐ Ringing in ears
- ☐ Nose bleeds
- ☐ Sores on lips/tongue
- ☐ Difficulty swallowing
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Recurrent sore throats/colds
- ☐ Dental problems
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Spots in front of eyes
- ☐ Grinding teeth
- ☐ Jaw clicks/locks
- ☐ Glasses
- ☐ Night Blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Facial pain
- ☐ Headaches

Cardiovascular

- ☐ Chest pain or pressure
- ☐ Cold hands/feet
- ☐ Shortness of breath
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of hands/feet
- ☐ Varicose/spider veins
- ☐ Spontaneous sweating
- ☐ Palpitations at rest
- ☐ Blood clots
- ☐ Pressure in chest
- ☐ Dizziness
- ☐ Fainting
- ☐ Phlebitis
- ☐ High blood pressure

Respiratory

- ☐ Cough/Wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing when lying down
- ☐ Coughing blood
- ☐ Pain with deep inhalation
- ☐ Asthma
- ☐ Tight sensation in chest
- ☐ Production of phlegm… what color? _____
- ☐ Bronchitis
- ☐ Difficult inhale/exhale

Gastrointestinal

- ☐ Nausea
- ☐ Gas
- ☐ Indigestion
- ☐ Bloating/Edema
- ☐ Changes in appetite
- ☐ Excessive appetite
- ☐ Vomiting
- ☐ Belching
- ☐ Bad breath
- ☐ Chronic laxative use
- ☐ Acid reflux/GERD
- ☐ Significant thirst
- ☐ Diarrhea
- ☐ Black stools
- ☐ Rectal pain
- ☐ Loose stools (>2 per day)
- ☐ Hernia
- ☐ IBS/Crohn's Disease
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Abdominal pain/cramps
- ☐ Poor appetite

Genito-Urinary

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Nocturnal emission
- ☐ Night urination… What time?_____ How often?_____
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Decreased libido
- ☐ Pain in testicles
- ☐ Blood in urine
- ☐ Scanty flow
- ☐ Urinary tract infection
- ☐ Prostatitis
- ☐ Herpes
- ☐ Urgent urination
- ☐ Copious flow
- ☐ Burning urination
- ☐ Dribbling after urination
- ☐ Infections
- ☐ Excessive libido

Gynecological/Reproductive

- ☐ Difficult/Painful intercourse
- ☐ Vaginal dryness
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Infertility
- ☐ Irregular menstruation
- ☐ Clots
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Uterine Fibroids
- ☐ Fibrocystic breast tissue
- ☐ Polycystic Ovarian Disease
- ☐ PMS
- ☐ Painful menstruation
- ☐ Age of first menses_____
- ☐ Date of last menses_____
- ☐ Date of last PAP/Pelvic_____
- ☐ Number of pregnancies____
- ☐ Number of ectopic pregnancies_____
- ☐ Number of live births_____
- ☐ Number of miscarriages_____
- ☐ Number of abortions_____

Do you practice birth control?_____
What type?_____ How long?_____

Musculoskeletal

☐Neck pain	☐Shoulder pain	☐Hand/wrist pain	☐Carpal Tunnel
☐Knee pain	☐Sprains/Strains	☐Sciatica	☐Foot/ankle pain
☐Hip pain	☐Muscle pain	☐Muscle weakness	☐Tendonitis
☐Back pain Low___ Middle___ Upper___		☐Bursitis	☐Rotator Cuff

