



Acupuncture Health Center

1303 Astor Street, Suite 101
Bellingham, WA 98225

(360) 715-1824 **Office**
(360) 715-1648 **Fax**

Scott Paglia, L.Ac
Tia Hutton, L.Ac

Structure of Appointments

Initial Exam: 45 minutes

- Review new patient paperwork
- Meet with Acupuncturist for thorough health intake. Includes complete health screening and pulse diagnoses
- No Treatment

Chinese Medical Exam: 1 hour 30 minutes

- Meet with Acupuncturist for a discussion on:
 - a. Results of Chinese Medical Exam
 - b. How Chinese Medicine works
 - c. What forms and Types of Treatment are Available
- Receive an Acupuncture treatment

Chinese Medical Exam Part 2: : 1 hour 30 minutes

- Meet with acupuncturist for a discussion on:
 - a. What type of care works best for you and your family
 - b. Treatment goals
- Receive an Acupuncture treatment

For Best Results, Complete All Three Visits Within One Week from Start to Finish

Future Acupuncture Appointments: 1 hour

- Meet with acupuncturist for brief health intake
- Receive Acupuncture treatment

Herbal Consultation: Up to 15 minutes

- Meet with Acupuncturist for herbal consultation
- Receive herbal formula specifically designed for patients health needs



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The following information is important to the maintenance of your account and/or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed. We will be happy to help you.

Patient Health And Insurance Information:

Name: _____ Social Security# _____

Date of Birth: _____ Male Female

Married Divorced Single Separated Widowed

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

Home Phone: _____

Work Phone: _____

Cell Phone: _____

On which number would you prefer to be reached? _____

Email: _____

Occupation: _____ Employer: _____

Responsible Party:

Name: _____ Relationship: _____

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

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Insurance Information:

Subscriber Name: _____ ID# _____

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

Customer Service Phone Number: _____ Relation to Insured: _____

Secondary Insurance: _____ ID# _____

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

Customer Service Phone Number: _____ Relation to Insured: _____

Emergency Contact/Next Of Kin:

Name: _____ Phone: _____ Relationship _____

Name: _____ Phone: _____ Relationship _____

Who may we thank for referring you? _____



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Health History Questionnaire *Information for your Acupuncturist*

Important: Complete these documents as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition. But they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

Name of your primary physician: _____

Is there anything limiting you from care? No Yes If yes, please list: _____

Other physician/therapists seen for the condition: _____

How did you hear about our office? _____

Medication(s) you are currently taking

Name	For treatment of	Dosage	Date Started
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Are you receiving relief from taking any of these medications? Please Explain: _____

Supplements (if any; vitamins, herbs, minerals, etc.)

Name	For treatment of	Dosage	Date Started
1.			
2.			
3.			
4.			
5.			

Major Complaints (in order of significance to you)

1.	4.
2.	5.
3.	Additional:

How do these conditions impair your daily activities? _____

Patient Medical History

How was your childhood health? _____ Hospital visits/stays: _____

Recent Tests (Please indicate test results and date below)

Test	Date	Result
1.		
2.		
3.		



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Informed Consent

By signing below, I do hereby voluntarily consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture by Scott A. Paglia L.Ac. (AC00000647) and/or Tia Hutton L.A.c (AC60193675) of the Acupuncture Health Center 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 above named acupuncturists, including those working at the clinic or office listed above 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 (Chinese massage), Chinese Herbal medicine and nutritional counseling. I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. The herbs may have 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 herbs.

I have been informed that the acupuncture is generally a safe method of treatment, but that it may have some side effects including: bruising, numbness, or tingling near the needling site that may last a few days and dizziness or fainting. Damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile and disposable needles and maintains a clean and safe environment. Burns and/or scarring are treatment other side effects and risks may occur. The herbs and nutritionally supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese 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 the clinical staff member 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 on the facts then known is in my best interest. I understand that results are not guaranteed.

I understand that 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 to me the above consent treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had opportunity to ask questions. I intend for this consent to cover the entire course. Of treatments for my present condition and for any future condition and for any future conditions for which I seek treatment.

