THE GARDEN of Natural Health
2910 Duniven Circle • Amarillo, TX 79109

1.Name_____
First Middle Last

2. Address_____
Street City State Zip

3. Home Phone_____ Business Phone_____

4.Email_____ Cell Phone_____

5. Age_____ 6. Date of Birth_____ 7. Sex_____ 8. Marital Status M S D W

9. Social Security_____ 10. Drivers License_____

11. Occupation_____ 12. Employer_____

12. Employers Address_____
Street City State Zip

Case History

13. Chief Complaint_____

14. Complaint result of: [] Auto Accident [] Injury [] Job Related [] Other

15. Date of Injury/Accident_____/_____/_____

16. Have you seen any doctor about this condition?_____ If yes, when?_____

Doctors Name_____ Address_____

17. Spouses Name_____ Spouses SS#_____

Occupation_____ Employer_____

Address_____ Phone_____

18. Nearest Relative that does not live with you_____

Address_____ Phone_____
Street City Zip

19.In Case of Emergency, Call_____

Date_____ Signature_____

Please circle any that you experience now and underline any that you have experienced in the past.

1. Emotional
   Mood Swings Nervousness Mental Tension

2. Energy and immunity
   Fatigue Slow wound healing Chronic Infections Chronic Fatigue Syndrome

3. Head, Eye, Ear, Nose and Throat
   Impaired Vision Eye Pain/ Strain Glaucoma Glasses/Contacts Tearing/Dryness

   Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds

   Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

4. Respiratory
   Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

   Persistent Cough Pleurisy Asthma Tuberculosis Shortness of Breath

   Other Respiratory Problems_____

5. Cardiovascular
   Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

   Palpatations/Fluterring Stroke Heart Murmurs Rheumatic Fever Varicose Veins

6. Gastrointestinal
   Ulcers Changes in Appetite Nausea/Vomiting Epigastria Pain Passing Gas

   Heartburn Belching Gall Bladder Disease Liver Disease Hep B or C

   Hemorrhoids Abdominal Pain

7. Genito-Urinary Tract
   Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow

   Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

8. Female Reproductive/Breasts
   Irregular Cycles Breast /Lumps Nipple Discharge Heavy Flow

   Vaginal Discharge Premenstrual Problems Clotting Bleeding Between Cycles

   Menopausal Symptoms Difficulty Conceiving Painful Periods

9. Menstrual/Birthing History
   Age of first Menses_____ Birth Control Type_____ # of Abortions_____

   # of Days of Menses____ # of Pregnancies_____ # of live Births_____

   Length of Cycles_____ # of Miscarriages_____

10. Male Reproductive
Sexual Difficult Prostate Problems Testicular Pain/Swelling Penile Discharge

11. Musculoskeletal
Neck/Shoulder Pain Muscle Spasms/Cramp Arm Pain Upper Back Pain Mild Back Pain

Lower Back Pain Leg Pain Joint Pain (if so where?)_____

12. Neurologic
Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

13. Endocrine
Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Hot or Cold

14. Other
Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Lifestyle:

Do you typically eat at least three meals a day? Y N If no, how many?_____

Exercise routine:_____

Spiritual Practice:_____

How many hours per night do you sleep?_____ Do you wake rested?_____

Level of Education Completed:_____

Occupation:_____

Do you enjoy work? Y N Why/Why not?_____

Nicotine/Alcohol/Caffeine Use:_____

Have you experienced any major traumas? If yes, explain:_____

_____

How much Caffeine do you consume in an average day?_____

Television Habits_____ Reading Habits_____

Interests and Hobbies_____

How did you hear about us?_____

Family History: Check those applicable Age(if living)	Father	Mother	Brothers	Sisters	Spouse	Children
Health(G=good P=poor)	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Age(at death)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Height: _____ Weight: _____ Past Maximum: _____ When?_____

Blood Pressure: What was your most recent reading?____/_____ When was it taken?_____

Hospitalization and Surgery:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Cat Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When
_____		_____	
_____		_____	

NUTRITIONAL SURVEY

Nutrition is an important part of health and healing. Please answer each section of this survey honestly. Diet does play a large role in your assessment and treatment.