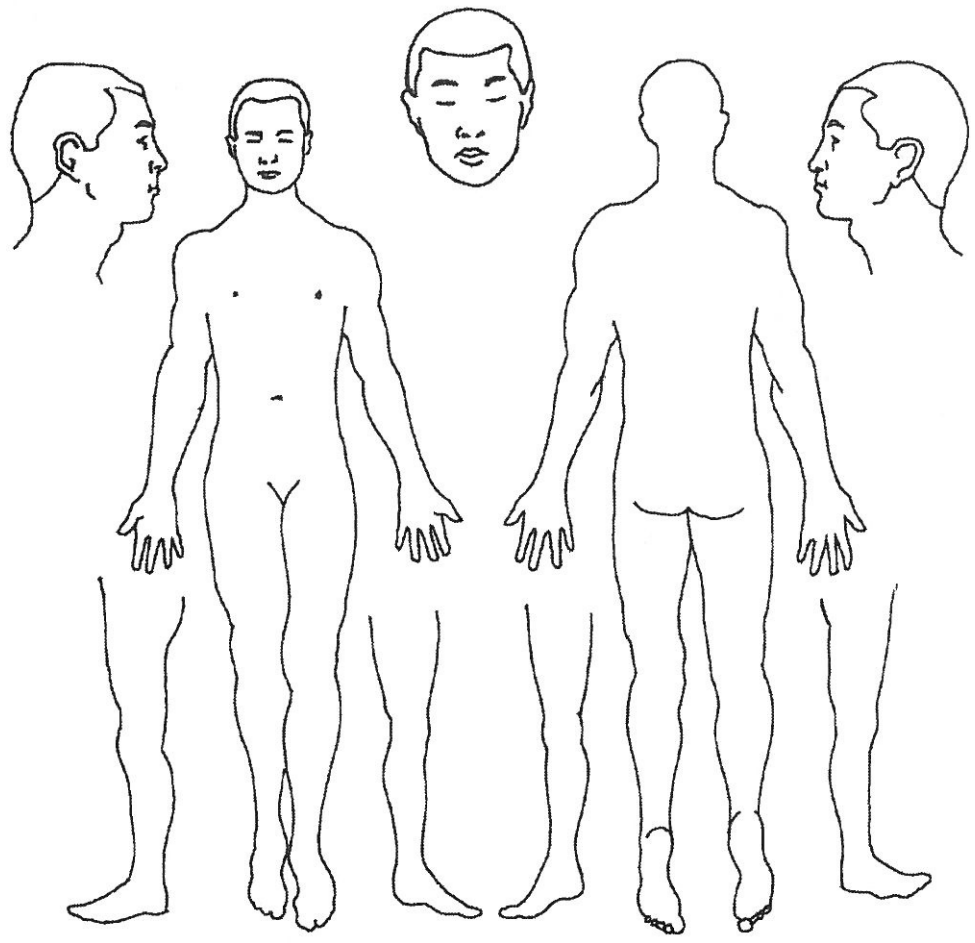
☐Soreness/weakness in lower body (back, knee, hip, ankle, foot)

Neuropsychological

☐Seizures	☐Loss of balance	☐Vertigo/Dizziness	☐Areas of numbness
☐Lack of coordination	☐Poor memory	☐Concussion	☐Depression
☐Anxiety/Panic attacks	☐Bad temper/irritable	☐Easily susceptible to stress	☐Seasonal Affective Disorder
☐Nervousness	☐ADD/ADHD	☐Manic Depression	

Have you ever been treated for emotional problems? ☐Yes ☐No
Have you ever considered or attempted suicide? ☐Yes ☐No
Have you ever been treated for substance abuse? ☐Yes ☐No

Comments Please inform me of any other problems you would like to discuss.



PATIENT INFORMED CONSENT FOR ACUPUNCTURE

I, _____, hereby voluntarily consent to be treated with acupuncture and/or Chinese herbs, administered by Dana Lundin or associates, hereinafter referred to as "Practitioner". I understand that acupuncture is performed by the insertion of fine, pre-sterilized disposable acupuncture needles through the skin, or the application of heat to the skin, or both, at certain points on the body in an attempt to improve body function and/or relieve pain.

I acknowledge that, although rare, certain side effects can result from acupuncture. These can include bruising, mild pain or discomfort, a feeling of weakness, fainting, nausea, and a temporary aggravation of symptoms. These effects are unusual and of short duration.

I accept the fact that no guarantee is made concerning the use and effects of acupuncture or Chinese Herbs.
I understand that I can stop treatment at any time.

I further understand that the evaluation given me is an energetic assessment of the acupuncture meridian network, and in no way purports to be, or replaces a western medical examination and diagnosis. In the course of evaluation, there may be reference to the state of various "organs", such as heart, liver, spleen, lung, kidney, etc., which actually refers to the energetics channels of the same name.

I acknowledge the fact that Dana Lundin/Practitioner is not and does not profess to be a western-trained medical doctor and does not advise on the use of medically-prescribed pharmaceuticals or medical treatments, not does the Practitioner give any substances by injection.

I acknowledge that the Practitioner has completed training in Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.)

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records to my family physician, named _____ _____ for the reasons listed above. _____
initials

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation. _____
initials

If clinical data is gathered it will be without names and may be used for statistical data and research. We are HIPPA compliant to protect your privacy. According to federal policy, we need your written consent for the following:

Do we have your permission to make appointment confirmation phone calls?

	Phone Number		*Yes or No*
Home	_____	May we leave a message?	_____
Cell	_____	May we leave a message?	_____
Work	_____	May we leave a message?	_____

_____ _____
Patient's Name Guardian's Name

_____ _____
Patient's or Guardian's Signature Date Signed

Dana Lundin Lic. Ac., Dipl. Ac. (NCCAOM), C.S.T.

_____ _____
Name of Acupuncturist Witness