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	Brothers	Sisters	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 | 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** (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: ____

COLORADO MANDATORY DISCLOSURE STATEMENT

WATER'S WAY CLASSICAL CHINESE MEDICINE

Eliza Worth McEmrys, MSOM L.Ac.
750 E 9th Ave, Suite 101 Phone: 303-587-7480
Denver, CO 80203

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. Eliza moved to Chicago after graduation, where she practiced until moving to Denver in 2006.

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

Eliza is a 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 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 Colorado Department of Health, 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): $125
Follow-up treatment (50 minutes): $ 85

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver Colorado, 80202. Telephone (303) 894-2440.

I, ____________________________, have read and understand this document.
(print name)

_____________________________________ ___________
(Patient's or Guardian's signature) (date)

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. I understand that acupuncturists practicing in the state of Illinois are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

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