Welcome!

INTRODUCING OUR SERVICES
ACUPUNCTURE & HERBAL MEDICINE

Thank you for considering our treatment services. Dr. Christopher Carlow, D. Ac. believes health care needs a holistic and complementary approach that promotes natural healing without dangerous side effects. This nurturing approach to healing has the potential to empower the patient with a higher level of self-awareness promoting wellness for a healthy mind, body, and spirit. In addition to offering acupuncture, herbal medicine, whole food nutritional supplements, diet and lifestyle counseling, we also offer massage therapy, reflexology and reiki – more info is listed on the left navigation menu on our website – www.NaturesHealing.info.

Before treatment begins your health history will be evaluated in detail. **It is important to complete the Patient History Form in detail before your consultation to ensure the best evaluation.** During the consultation you will have a chance to ask questions about treatment. **Your health and comfort in the treatment process is very important to us!**

This traditional medicine is based on a different set of principles for diagnosing and treatment. This medicine is not disease-based but pattern-based which is to say two people diagnosed in Western medicine with the same disease may display different signs and symptoms making each patient's diagnosis and treatment unique under the medical scope of Acupuncture and Oriental Medicine. It is also important to consider this medicine as a form of therapy, which often requires multiple treatments. People often ask, how many treatments will it take? This is difficult to determine because each patient is treated as individuals with unique imbalances and lifestyles that can change the course of treatment time. In general, a course of therapy would be 10 to 12 treatments to observe a beneficial response. Some conditions may require 1 treatment per week. The benefits of acupuncture are accumulative and some conditions may require multiple treatments per week for better results. This can be determined during your initial consultation. Acupuncture and Herbal Medicine greatly emphasizes practices in prevention. Therapy can include maintenance and general wellness treatments to promote balance in health.

Cancellation Policy: Business hours are by appointment only. A room will be reserved specifically for you generally without delay, so it is important to arrive on time. We'll be happy to reschedule your appointment with at least 24 hours notice. As valuable time, space and resources are reserved for your appointment; a **minimum of 24 hours notice is required when canceling your appointment**. Patients canceling with **less than 24 hours notice will be charged $20**. Only notification by telephone is accepted. Infrequent ability to monitor e-mail makes it an inefficient means of communication. Clinic hours are limited so a timely cancellation can help make the treatment room available for other patients.

We also offer **Wellness Workshops** on various health topics including Nutritional Counseling, Lifestyle Counseling, Chinese Herbal Medicine, Tui Na Massage, Tai Chi Chuan & Chi Kung - all based on the time-honored principles of Traditional Oriental Medicine and integrated into a patient's course of treatment within the medical practice of Acupuncture & Oriental Medicine. In modern times there is a misconceived attitude that suggests - "DON'T FIX IT UNTIL IT BREAKS", but age-old wisdom conveys a superior approach - "PREVENT IT BEFORE IT HAPPENS". Prevention is the key to good health. "*An ounce of prevention is worth a pound of cure*." You can provide the best care for yourself if you have the knowledge. Self-cultivation and self-care can shine a path to optimal health. To be notified of upcoming workshops please include your email on the following form or **join the Nature's Healing E-Mail** list at www.NaturesHealing.info.

Dr. Christopher Carlow, D. Ac. is a licensed Doctor of Acupuncture in Rhode Island and is nationally certified as a Diplomate in Oriental Medicine - a combined certification in Acupuncture & Chinese Herbology offered by the National Certification Commission for Acupuncture and Oriental Medicine with staff privileges at Kent County Hospital. He holds a Masters Degree in Acupuncture and Oriental Medicine with special training in Medical Chi Kung and Tai Chi Chuan. Chris holds certifications as an Assistant Chi Kung Instructor by Dr. Yang, Jwing-Ming, YMAA and as a Arthritis Foundation Tai Chi Program Instructor.

PATIENT CONFIDENTIALITY IS HIGHLY RESPECTED. ALL COMMUNICATION IN THIS DOCUMENT IS CONSIDERED CONFIDENTIAL INFORMATION IN ACCORDANCE WITH FEDERAL HIPPA REGULATIONS.

