Patient Information

Last Name: First Name: MI: Date:

Contact Information

Address:

City:

State/Prov: Zip/Postal Code:

Phone:

Cell Phone:

eMail:

Work Phone:

Identification

Age: Birth Date:

Height: Weight:

Gender: ☐ F ☐ M

Ethnicity:

Status: ☐ Married/Partner ☐ Single

Occupation:

Employer:

Employer Phone:

Primary Physician

Name:

Clinic name:

Address:

City

State/Prov: Zip/Postal Code:

Phone:

Emergency Contact

Name:

Relationship:

Address:

City:

State/Prov: Zip/Postal Code:

Cell Phone:

eMail:

Phone/Daytime:

Phone/Evening:

Insurance

NOTE: Fill-in only if your insurance covers acupuncture

Policy holder name:

Relationship to patient:

Policy No. / ID No.:

Group Number:

Company:

Address:

City:

State/Prov: Zip/Postal Code:

Phone:

Notes

Reason for Visit

Last Name: First Name: MI: Date:

Visit Information

Primary reason for visit:

Have you seen other practitioners about this issue? ☐ No ☐ Yes

If yes, name and specialty of practitioner:

Diagnosis, test or lab results:

Medications or treatments received:

Secondary issue:

Have you ever had an acupuncture treatment? ☐ No ☐ Yes

How do you *feel* about recieving an acupuncture treatment?

Symptoms

Date symptoms started:

Describe:

Location:

Was there a triggering event?

My symptoms are: ☐ Improving ☐ Worsening ☐ Unchanged

How long do symptoms last?

Symptoms occur at certain times of day: ☐ No ☐ Yes:

Are you in a specific location or position when symptoms occur?

☐ No ☐ Yes:

How severe are symptoms? ☐ Severe ☐ Moderate ☐ Mild

What makes symptoms improve?

What makes symptoms worse?

Are symptoms affected by eating, sleeping, or other activities? ☐ No

☐ Yes, describe:

Do symptoms affect your daily activities? ☐ No

☐ Yes, describe:

What do *you* think your symptoms mean?

☐ I have traveled outside USA/Canada recently (within the last 6 months).

Country traveled to:

Medical Information

Last Name: First Name: MI: Date:

Current Medications

List all current medications, supplements and herbs, and reason for taking each:

Allergy Checklist

☐ Medication, list:

☐ Food, list:

☐ Environmental (pollens, molds, etc.), list:

☐ Insect (bee stings, etc.), list:

☐ Contact dermatitis (hair dye, jewelry, etc.), list:

☐ Latex ☐ Cosmetics ☐ Lactose intolerance

☐ Other:

Electronic Implant / Blood Disorder

I have an electronic implant: ☐ No

☐ Yes, describe:

I have a bleeding disorder: ☐ No

☐ Yes, describe:

I am taking anticoagulant medication (blood thinner): ☐ No

☐ Yes, medication name:

Illness & Injury

List any serious illnesses, include dates:

List any serious injuries, include dates:

List any surgeries, include dates:

List any long-term or persistent condition, include date condition began:

Family Medical History

List any serious illnesses, persistent condition, and cause of death for your parents and your siblings:

Informed Consent

Statement of Informed Consent

I hereby request and consent to the performance of acupuncture and other Traditional Chinese Medicine (TCM) treatments on me (or, if the patient is a minor, on the patient named below, for whom I am legally responsible).

I understand that acupuncturists are not allopathic care providers and that care by a licensed allopathic physician may be recommended by this clinic depending on medical needs.

Acupuncture/Moxibustion/Cupping

I understand that the scope of practice for acupuncture includes but is not limited to: insertion of sterile acupuncture needles through the skin, electrical stimulation or the application of heat, moxibustion, cupping, dermal friction, dietary counseling, exercise and breathing techniques based on traditional Chinese medical principles. I am aware that certain adverse side effects may result. These could include, but are not limited to: transient bruising, bleeding, skin irritation, mild pain in the treated area, muscle weakness and soreness, brief generalized fatigue or nausea, sensations of heat or cold, tingling or numbness, brief lightheadedness or fainting, broken needles and risks of infection or pneumothorax, and the possible aggravation of symptoms existing prior to acupuncture treatment. 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. I understand that if I receive moxibustion as part of therapy, there is a risk of mild burning from its use.

I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Herbal Therapy

I understand that substances from the Oriental Materia Medica may be recommended to me to treat 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 substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I will stop taking them and call the clinic as soon as possible.

Acupressure/Tui-Na Massage

I understand that I may be given acupressure/tui-na massage as part of my 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, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Patient Agreement

I have had the opportunity to discuss with the acupuncturist the nature and purpose of acupuncture. All of my questions have been answered to my satisfaction. I understand that results are not guaranteed. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the information on this form and am fully aware of what I am signing. I intend for this consent form to cover the entire course of treatment for my present condition, as well as any future conditions for which I may seek treatment at this clinic. I give my permission and consent to treatment.

To indicate that you have read, understand and agree with this document, please sign and date below. Patient Signature (or Guardian, if minor):

Signature: .....

Printed Name: .....

Date: .....

Address: .....

.....

City: .....

State/Prov: ..... Zip/Postal Code: .....

Phone: .....

Cell Phone: .....

Following Your Treatment

Occasionally a person may feel light headed after an acupuncture treatment. If this happens to you, please sit down and rest. You will feel fine in a few minutes.

Medicinal herbs are prescribed for individual patient use **only**. Herbs prescribed for medical purposes should **not** be used by anyone else.

Clinic: .....

Address: .....

.....

City: .....

State/Prov: ..... Zip/Postal Code: .....

Phone: .....

Website (URL): .....