wise body wellness

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Health and Wellness History

Welcome to **Wise Body Wellness**. My purpose is to help you achieve your health goals. As a practitioner, I am in partnership with you, bringing my knowledge, skills and compassion to address and support you in your health. Your desire to seek help with your health challenges indicates that you are taking steps for your own well being. I believe that an important contribution to your healing is a commitment to this process.

I ask that you take the time and energy to provide me with the information that will help me be of service to you. This health and wellness history may be more extensive than others you have completed in the past. In Chinese medicine we assess the state of health by looking at many systems of the body to see what is functioning optimally and what is not. The information you provide here and in our appointment, in addition to a physical exam will provide me with a overall picture of your health as well as your health goals. By completing this form prior to your visit, you will allow us to make the best use of our time together, focusing on the issues most important to your overall health.

Once again, welcome to Wise Body Wellness. I look forward to becoming a health partner with you.

Name:	Date:

Date of Birth:	Age:	Sex:	Legal Guardian:
Home Phone:			Mailing Address:
Work Phone:			
Cell Phone:			
E-mail:			

Insurance Company:	Group #
Policy Holder Name:	Member ID #

Emergency Contact:		Relationship to you:
Day phone:	Evening phone:	Alt. phone:
Address:		

Referred By:

- ☐ Name: _____
- ☐ E-mail: _____
- ☐ Internet: _____
- ☐ Other: _____
- ☐ Flyer: _____
- ☐ Walk-in:

Name:	Date:

Health and Wellness Goals: What would you most like to achieve through your sessions at Wise Body Wellness?

_____

_____

_____

_____

_____

Major Symptoms: Please list in order of importance what symptoms are of concern to you, along with the duration of the symptom.

1. _____
2. _____
3. _____
4. _____
5. _____

Pain and Symptom Map: Please use the letter symbols listed below to indicate location and nature of painful or distressed areas.

Symbol index

D - dull ache

S - sharp pain

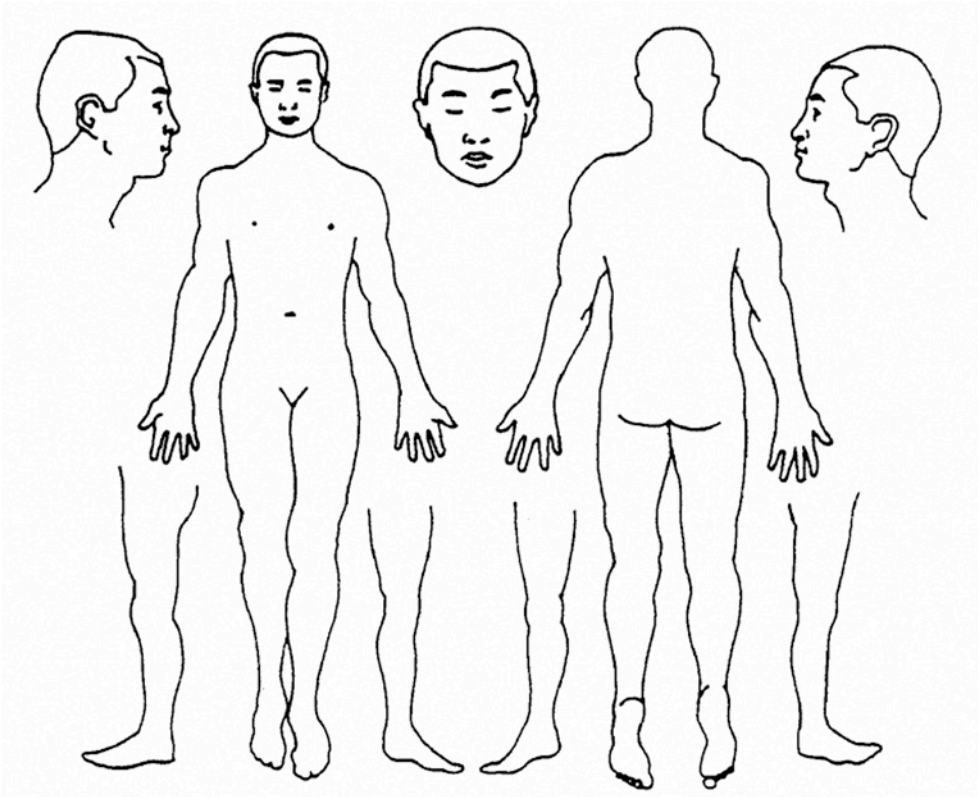
T - throbbing pain

B - burning pain

N - numbness

I - itching pain

* Insert your own symbols if necessary



Left outer leg | Left inner leg | Right inner leg | Right outer leg

Name:	Date:

Symptoms: Please circle all of the following symptoms (or diagnosis) that you have experienced in the last 3 months.