Welcome! This questionnaire is a very important diagnostic procedure for assessing your health. Please take the time to thoroughly complete this form. Your personal information will be kept confidential according to federal HIPPA regulations.

1. PATIENT INFORMATION

a. Name	First	Middle	Last
Address	Street	City	State / Zip

b. Phone: Home		**c.** Date of Birth	/ /	**d.** Occupation	
Work		Age		**e.** Health Ins.	
Email		Weight		Plan Type	
Emergency #		Height		Member ID#	
Fax		Sex	M / F	*If you are not the primary Ins. Holder:*	
Referred by		Marital Status	M S D W	Primary Name	
f. Physician's Name		Phone		Date of Birth	
Address				Relationship to Primary	

2. CASE HISTORY – PURPOSE OF VISIT

Chief Complaint		Onset Date
List symptoms, location, duration, severity		

List any conditions that make your symptoms better or worse:

Better	Worse

Complaint is the result of ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other ____________________

Other Concurrent Therapies

Have you seen other doctors about this condition? YES / NO If yes, when?

If yes, list doctor's name and treatment results:

Please list current prescriptions, over-the-counter medications, supplements, herbs, and vitamins (attach additional pages if necessary):

Names of Medications Taken	Purpose/Use	Any Side Effects?

3. FOR FEMALES

Are you pregnant? YES / NO IF YES, HOW LONG?________________________________

4. FOR MINORS

List both parents names and addresses	

5. PATIENT'S PAST MEDICAL HISTORY (check all that apply and include dates in spaces provided)

☐ Allergies __________	☐ High blood pressure __________	☐ Seizures __________	☐ Thyroid disease __________
☐ Pneumonia __________	☐ Heart disease __________	☐ Hepatitis __________	☐ Birth trauma __________
☐ Surgeries __________	☐ Injuries/accidents __________	☐ AIDS __________	☐ Frequent colds __________
☐ Trauma __________	☐ Childhood illness __________	☐ TB __________	☐ Rheumatic fever __________
☐ Cancer __________	☐ Tumors/growths __________	☐ Diabetes __________	☐ Venereal disease __________
☐ Anemia __________	☐ Hospitalizations __________	☐ Herpes __________	☐ Food/med allergies __________

Additional comments / Other:

6. LIFESTYLE

Do you drink coffee or soda?	YES / NO	Do you smoke?	YES / NO	Do you use recreational drugs?	YES / NO	List factors that decrease stress
How many drinks per day?		How many packs per day?		How many times per week?		
Do you eat fast food?	YES / NO	Do you drink alcohol?	YES / NO	Do you feel stressed?	YES / NO	List factors that increase stress
How many times per week?		How many drinks per week?		Stress level (1 min – 10 max)		

---- TURN OVER PLEASE →

7. FAMILY MEDICAL HISTORY

☐ Alcoholism ☐ Asthma ☐ Diabetes ☐ High blood pressure ☐ Seizures ☐ Tobacco use
☐ Allergies ☐ Cancer ☐ Heart disease ☐ Recreational drugs ☐ Stroke ☐ Tumors/Growths

Additional Family Medical History Comments:

8. EXERCISE

Describe any exercise you may practice	

9. DIET

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	
Cravings	

10. GENERAL (please check √ any you are currently experiencing and X any that you have experienced in the past)

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep ☐ Fevers ☐ Chills
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo ☐ Night sweats ☐ Sweats easily
☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen ☐ High energy ☐ Localized weakness
☐ Poor coordination ☐ Sudden energy drop at _________(time) ☐ Strong thirst (cold / hot drinks) ___________ ☐ Change in appetite
☐ Peculiar tastes / smells _________________ ☐ Bleed or bruise easily (where) ________________________ ☐ Cravings ____________

Additional comments / Other:____

11. Head, Eyes, Ears, Nose, Throat (please check √ any you are currently experiencing and X any that you have experienced in the past)