Please describe a typical:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

What do you snack on? _____

Where do you eat out? _____

Do you eat fast food? _____

What type of fast food? _____

Where do you buy groceries? _____

What percentage of diet is home cooked? _____

What percentage of diet is canned goods? _____

What percentage of diet is fresh produce? _____

How much alcohol do you drink a week? _____

When you drink water do you tend to drink cold, room temp., or hot water? _____

What vitamins and supplements do you take? _____

_____

How do you feel about your diet? _____

_____

Do you notice any foods that may lower your energy or digestive faction? If so, what are they?

_____

_____

CONSENT TO RECEIVE ACUPUNCTURE AND ORIENTAL MEDICINE
AND/OR HERBAL CONSULTATION FROM
TRACI MAHANNAH

DISCLAIMER

I understand Traci Mahannah is not licensed as a chiropractor, counselor, medical doctor, psychologist, or psychotherapist and does not portray herself as such. I understand, she will not diagnose, evaluate, treat, cure, mitigate or prevent any nutritional, medical or psychological counsel me on any medical or psychological treatment, condition, disorder, or disease of any kind. I further understand it is my responsibility to continue my medications and remain under the care of my primary physician.

CREDENTIALS

I understand Traci Mahannah is a Licensed Acupuncturist and Herbalist. I understand that by signing this consent form she is authorized to perform on me the following treatments known as acupuncture, herbology, gua sha, tui na, and cupping. All of the above being therapeutic methods Traci has been trained in and has practiced.

SCOPE OF HERBAL PRACTICE

I understand that herbal and nutritional supplements are considered safe by the Federal Drug Administration but that all known interactions and side effects are not yet fully known. I agree to advise Traci Mahannah anytime I feel any side effects, so corrective steps may be taken to alleviate my discomfort.

I further understand herbal and nutritional supplements are not a substitute for effective standard medical, chiropractic, or psychotherapy treatment. Traci Mahannah has advised me to continue ongoing medical treatment and therapies until otherwise advised by my psychotherapist, physician or medical practitioner. I understand it is important for me to stay in close communication with my physician.

I understand it is my responsibility to monitor the effects of herbal and nutritional supplements and to continue the herbal and nutritional supplements as long as it is beneficial to me. I further understand that research suggests that while most people gain considerable benefits from herbal and nutritional supplements, some people may not gain any benefit. I have every expectation that herbal and nutritional supplements will

provide me some benefit, but I understand there is no guarantee that it will.

CLIENT CONFIDENTIALITY

I understand my identity and any information about me, whether I share it with Traci Mahannah or she discovers it on her own, will be held in the strictest confidence, except when released by me or specifically required by law. I have the right to waive this confidentialiy agreement in whole or part at any time. I also understand that I may give Traci Mahannah permission in writing to contact my primary care practitioner or specialist with regard to the training provided by her and the results I obtain. I have the right to withdraw this permission at any time.

PAYMENT FOR SERVICES

I agree to pay Traci Mahannah the required fee for her services. I also agree to responsibly give a minimum of 24 hours prior notice if I am unable to keep my scheduled appointment. I understand that a fee of $30 will apply for any improper notifications.

ARBITRATION

I agree that in the event Traci Mahannah and I are unable to reach an amicable solution to any issues involving acupuncture or any other therapeutic methods she may deem fit, we will ask an arbitrator to settle the issue between us and both Traci Mahannah and I agree to accept and be bound by the arbitrator's decision.

CLIENT WARRANTY

By signing below, I acknowledge that I have read and understand this document, and have received acceptable answers to all of my questions about acupuncture and therapeutic services Traci Mahannah offers. I warrant I am not under duress at this time and my consent is given voluntarily and without coercion. I further understand I may discontinue treatments at any time and that I may refuse to participate in any particular or specific therapeutic methods she may offer.

Signature:_____Date:_____

Name (Please Print)_____

Address_____
_____

Phone:_____

Email:_____