Signature: _____

Date: _____

Printed Name: _____

Date of Birth: _____



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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. **Please review it carefully.**

- In my practice, I have always kept your health information secure and confidential. A new law requires me to continue maintaining your privacy, to give you this notice, and to follow the terms of notice.
- I may use or disclosed your health information for my normal healthcare operations. For example one of my staff will enter your information into my computer.
- I may share your medical information with my business associates, such as a billing service. I have a written contract with each business associate that requires them to protect your privacy.
- I may use information to contact you. For example, I may send newsletters or other information. I may also want to call and remind you about your appointments. If you are not at home, I may leave this information on your answering machine or with the person who answers your telephone.
- In an emergency, I may disclosed your health information to a family member or another person responsible for your care.
- I may release some, or all, of your health information when required by law.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that I not use or disclose your health information as described above, I will let you know if I can fulfill your request.
- You have the right to know of any uses or disclosures I make with your health information beyond the above normal uses.
- Because I may need to contact you from time to time, I will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. I will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give me written request regarding the information you want to see. If you also want a copy of your records, I may charge you a reasonable fee for the copies, \$23 administrative fee, plus .15 cents per page copied.
- You have right to request and amendment or change to your health information. Give me your request to make changes in writing. If you want to include a statement in your file. Please give it to me in writing. I may or may not make the changes you request, but will be happy to include your statement in your file. If I agree to an amendment or change, I will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If I change any of the details of this notice, I will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence A venue, SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- This notice goes into effects as of April 14,2003.

Acknowledgement

Your signature below is acknowledgment that you have been provided with a copy of our Notice of Privacy Practices to read.

Signature: _____

Date:_____

Printed Name: _____

Patient/Client name if being signed as a parent or guardian: _____



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Patient Name: _____

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical mal practice, that is as to whatever 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, will also be determined by submission to binding 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 whether born and unborn at the time of the occurrence, giving rise to any claim. This agreement is intended to bind the patient and employees 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, 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 healthcare provider, including those working at the health care provider's associates , associations, corporation, partnership, employees, agents and estate, must be arbitrated including without limitation, claims for loss of consortium, 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 arbitrator, together with others expenses incurred by a party for such 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 shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing 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 claims 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 provisions 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 provisions. 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 <i>(Indicate relationships if signing for patient)</i>	(Date)
OFFICE SIGNATURE	X	(Date)



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Objective of Care

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problems as well as the symptoms corrected and relieved (Corrective care). Your Acupuncturist will weigh your needs and desire when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Relief
- Corrective
- Check here if you want the Acupuncturist to select the type of care appropriate for your condition.

Patient's Signature: _____ Date: _____



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Agreement By The Patient / Guarantor To Be Financially Responsible For Fees

I _____ (patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% may applied to any unpaid patient balance over 30 days past due.

Patient Signature: _____ Date: _____

Agreement By The Patient Regarding Cancelled/Missed Appointments

Patient understand that a missed appointment (No Show) will result in a \$65 charge being issued for that appointment.
If a patients fails to give the clinic 24 hours notice of a change of appointment.

Patient Signature: _____ Date: _____

Medical Release To Insurance Company & Notice Of Privacy Practices

I authorize the release of medical information to my insurance company/ companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company / companies to pay directly to Acupuncture Health Center for those medical Services.

Patient Signature: _____ Date: _____



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1. Payment Option

- Cash
- Personal Check
- Credit Card (Visa & MasterCard)

2. Treatment Rates

- Chinese Medical Exam - \$190
- Chinese Medical Exam II - \$110
- Acupuncture Treatment - \$110
- New patient Herbal Consultation - \$100
- Herbal Consultation - \$65
- Herbal Formulas - \$.50 per gram + tax
- Re-Exams - \$75
- Acupressure Class - \$50

3. Chinese Herbal Medicine

All Herbal Consultation and Herbal Formulas are NOT covered by an insurance policy and are non-refundable.

Patient Signature

Date

Patient Name

Acupuncturist Signature



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New Patient Health History Questionnaire

Dear New Patient:

- a. Please read and fill in all of the information all that pertains to you.
- b. On pages 2 through 11, under each category, check all symptoms that you have or are experiencing in the last six months.
- c. Add and total all of the boxes you checked.

Test	Date	Test Results
Physical		
Cholesterol		
Prostate		
Mammography		
Pap Smear		
Blood (which test?)		
HIV/STD		
Other		

Please indicate if you have (or have been tested for) any of the following :

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Vein Condition
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Polio
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> migraines
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Other Liver Illnesses
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Fever	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Other Heart Illnesses
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Other Kidney Illnesses
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Mumps	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Other Lung Illnesses

Immunizations?	Surgeries?



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New Patient Health History Questionnaire

1. Pain :

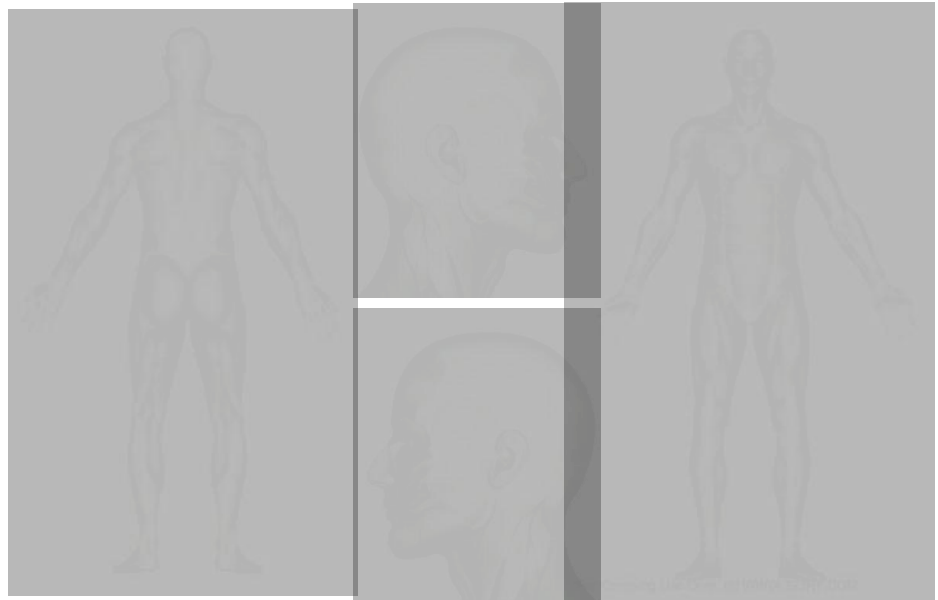
What makes the pain better?

- Soft Pressure
- Hard Pressure
- Cold
- Heat
- Exercise
- Rest
- Other

What makes the pain worse?

- Soft Pressure
- Hard Pressure
- Cold
- Heat
- Exercise
- Other

On the figures below, please mark clearly any areas of pain and indicate any scars.



FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

2. Describe your pain:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="radio"/> Sharp	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Fixed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Moving	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cramping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Aching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Dull	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Boxes Checked:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Date: _____



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3. Kidney Function (Overall Temperature):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Cold Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cold Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cold Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cold Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sweaty Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sweaty Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hot Body Temperature Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cold Body Temperature Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Afternoon Flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heat in hands, feet & chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hot flashes any time of day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thirsty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Perspire easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lack of perspiration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Do you take water to bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

4. Lung, Kidney Function (Overall Energy):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Difficulty keeping eyes open (day-time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> General weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Easily catch cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Feel worse after exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic (daily) fatigue and malaise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---



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5. Liver Function:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> See floating black spots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

6. Heart Function:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sores on tip of tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Restlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest pain traveling to shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wake un-refreshed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coffee? How much per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

7. Spleen Function (continued on page 5):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Low appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abrupt weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abrupt weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdominal gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gurgling noise in stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fatigue after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prolapsed organs? Which ones?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---



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7. Spleen Function (continued from page 4):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="radio"/> Bruise easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Over-Thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Worry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