☐ Concussions ☐ Eye pain / strain ☐ Blurry vision ☐ Ear ringing / tinnitus ☐ Mucus ☐ TMJ / jaw problems
☐ Facial tension / pain ☐ Night blindness ☐ Cataracts ☐ Sinus problems ☐ Dry throat ☐ Sore(s) on lip
☐ Dizziness ☐ Spots in vision/floaters ☐ Poor vision ☐ Nose bleeds ☐ ☐ Sore(s) in mouth
☐ Migraines ☐ Color blindness ☐ Glaucoma ☐ Gum problems ☐ Dry mouth ☐ Sore(s) on tongue
☐ Swollen glands ☐ Glasses / contacts ☐ Hearing loss ☐ Teeth grinding ☐ Hay fever ☐ Poor sense of smell
☐ Thyroid problems ☐ Tearing / dryness ☐ Earaches ☐ Copious saliva ☐ Teeth problems ☐ Poor sense of taste
☐ Headaches (where & when) ____________ ☐ Other head or neck problems ____________ ☐ Recurrent sore throats ________ per month

Additional comments / Other:____

12. Respiratory (please check √ any you are currently experiencing and X any that you have experienced in the past)

☐ Chest pain /pressure ☐ Difficulty breathing ☐ Night sweats ☐ Persistent coughing ☐ Asthma ☐ Spontaneous sweating
☐ Shortness of breath ☐ Restricted breathing ☐ Pleurisy ☐ Phlegm / Mucous ☐ Emphysema ☐ Spitting / coughing blood

Additional comments / Other:____

13. Gastroitestinal (please check √ any you are currently experiencing and X any that you have experienced in the past)

☐ Abdominal pain ☐ Bad breath ☐ Black stools ☐ Blood / pus in stools ☐ Colitis ☐ Recurrent belching
☐ Constipation ☐ Diarrhea ☐ Gas ☐ Hemorrhoids ☐ Indigestion ☐ Weight loss
☐ Motion sickness ☐ Nausea ☐ Heartburn ☐ Rectal pain ☐ Liver disease ☐ Appetite change
☐ Recurrent hiccups ☐ Ulcers ☐ Vomiting ☐ Weight gain ☐ Hepatitis B or C ☐ Gall Bladder disease

☐ Laxative use:_______/week; type_____________________ Additional comments / Other:_______________________________

14. Musculoskeletal (please check √ any you are currently experiencing and X any that you have experienced in the past)

☐ Ankle pain ☐ Wrist pain ☐ Shin pain ☐ Upper back pain ☐ Broken bone(s) ☐ Decreased range of motion
☐ Knee pain ☐ Elbow pain ☐ Neck pain ☐ Lower back pain ☐ Joint pain ☐ Sensitivity to weather
☐ Leg pain ☐ Arm pain ☐ Hand pain ☐ Muscle pain ☐ Osteoporosis ☐ Facial pain
☐ Hip pain ☐ Shoulder pain ☐ Foot pain ☐ Traumatic injury ☐ Arthritis ☐ Rib pain

Additional comments / Other:____

15. Neuropsychological (please check √ any you are currently experiencing and X any that you have experienced in the past)

☐ Speech problems ☐ Numbness / tingling ☐ Bad temper ☐ Hearing voices ☐ Concussion ☐ Difficulty staying asleep
☐ Obsessive thoughts ☐ Seizures / Epilepsy ☐ Paralysis ☐ Panic attacks ☐ Fever / chills ☐ Loss of consciousness
☐ Compulsive behavior ☐ Depressed mood ☐ Loss of balance ☐ Vertigo / dizziness ☐ Insomnia ☐ Difficulty falling asleep
☐ Dreams / nightmares ☐ Paranoid thoughts ☐ Anxiety ☐ Shakes / tremors ☐ Shingles ☐ Poor memory
☐ Treated for emotional problems___________________________ ☐ Easily stressed ☐ Considered/attempted suicide

Please list any psychological problems you have been treated for, if any?_______________________________________

16. Skin and Hair (please check ☐√ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Change in skin color	☐ Boils / Carbuncles	☐ Acne	☐ Ulcerations	☐ Dandruff	☐ Change in hair texture
☐ Easily bruised	☐ Eczema	☐ Hair loss	☐ Hives	☐ Itching	☐ Sores that don't heal
☐ Pimples	☐ Rashes	☐ Swelling	☐	☐	☐

Additional comments / Other:______________________________________

17. Cardiovascular (please check ☐√ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Irregular heartbeat	☐ Chest pain	☐ Blood clots	☐ Fullness in chest	☐ Stroke	☐ Palpitations / fluttering
☐ High blood pressure	☐ Cold hands / feet	☐ Bleeding easily	☐ Low blood pressure	☐ Heart murmurs	☐ Swelling of feet / ankles
☐ Rheumatic fever	☐ Varicose veins	☐ Heart disease	☐ Angina	☐ Fainting	☐ Phlebitis

Additional comments / Other:______________________________________

18. Genitourinary (please check ☐√ any you are currently experiencing and ☒ any that you have experienced in the past)

☐ Change in urine flow	☐ Sexual dysfunction	☐ Blood in urine	☐ Frequent urination	☐ Frequent UTI	☐ Decreased sexual desire
☐ Unable to hold urine	☐ Restricted urination	☐ Impotency	☐ Pain on urination	☐ Kidney stones	☐ Pain during intercourse
☐ Waking up to urinate	☐ Sore(s) on genitals	☐ Genital pain	☐ Urgent urination	☐ Discharge	☐ Burning upon urination

Additional comments / Other:______________________________________

Are you sexually active? YES / NO

How many times do you urinate per 24 hours? __________

Additional comments / Other: ______________________________

Describe the qualities of your urine		
	☐ Clear	☐ Copious
	☐ Yellow	☐ Scanty
	☐ Cloudy	☐ Strong smelling

19. OB/GYN (for females only - please check all that apply)

Pregnancies	YES / NO	Miscarriages	YES / NO	# of Births		Birth control	YES / NO	Premature births	YES / NO
#		#		# of Abortions		Type		#	
						Duration			

☐ Amenorrhea	☐ Hot flashes	☐ Vaginal sores	☐ Changes to body / psyche prior to menstruation ____________
☐ Breast tenderness	☐ Vaginal discharge	☐ Breast lumps	☐ PMS

Describe your last menstrual						
	☐ Change in flow	☐ Clots	Last menses		Duration of menses	
	☐ Heavy flow	☐ Irregular flow	Color		Age at 1st menses	
	☐ Light flow	☐ Painful menstruation	Cycle length (in days)		Age at menopause	

Additional comments / Other:______________________________________

20. CLASSICAL (check all that apply to describe your preferences)

General mood / emotionally	☐ Angry	☐ Joyful	☐ Worried	☐ Pensive	☐ Sad	☐ Scared	☐ Frightened
Favorite season(s)	☐ Spring	☐ Summer	☐ Late/Indian summer		☐ Autumn	☐ Winter	
Least Favorite season(s)	☐ Spring	☐ Summer	☐ Late/Indian summer		☐ Autumn	☐ Winter	
Favorite climate	☐ Windy	☐ Hot	☐ Humid	☐ Damp	☐ Dry	☐ Cold	
Least favorite climate	☐ Windy	☐ Hot	☐ Humid	☐ Damp	☐ Dry	☐ Cold	
Taste(s) you enjoy	☐ Sour	☐ Bitter	☐ Sweet		☐ Acrid/Pungent/Spicy	☐ Salty	
Taste(s) you dislike	☐ Sour	☐ Bitter	☐ Sweet		☐ Acrid/Pungent/Spicy	☐ Salty	
Favorite time of day	☐ Before sunrise		☐ Morning		☐ Afternoon	☐ Evening	
Problematic time of day	☐ Before sunrise		☐ Morning		☐ Afternoon	☐ Evening	
Favorite color(s)	☐ Green	☐ Red	☐ Yellow		☐ White	☐ Blue	☐ Black ☐ Purple

Final comments / Other: ______________________________________

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I understand the information I provided on this questionnaire is essential to determine my health and treatment needs. I have read and understood each question and certify it to be true and correct to the best of my knowledge and belief and hereby grant authorization for treatment, in accordance with state statutes, for the care and management of this complaint.

PATIENT'S SIGNATURE ____________________________ DATE __________

(PARENT'S SIGNATURE IF PATIENT IS A MINOR)