General

Poor sleeping
Fatigue
Fevers
Chills
Sweat easily
Night sweats
Edema (swelling)
Strong thirst
Poor appetite
Appetite change
Cravings
Weight gain / loss
Localized weakness
Poor balance
Bleed / bruise easily
Hot flashes
Catch cold easily
Peculiar tastes / smells
Fainting
Allergies
Sudden energy drop*
* time of day? _____
Heaviness in body sluggishness
Mental heaviness fogginess
Chronic infection
Slow wound healing
Tremors
Seizures
Numbness

Eye, Ear, Nose, Throat

Glasses / contacts
Poor vision
Blurry vision
Eye strain
Eye pain
Night blindness
Color blindness
Spots in front of eyes
See floating black spots
Blood shot eyes
Dry eyes
Cataracts
Earaches
Frequent ear infections
Discharge from ears
Ringing in ears
Poor hearing
Nose bleeds
Sinus pain / congestion
Sinus infection
Nasal drainage
Bleeding gums
Swollen, painful gums
Recurrent sore throat
Dry mouth / throat
Swollen glands
Sores on lip / tongue
Teeth problems
Grinding teeth
Jaw clicks
Hoarseness

Gastrointestinal

Nausea
Vomiting
Diarrhea
Diarrhea alternating with constipation
Loose stools
Constipation
Chronic laxative use
Difficulty swallowing
Burning sensation after eating
Acid reflux / GERD
Heartburn
Indigestion
Stomach pain
Abdominal pain/cramps
Gas
Belching
Abdominal bloating and/or gas after eating
Fatigue after eating
Bad breath
Bitter taste in mouth
Rectal pain
Hemorrhoids
Black stools
Bloody stools
Hernia
Prolapsed organ*
*(previously diagnosed)
I.B.S.
Chrohn's disease
Other: _____
_____

Genito-Urinary

Urinary tract infection
Kidney stones
Genital sores / warts
S.T.D.
Vaginal /penile discharge
Dribbling
Wake to urinate*
*frequency _____
Other _____
_____

Urination

Urination is:

Normal color
Clear / pale
Dark yellow
Reddish
Cloudy
Scanty
Odorous
Painful
Burning
Bloody
Urgent
Difficult to hold
Decreasing in flow
Infrequent
Frequent

Musculoskeletal

Stiff neck / shoulders
Back pain
Neck pain
Shoulder pain
Hip pain
Knee pain
Hand pain
Wrist pain
Foot pain
Ankle pain
Muscle spasm
Muscle cramps
Muscle twitching
Muscle weakness
Muscle strain / sprain
Sore knees
Weak knees
*Other joint pain**
**location* _____
**location* _____
Sciatica
Herniated disc
Bursitis
Carpal tunnel
Tendonitis
Fracture / broken bone
Osteoporosis
Whiplash
Other _____
_____
_____

Name:	Date:

Symptoms: Continued

Cardiovascular	Skin & Hair	Behavioral	Respiratory	Head & Face
High blood pressure	Rashes	Insomnia	Frequent cough	Headaches*
Low blood pressure	Ulcerations	Anxiety	Coughing blood	*frequency _____
Chest pain	Hives	Depression	Asthma / Wheezing	Migraines*
Irregular heartbeat	Itching	Panic attacks	Bronchitis	*frequency _____
Palpitations	Eczema / Psoriasis	Easily stressed	Pneumonia	Pressure feelings
Fainting	Acne / Pimples	Poor memory	Excess phlegm	Facial pain
Cold hands or feet	Recent moles	Depression	Pain with deep breath	Twitches
Swelling of hands	Warts / other growths	Lack of coordination	Shortness of breath* *with rest or exercise	Dizziness
Swelling of feet	Dry skin	Poor balance		Vertigo
Myocardial infarction	Skin discoloration	Unable to concentrate	Difficult breathing when lying down	Concussion
Blood clots	Fungal infection	Anger		
Phlebitis	Hair loss	Bad temper / violent		
Chest pain radiating to shoulders	Dandruff	Seasonal Affective		
	Face flushing	Disorder		
Tight feeling in chest	Heat sensation in hands, feet, chest	A.D.D. / A.D.H.D.		
Numbness of hands or feet	Other skin, hair, nail changes	Obsessive Compulsive		
Varicose veins	Other: _____	Eating disorder		
Other heart or blood vessel issues	_____	Other: _____		
		_____		

Other symptoms / diagnoses
_____
_____
_____
_____
_____
_____

Questions for Men:

1. Do you have any bothersome urinary symptoms that was not indicated in the previous symptom list? If yes, describe:

_____

2. Do you get up at night to urinate? ☐ No ☐ Yes How often? _____

3. Circle all that apply:

Difficulty with orgasm	Premature ejaculation	Coldness of external genitalia	Numbness of external genitalia
Pain in testicles	Pain and swelling of testicles	Erectile dysfunction	Impotence / erectile dysfunction

4. Have you sought medical intervention or other treatments for these problems? If so, what and when:

_____

_____

Name:	Date:

Questions for Women:

1. Are you pregnant now? ☐ Yes ☐ No ☐ Unsure

2. Indicate number of occurrences: Live births _____ Pregnancies_____ Miscarriages _____ Abortions _____

3. Age of: First period (menarche) _____ Menopause (if applicable) _____

4.. Date of: Last PAP smear _____ / _____ Last Mammogram _____ / _____

5. Any history of an abnormal PAP smear? ☐ Yes ☐ No. If so what/when? _____

6. Is your menstrual cycle regular? ☐ Yes ☐ No Approximately how many days? _____

a. Average number of days of flow _____

b. The flow is: ☐ "Normal " ☐ Heavy ☐ Light

c. The color is: ☐ Dark red ☐ Light red ☐ Medium red ☐ Purple ☐ Light brown ☐ Brown

3. Circle all that apply:

Painful periods	Breast distention	Difficulty with orgasm	Vaginal discharge	Endometriosis
P.M.S.	Nipple discharge	Pain with intercourse	Vaginal dryness	Uterine fibroids
Cramps	Breast lumps	Difficulty conceiving	Bleeding between periods	Polycystic ovarian dz.
Nausea	Fibrocystic breast tissue	Blood clots	Heavy vaginal discharge between periods	

Nutrition:

1. Do you follow a special diet? ☐ Yes ☐ No. If yes, how would you describe the diet? (Vegetarian, Vegan, Low Card, etc.)

_____

2. What do you eat on a "typical" day?

a. Breakfast _____

b. Lunch _____

c. Dinner _____

d. Snacks _____

3. What are foods you tend to crave?

_____

4. What are foods you dislike?

_____

Name:	Date:

General:

1. Where and when did you last receive healthcare?

_____

_____

2. Please list any previous diagnosis and treatment that you received for the stated concerns.

_____

_____

_____

_____

3. Please circle any of the following that you are currently experiencing:

Cold / Flu Fever Infection Inflammation Contagious disease

4. Please describe any allergies or intolerances (chemical, environmental, food or drug) and the adverse effect they cause to you.

_____ _____

_____ _____

_____ _____

_____ _____

5. Do you exercise? If so, please describe your activities, the frequency per week and length of time per activity.

_____ _____

_____ _____

_____ _____

6. NOTE: Do you utilize a pacemaker? ☐ YES ☐ NO

Medications / Supplements:

Please list all prescriptions, over the counter drugs, supplements and herbal supplements that you take on a regular basis, with the dosages and manufacture's name if known.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Name:	Date:

Social History:

