Acupuncture

Personal Information Form

Last Name		First Name		Middle Initial
Age	Sex	Date of Birth	Current Date	
Address				
City		State	Zip Code	
Occupation		Referred by		
Telephone (Home / Mobile)		Telephone (Office)		
Marital Status		Height	Weight	

REASON FOR YOUR VISIT ____

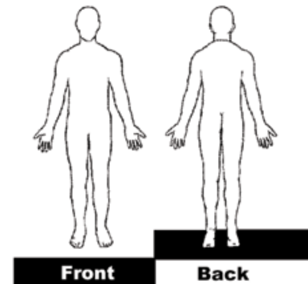
____

____

Secondary concerns ____

____

Is this condition getting progressively worse? o **Yes** o **No** o **Unknown**
Rate severity of pain (circle one)
LOW 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 HIGH
Type of Pain:
o **Tingling** o **Sharp** o **Shooting** o **Dull** o **Stiffness**
o **Throbbing** o **Aching** o **Swelling** o **Burning**



How often do you have this pain?______________________________.
Is it constant o **Yes** o **No**
Movements that are painful to perform?
o **Sitting** o **Standing** o **Walking** o **Bending**

Major Hospitalizations/Accidents/Surgeries ____

____

Medications, Supplements & how long taken? ____

____

Alcohol _____________**# of drinks per week** **Cigarettes** ___________**Packs per week**
How many of the following do you consume a day?
_____ **Oz of water** _____ **cups of coffee** _____ **Oz of soda** _____**cups of Tea**
Do you exercise? ___________**How often?**_________________
What kind of exercise? ____
Do you eat Cheese? _________**How many times per week?**______________________________
Do you drink Milk? __________**How many times per week?**______________________________
Do you crave certain foods, if so what kinds?______________________________

____

Describe a typical breakfast of yours? ____

____

Acupuncture

Personal Health History

- o **Adverse Reaction to Medial Treatment**
- o **Allergies**
- o **Anemia**
- o **Arthritis**
- o **Artificial Heart, Valve or Joints**
- o **Bleeding Disorder**
- o **Cancer or Tumor**
- o **Chemical Dependency**
- o **Diabetes**
- o **Eating Disorder**
- o **Gout**
- o **Headaches**
- o **Heart Disease**
- o **Hepatitis, Jaundice or Liver Disorder**
- o **Herpes**
- o **High Blood Pressure**
- o **Immune Disorders**
- o **Kidney Disorders**
- o **Low Blood Pressure**
- o **Musculo-Skeletal Disorder**
- o **Organ Transplant**
- o **Pacemaker**
- o **Respiratory Disorder**
- o **Rheumatic Fever**
- o **Sciatica**
- o **Seizures/Epilepsy**
- o **Skin Disorders**
- o **Special Diet**
- o **Stomach or Intestinal Disorder**
- o **Stroke**
- o **Thyroid Disease**
- o **Transfusion**
- o **Tuberculosis**
- o **Ulcer**
- o **Urinary Tract Disorder**
- o **Venereal Disease**
- o **Other, explain** ____

____

____

Acupuncture
Informed Consent Form

I herby request and consent to the performance of acupuncture treatment and other procedures with in the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below.

I understand the method of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental therapeutic massage), Oriental herbal medicine, and nutritional counseling. I will immediately notify a member of the clinical staff of any anticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumonthorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clear and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 Oriental Medicine, although some may be toxic on large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring or me if I am becoming pregnant.

I do no expect the acupuncturist to be able to anticipate or explain all possible risks and complications of treatment, and I understand that the acupuncturist will exercise judgment during the course of treatment, which the person thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand staff may review my patient records and reports, but all my records will be kept confidential and will not be released with out written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

____ ______________________.
PATIENT / AUTHORIZED PERSONS SIGNATURE DATE

____ ______________________.
PRACTITIONER DATE

We request that our charges for office visits be paid at the conclusion of each visit. Please be mindful and provide at least 24 hour notice should you need to cancel. Missed appointments will result in a $25 cancellation fee.