



**Brief Health History: (list major diseases, surgeries, etc.)**

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How many times per year do you get a cold or the flu? \_\_\_\_\_

**Family Medical History:**

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<b>What other medication and/or supplements are you taking?</b>	<b>How long have you taken them?</b>
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**Emotions:**      \_\_\_ Normal                      \_\_\_ Problem

\_\_\_ Depression      \_\_\_ Sadness                      \_\_\_ Panic attack      \_\_\_ Sensitive

\_\_\_ Worries              \_\_\_ Overly excited                      \_\_\_ Angry              \_\_\_ Anxiety

Describe: \_\_\_\_\_

**Energy:**      \_\_\_ Normal              \_\_\_ Problem              \_\_\_ Low              \_\_\_ Up and down

\_\_\_ Exhausted              \_\_\_ Hyperactive              \_\_\_ Nervous energy      \_\_\_ Abundant

Describe: \_\_\_\_\_

**Sleep Pattern:**      \_\_\_ Normal              \_\_\_ Insomnia

Falling Asleep:      \_\_\_ Sometimes difficult      \_\_\_ Always difficult      \_\_\_ Sometimes very difficult

                            \_\_\_ Always very difficult      \_\_\_ Sleepy in daytime      \_\_\_ Take naps

Waking up:      \_\_\_ Times per night              \_\_\_ Wake up too early

                            \_\_\_ Wake up at night and cannot go back to sleep again

Sleep Quality:      \_\_\_ Deep              \_\_\_ Light              \_\_\_ Poor              \_\_\_ Many dreams

                            \_\_\_ Bad dreams      \_\_\_ Grinding teeth              \_\_\_ Talking in sleep      \_\_\_ Other

Describe: \_\_\_\_\_

**Diet:** Any special diet?

\_\_\_ Food cravings :      \_\_\_ Sugar              \_\_\_ Salt              \_\_\_ Food allergies

Describe: \_\_\_\_\_

**Temperature:**      \_\_\_ Normal              \_\_\_ Abnormal

\_\_\_ Feel cold easily              \_\_\_ Cold hands              \_\_\_ Cold feet              \_\_\_ Feel hot easily

\_\_\_ Alternating hot & cold              \_\_\_ Hot flash              \_\_\_ Sensitive to weather changes

Describe: \_\_\_\_\_

**Sweating:**      \_\_\_ Normal              \_\_\_ Abnormal              \_\_\_ Too easily              \_\_\_ Too much

                            \_\_\_ Difficult              \_\_\_ Too little              \_\_\_ Night sweats              \_\_\_ Other

Describe: \_\_\_\_\_

**Sensitivity and Allergy:**      No      Yes

Temperature:    Cold      Hot      Dampness      Light  
                    Noise      Airborne particles      Drugs      Other

Describe: \_\_\_\_\_

**Appetite and Digestion:**      Normal      Abnormal

Rapid hungering      Poor appetite      Nausea      Anorexia  
 Hungry, but no desire to eat      Bloating      Gas      Other

Describe: \_\_\_\_\_

**Bowel Movement:**      Normal      Abnormal      Time of day

Constipation      Diarrhea      Loose      Watery      Incomplete  
 Hard and dry      Strong smell      With mucus      With blood      Other

Describe: \_\_\_\_\_

**Body Weight:**      Normal      Overweight      Underweight

If overweight:    How many pounds would you like to lose?  
                           How many years ago did you first start to gain weight?  
                           Are you following a weight control program at this time?

Describe: \_\_\_\_\_

**Drinking:**      Normal      Abnormal

Thirsty      Dry mouth      Drink a lot  
 Dry mouth but no desire to drink  
 Not thirsty, but drink a lot of water anyway

Describe: \_\_\_\_\_

**Urination:**     Normal     Abnormal

Frequent     Urgent     Burning     Painful     Cloudy  
 Dark color     Foul smell     Bloody     Difficult     Retention  
 Number of time per day     Number of times you get up to urinate at night     Other

Describe: \_\_\_\_\_

**Eye, Ear, and Nose:**     Normal     Abnormal

Describe: \_\_\_\_\_

**Sex Function:**     Normal     Abnormal

Describe: \_\_\_\_\_

**Menstrual Cycle:**    Age of onset: \_\_\_\_\_ years old    Date of last period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Regular     Irregular     How many days between cycles? How many days did it last?Color:     Pale red     Dark red     Bright red     PurplishWere there clots?     Yes     No

Menstrual Pain:     Yes     No  
 Before flow     During flow     After flow  
 Abdomen     Back     Breast

Emotion around period:     Normal     Abnormal

Before flow     During flow     After flow     Depression  
 Irritability     Anger     Sadness     Crying     Other

Describe: \_\_\_\_\_

**Addictions:**     Tobacco     Alcohol     Others

Describe: \_\_\_\_\_

**Any other disorders or abnormalities:**

Describe: \_\_\_\_\_

## PATIENT INFORMED CONSENT FOR ACUPUNCTURE AND/OR HERBS

I, \_\_\_\_\_, hereby voluntarily consent to be treated with acupuncture and/or Chinese Herbs, administered by Ton Shen Health, Inc.. I understand that acupuncture is performed by the insertion of fine, pre-sterilized, disposable acupuncture needles (with or without the addition of electric current) through the skin, or the application of heat to the skin, or both, at certain points on the body, in an attempt to improve the body function and/or relieve pain.

I acknowledge that, although rare, certain side effects may 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 may 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 the evaluation, there may be reference to the state of various "organs", such as heart, liver, spleen, kidneys, etc., which actually refers to energetic channels of the same name.

I acknowledge the fact that the practitioners of Ton Shen Health, Inc. are not and do not profess to be a western-trained medical doctors and do not use or advise on the use of medically-prescribed pharmaceuticals or medical treatments, nor do the practitioners give any substances by injection.

I acknowledge that all the Life Rising herbal products are not approved by Food and Drug Administration of USA (FDA).

I acknowledge that the practitioners of Ton Shen Health, Inc. have completed a minimum of three years training in Acupuncture and Oriental Medicine, is National Board Certified (NCCAOM) and a Licensed Acupuncturist (L.Ac.) in the State of Illinois.

If clinical data is gathered it will be without names and may be used for statistical data and research. According to federal policy, we need you written consent for the following:

Do we have your permission to make appointment confirmation calls? Yes or No  
If yes, what number(s) shall we call?

Home \_\_\_\_\_ May we leave a message? \_\_\_\_\_

Cell \_\_\_\_\_ May we leave a message? \_\_\_\_\_

Work \_\_\_\_\_ May we leave a message? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

Patient or guardian

Practitioner