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ACUPUNCTURE

WELLNESS CENTER

PATIENT INFORMATION

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone numbers: Home _____ Work_____ Cell_____

Sex: Male _____ Female _____ Age: _____ Date of Birth: _____

In case of emergency who should be notified? _____

Relationship with patient: _____ Phone: _____

Primary Physician: _____ Phone: _____

CHIEF COMPLAINT

What is the condition for which you are seeking treatment:

_____

_____

_____

Rate the severity of your condition (circle one):

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Mild Moderate Severe

Other health concerns:

_____

_____

Please leave lines blank - OFFICE USE ONLY - answer questions below

1. How would you describe your general mood? ☐ Normal ☐ Depressed ☐ Other ☐ Anxious ☐ Irritable _____

2. Has your appetite ☐ increased ☐ decreased ☐ same

3. How is your digestion? ☐ Normal ☐ Bloating ☐ Tired after meals ☐ Other ☐ Reflux ☐ Full easily ☐ Lots of gas _____

4. Do you have a daily bowel movement? Yes / No ☐ Tendency toward constipation ☐ Tendency toward loose stools ☐ IBS

5. Do you have any issues with regard to urination? Yes / No ☐ Frequent ☐ Several times at night ☐ Urgency ☐ Other ☐ Incontinence _____

6. Generally speaking are you ☐ hot easily ☐ cold easily ☐ neither

7. Do you perspire easily (with very little exertion)? Yes / No Any night sweats? Yes / No

8. Are you thirsty easily? Yes / No Preference for: ☐ Room temp. ☐ Cold ☐ Warm liquids?

9. How is your sleep? ☐ Generally sound sleep & at least 6 - 8 hours per night ☐ Trouble falling asleep, but sleep well thereafter ☐ Toss and turn most of the night ☐ Wake early and can't go back to sleep

10. How is your energy level? ☐ Very good ☐ Always tired ☐ Typically ok, but could be better ☐ Other _____ ☐ Tired easily _____

Female patients: Is your cycle regular? Yes / No ☐ Normal Flow ☐ Heavy Flow ☐ Scanty ☐ Clots
Do you have PMS? ☐ Cramping ☐ Emotional ☐ Other _____
Are you taking birth control? Yes / No
Menopausal? Yes / No Postmenopausal? Yes / No Children? Yes / No

Medications: ☐ None ☐ Pain ☐ Cholesterol ☐ Heart ☐ Anxiety ☐ Muscle Spasms ☐ Thyroid ☐ Other _____ ☐ Depression ☐ Blood pressure ☐ Hormone (HRT) ☐ Other _____

Other
Any significant traumas? Yes / No _____
Any major surgeries? Yes / No _____
Allergies _____ ☐ Headaches ☐ Ringing in the ears ☐ Visual Floaters

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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 Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturists at Acupuncture Wellness Center, LLC.

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, and nutritional counseling. I will be notified of and be given the opportunity to ask questions about any and all of the aforementioned methods of treatment before they are performed.

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, and dizziness or fainting. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe work environment. Bruising is a common side effect of cupping. The herbs and supplements 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. 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 my treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest.

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:	Date: