**Henry E. Strozier, L.Ac., M.Ac., Dipl.Ac.** **Health History Form** Date____________________

Name ________________________________________________ __Birthday____________Age____Gender __________

Address ______________________________City _____________________________State ________ Zip______________

Home Phone______________________Cell Phone ______________________Work Phone _________________________

Email__________________________________________________Height_____________Weight ____________________

Family Physician Phone _________Referred by ________________________

Emergency Contact___________________________Phone______________________Relationship______________________

___________________________ ______________________ _______________________

I. Goals: What would you like to address through treatment?

____________________________________________________________________________________________

________

II. Medications / Supplements
Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

________________________________ ________________________________ _______________________________

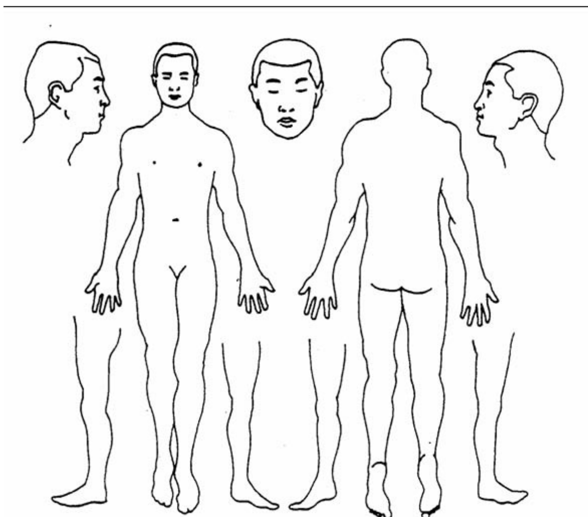
________________________________ ________________________________ _______________________________

Allergies (to medications, chemicals or foods):______________________________________________________________

IV. Surgical History/ Recent Hospitalizations
__________________________________________________________________________Date ________

__________________________________________________________________________Date________

V. Pain
Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? Y / N

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

Other relevant information:

____________________________________________________________________________________________

____________________________________________________________________________________________

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L.Ac.
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808.226.3321 ~ henry@mak.ai
NPI# 1417044306  ~ Hawaii License 1047

# Acupuncture Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by H. E. Strozier, L.Ac. I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese or Western herbal medicine, and nutritional counseling. ________
initials

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If I experience any gastro-intestinal reactions to the herbs I will inform the acupuncturist immediately. ________
initials

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. ________
initials

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.
I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. ________
initials

My signature gives my practitioner permission to release my medical records for the reasons listed above. ________
initials

Appointments may not be cancelled by text, or in response to a reminder, but must be done by phone or email. I agree to pay $50 for any missed or forgotten appointments without 24-hour notice of cancellation. This fee is not covered by insurance. ________
initials

I agree to pay all charges incurred for services rendered, over and above insurance coverage.
__________
initials

Name:________________________________________

Signature:____________________________________

Date _________________________________________