PATIENT INFORMATION

Today's date____/____/_____

Name_____
(first) (middle) (last)

Birth date____/____/_____ Age _____

Weight _____ Height _____

Occupation _____

Company name _____

How did you hear about us? _____

_____

CONTACT INFORMATION

Address_____

City_____State_____Zip_____

Cell phone _____

Work phone _____

Email _____

Another person we may contact if needed:

Name _____

Relationship_____

Cell phone _____

HEALTH HISTORY

What are your primary reasons for seeking care?

1 _____

How long have you had the problem? _____

2 _____

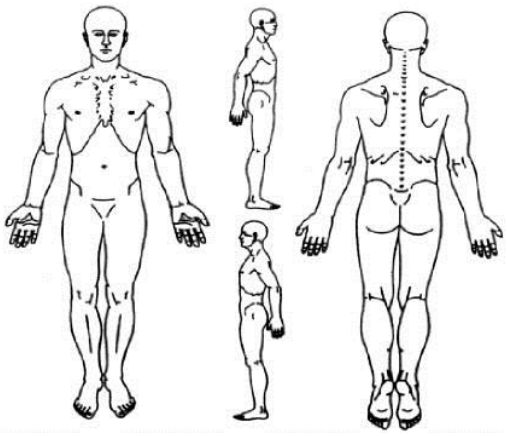
How long have you had the problem? _____

3 _____

How long have you had the problem? _____

Please circle on the image the area of your pain, if present. Indicate with a letter below the nature of pain:

A: ache **B**: burning **C**: cramping **D**: dull
SH: Sharp **N**: numb **T**: tingling **S**: stiff **W**: weak



Rate your pain:

(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

What worsens your pain? _____

What relieves your pain? _____

List all allergies _____

_____

List medications or food supplements you are taking

_____

_____

List serious illnesses, accidents or surgeries

_____

_____

Check illnesses that have occurred in blood relatives.

☐ Diabetes ☐ Stroke ☐ High blood pressure
☐ Cancer ☐ Heart disease ☐ Kidney disease
☐ Other: _____

Check conditions you have or have had in the past:

☐ Diabetes ☐ Stroke ☐ High blood pressure
☐ Cancer ☐ Heart disease ☐ Kidney disease
☐ Bleeding disorder
☐ Other: _____

How long has it been since you have had a complete medical exam? _____

HEALTH HISTORY… (CONTINUED)

Check symptoms you have or have had in the last year:

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats

GENITO/URINARY

- □ Frequent urination
- □ Difficulty urinating
- □ Inability to control urine
- □ Kidney infection/stones
- □ Low libido

NEUROLOGICAL/MIND

- □ Poor memory/confusion
- □ Vertigo/Dizziness
- □ Seizures
- □ Stress ___/10
- □ Depression
- □ Poor sleep

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure (please circle)
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Vomiting
- □ Pain over stomach
- □ Poor appetite

IF APPLICABLE:

- □ Prostate trouble
- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Scanty menstrual flow

Could you be pregnant?_____

Is there anything additional you would like us to know?

_____

_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date_____

ACUPUNCTURE CONSENT

By signing below, I give consent to be treated by the Acupuncture Physician within the practice scope of Traditional Chinese medicine.

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, and pain or discomfort. 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.

Herbal Medicine: I understand that the physician may recommend Chinese and Western herbs for treatment of 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 herbs 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 such herbs. These could include, but are not limited to: changes in bowel movement, and abdominal pain or discomfort. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic as soon as possible.*

Acupressure/Tui-Na Massage/cupping/gua sha: I understand that I may also be given acupressure/tui-na massage/cupping as part of 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, and sore muscles or aches. 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. The impulses used are mild, but occasionally create discomfort. I will inform the practitioner of any discomfort produced during the treatment so that the stimulation can be adjusted.

Injection Therapy: I understand that the doctor/therapist may recommend the administering of trigger point injections using homeopathic solutions and/or B12 solution to aid in the healing of my condition. I understand that Homeopathy is a very safe, effective treatment modality with little to no known risk factors. However, I agree to inform doctor/therapist of any discomfort or side-effects I feel may be as a result of my therapy.

I agree to notify physician/therapist if I have a pacemaker, cardiac condition, bleeding disorder, history of seizures, is or may be pregnant. Further, I agree to update the physician/therapist in regard to changes in my health and I hold the physician/therapist harmless of any adverse reactions to any therapy administered if I fail to inform him/her and there shall be no liability on the physician/therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including all volunteers, from and against any and all claims.

I do not expect the physician/therapist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which based on the facts then known is in my best interest. I am also aware that possible aggravation to my physical condition could occur post-treatment. Such aggravation is in most cases followed by a decrease and/or resolution of the condition. I understand that results are not guaranteed, and that there may be other treatment alternatives, including treatment offered by another licensed physician/therapist.

I understand that the practitioner and/or clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

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 physician/therapist for a more detailed explanation. I give my permission and consent to treatment by the above initialed modalities.

Signature: _____ **Date:** _____

☐ Patient ☐ Parent ☐ Guardian