Acupuncture Health History Questionnaire & Registration

Patient Information	**Contact Information**
Date _____ Name_____ Address _____ City State Zip _____ Age _____ Birth Date _____ Occupation _____ Company Name _____ Primary Physician _____ Physician Phone Number _____ How did you hear about us? _____ _____	Home phone _____ Work phone _____ Other/cell phone _____ Email _____ Another person we may contact if needed Name _____ Relationship _____ Home phone _____ Work phone _____

Health History

What are our primary reasons for coming in for treatment?
1_____
2_____
3_____

How is your sleep? _____

How is your digestion? _____
_____

List medication or food supplements you are taking. _____
_____
_____
_____
_____
_____

List serious illnesses, accidents or surgeries.
_____
_____
_____
_____
_____

Check illnesses that have occurred in blood Relatives.
___ Diabetes ____High blood pressure __Stroke
___ Cancer ____ Heart Disease _____Kidney disease

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

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/ poor sleep
- Loss or weight gain
- Nervousness/ irritability
- Overwhelmed by life

Check conditions you have or have had in the past:

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes

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

Health History …. (CONTINUED ON BACK)

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

MUSCLE/JOINT/BONES

- Tremors
- Swollen joints

PAIN, WEAKNESS, NUMBNESS IN:

- Arms or hips
- Backs or legs
- Feet
- Neck
- Hands
- Shoulders
- Other _____

EYES/EARS/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
- Sweat

GENITO/URINARY

- Blood/Pus in Urine
- Frequent Urination
- Inability to control urine
- Kidney infection/stones
- Lowered Libido

CARDIOVASCULAR:

- Chest pain
- Hardening of arteries
- High or low blood pressure
- 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 (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting
- Acid reflux

IF APPLICABLE:

- Erection difficulties
- Penis discharge
- 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? _____

Signature

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

Signature _____ Date _____

ACUPUNCTURE 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(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. 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 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. 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, stomachache, 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.

Patient Signature X _____ (Date) _____ (Or patient representative) (indicate relationship if signing for patient)
Acupuncturist Signature_____ (Date) _____

CANCELLATION/ LATENESS POLICY

LATE ARRIVALS

We will do our best to accommodate patients who arrive up to 15 minutes later after their scheduled treatment time. However, you may be asked to wait or your treatment may be cut short in order to treat on-time patients.

Patients more than 15 minutes late will be considered cancelled. Please refer to our cancellation policy.

CANCELLATIONS

If you provide more than 24 hour notice when cancelling your appointment, no cancellation fee will be charged. However, cancelling less than 24 hours before your scheduled appointment or not showing up will result in a cancellation fee of $35.

By signing below, I acknowledge that I understand and will abide by the above Cancellation and Lateness Policy.

Signature _____ Date _____