1. How much per day / week do you use of the following?

   a. Coffee, tea, soft drinks: _____

   b. Cigarettes, cigars, other tobacco: _____

   c. Alcohol (specify liquor, wine, beer): _____

   d. Other drugs: _____

2. If you smoke, are you interested in learning about a stop smoking program? ☐ Yes ☐ No

3. Have you ever had a problem with alcohol or alcoholism? ☐ Yes ☐ No

4. Have you ever had a problem with dependency on other drugs? ☐ Yes ☐ No

5. Do you have a known history of any exposure to toxic substances? ☐ Yes ☐ No

   * If yes, please list which and when you first noticed symptoms: _____

   _____

6. In the past **year**, how many days have been **significantly** affected by ill health? _____

7. In the past **year**, how many days did you feel generally poor in health? _____

8. In the past **year**, how many times where you in the hospital? _____

9. How many hours of sleep do you usually get per night during the week? _____

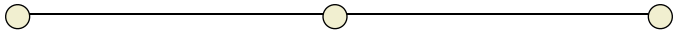
10. Do you feel you sleep well at night? ☐ Yes ☐ No

11. Do you awake feeling rested? ☐ Yes ☐ No

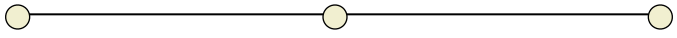
** For the following 3 questions, place an X on the scale:*

None — Very high

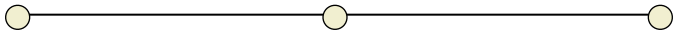
12. To what degree do you experience stress in your life?



13. To what degree do you experience stress at your job?



14. To what degree do you enjoy your job or work?



15. Do you have a source of primary social support? ☐ Yes ☐ No

16. Please describe below what you do for fun?

_____

_____

17. Please describe below what you do for relaxation?

_____

_____

Name:	Date:

Medical History:

1. Please describe any traumas (physical/emotional), serious illnesses, hospitalizations or surgeries you have had and the date.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

2. Please check if you or any family member have been diagnosed with the following and whether it is in **past** (P) or **current** (**C**):

Condition	You	P / C	Family member	P / C	Condition	You	P / C	Family member	P / C
Allergies					Hypertension				
Anemia					Hypoglycemia				
Arthritis					Mental disease				
Asthma					Neurological d/o				
Cancer					Osteoporosis				
Chronic fatigue					Seizures				
Chronic pain					S.T.D.				
Congenital disorders					Stroke				
Diabetes					Thyroid d/o				
Endocrine imbalance					Tumor / growth				
Fibromyalgia					Ulcer				
Gastrointestinal d/o					Substance abuse				
Heart disease					OTHER				
Hepatitis									
High blood pressure									
High cholesterol									
H.I.V. / A.I.D.S.									

Name:	Date:

Wise Body Wellness Confidentiality, Informed Consent and Payment Agreement

A. Wise Body Wellness follows HIPPA guidelines. Please download a copy of the Notice of Privacy Practices explaining these guidelines and how we implement them from our website: www.wisebodywellness.com or contact the office for a copy.

Initial here _____ to acknowledge that you have read our HIPPA guidelines and agree with our approach.

B. I authorize Wise Body Wellness / Marshall DeCouto L.Ac. to release information to my insurance company, pertaining to my care, in order for them to process a claim which is being submitted for reimbursement.

Initial here _____

C. I have read and signed the Informed Consent letter. Please download a copy from our website: www.wisebodywellness.com or contact the office for a copy.

Initial here _____ to acknowledge receiving, reading and signing the Informed Consent document.

D. Please read throughly and acknowledge that you will adhere to the following Wise Body Wellness payment policies:

1. I am responsible for paying fees at the time of service unless a previous arrangement to bill my insurance company has been arranged (Please contact me with your insurance information BEFORE our first session so your acupuncture benefits can be verified). I will be responsible for a $25.00 service charge if my payment at time of service is returned for non-sufficient funds.
2. Insurance benefits quoted are not guaranteed to the provider and I accept financial responsibility for services rendered.
3. I will inform Marshall DeCouto L.Ac. 24 hours in advance, should I need to cancel an appointment, or I may be held responsible for a fee.
4. I understand that herbal products and supplements are not paid by insurance and are not returnable.

E. I understand that services do not take the place of a physician's care when indicated and do not take the place of Western medical care, medical examination or diagnosis. I understand that Marshall DeCouto, L.Ac. does not provide Western medicine diagnosis. Information shared by Marshall DeCouto L.Ac. during my treatment (written or otherwise) is educational in nature so that it may assist in creating a healthy supportive lifestyle. I may use the information at my discretion.

I have read and agreed to the terms and conditions in this agreement:

Print name: _____

Signature: _____ Date: _____