8. Lung Function:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="radio"/> Nasal Discharge (color _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Nose Bleeds	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Sinus Congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Dry Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Dry Throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Dry Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Dry Skin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Allergies (what ? _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Alternating Chills/Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Sneezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Headache (location _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Overall achy feeling in body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Stiff Neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Stiff Shoulders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Sore Throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Difficulty breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Tobacco (# per day _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Sadness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Melancholy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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9. Spleen, Stomach (Small/Large Intestine Function):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Loose Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Constipated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Incomplete Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blood in Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mucous in Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Undigested food in the Stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

10. Stomach Function:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Burning sensation after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Large appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Canker Sores (mouth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding, swollen or painful gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acid Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ulcer (diagnosed?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hiccups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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11. Dampness (Trapped in body):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Bodily sensation of heaviness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental heaviness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental sluggishness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental fogginess	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swollen hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swollen feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

12. Liver Function (Eyes):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Itchy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bloodshot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Watery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gritty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Blurry Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Decreased Night Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Near-sighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Far-sighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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13. Liver, Gall Bladder Function:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Alternating Diarrhea & Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bitter taste in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Frustration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headache at the top of the Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tingling Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lump in the throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Limited Range-of-Motion (Neck)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Limited Range-or-Motion (Shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> How much Alcohol/day? (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Recreational drugs? Which? (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High-pitched Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gall Stones (history or current)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> STD's? Which (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unable to adapt to Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____	_____	_____	_____	_____	_____	_____



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14. Kidney, Urinary Bladder Function:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="radio"/> Frequent Cavities, Teeth Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Easily Broken Bones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Sore Knees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Weak Knees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cold Sensation In The Knees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Low Back Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Memory Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Excessive Hair Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Low-Pitched Ringing In The Ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Kidney Stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Bladder Infections	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Lack Of Bladder Control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Wake During The Night 2 (Or More)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Times To Urinate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Fear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Easily Startled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---

15. Libido:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="radio"/> High	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Low	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: ____	---	---	---	---	---	---



Acupuncture Health Center

1303 Astor Street, Suite 101
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(360) 715-1824 **Office**
(360) 715-1648 **Fax**

Scott Paglia, L.Ac
Tia Hutton, L.Ac

New Patient Health History Questionnaire

FOR LONG TERM-CARE PATIENTS ONLY: On the day of your re-exam, only check the boxes that NO LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two weeks. Add up your boxes and date.

16. Urination (Bladder Function):

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="radio"/> Color: <input type="radio"/> Pale <input type="radio"/> Dark Yellow <input type="radio"/> Clear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Reddish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Cloudy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Scanty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Profuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Strong Oder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Painful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Difficult	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Urgent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> Frequent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____	_____	_____	_____	_____	_____	_____

Women Only

- Yes No Do you have a regular menstrual cycle? _____ Age of first menstruation
 Yes No Are you pregnant? _____ Average number of days in flow
 Yes No Do you have bleeding between periods? _____ Average number of days in entire cycle
 Yes No Do you have a vaginal discharge? _____ Number of children
 _____ Number of pregnancies
 _____ Age of menopause (if applicable)

Please Fill In The Menstrual Chart	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color: Normal, Pale, Bright, Red, Brown, Rust, Dark, Purple, Other							
Amount of Flow: Normal, Heavy, Light							
Pain/Cramps: Dull, Sharp, Other							
Vomiting (Yes or No)							
Nausea (Yes or No)							



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Women Only:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Irregular Menstrual Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bleeding Between Periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Excessive Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cramping With Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Food Cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dull Pain? Where? (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sharp Pain? Where? (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression Surrounding Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Irritability Surrounding Period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain During Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other? Explain: (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____	_____	_____	_____	_____	_____	_____

Men Only:

	ReExam 1	ReExam 2	ReExam 3	ReExam 4	ReExam 5	ReExam 6
<input type="checkbox"/> Swollen Testes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Testicular Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premature Ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Feeling of Coldness or Numbness in External Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain During Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other? Explain: (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Total Boxes Checked:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____	_____	_____	_____	_____	_____	_____