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? Yes No Unknown

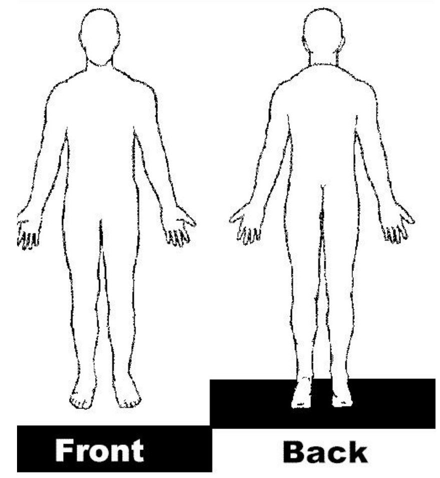
Rate Severity of Pain (Circle one) : LOW 1 - 2 - 3 - 4 -5 - 6 - 7 - 8 - 9 - 10 HIGH

Type of Pain: Tingling Sharp Shooting Dull Stiffness
Throbbing Aching Swelling Burning

How often do you have this pain?______________________________

Is it Constant? Yes No

Movements that are painful to perform?
Sitting Standing Walking Bending



Major Hospitalizations/Accidents/Surgeries:____

____

Medications, Supplements and 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?____

____

PERSONAL HEALTH HISTORY

O Adverse Reaction to Medical 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, please explain____

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, pulsed electromagnetic therapy, infrared light therapy and nutritional counseling. I understand that the herbs/supplements are to be consumed according to the instructions provided orally and in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture and Chinese medical massage (Tui-Na) 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 Chinese Medicine, although some may be toxic in large doses.

I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest.

I understand that results are not guaranteed. I understand the clinical and administrative 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. 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.

____Date:_______________________

(Patient or Authorized Person)

____ Date:_______________________

(Practitioner)