Acupuncture & Herbal Intake

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential.

IDENTIFICATION

Name _____ Sex o M o F Date _____

Address _____ City_____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth _____ Age _____ Email _____

o Single o Married o Partnered o Widowed o Separated/Divorced

Height _____ Weight _____ Occupation _____

Education _____

Emergency contact _____ Relation _____

Emergency contact telephone: Home _____ Cell _____

Name of physician* _____ Phone number _____

Address _____ City_____ State _____ Zip _____

Name of counselor/psychologist* _____ Phone number _____

Address _____ City_____ State _____ Zip _____

Special problems or symptoms:

FAMILY HISTORY Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partne	children
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)	N/A					

PERSONAL LIFESTYLE HABITS For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day)
Alcohol (drinks per week)
Drug use (recreational) o Yes o No
How often? _____

Coffee/Tea (cups per day) _____
Soda (regular or diet) _____
Exercise o Yes o No How often? _____
What kind of exercise? _____

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS	HOSPITAL OR TREATMENT LOCATION

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medication _____ Dosage _____ For what condition? _____
Medication _____ Dosage _____ For what condition? _____
Medication _____ Dosage _____ For what condition? _____

Vitamin _____ Dosage _____ For what condition? _____
Vitamin _____ Dosage _____ For what condition? _____
Vitamin _____ Dosage _____ For what condition? _____

Food Supplements _____ For what condition? _____

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

General
___ Insomnia
___ Dreams/nightmares
___ Fatigue
___ Poor memory
___ Strongly like cold drinks
___ Strongly like hot drinks
___ Recent weight gain/loss
___ Cold hands/feet
___ Chills
___ Fever
___ Bad breath
___ Other (describe
_____

Head & Neck
___ Headaches
___ Migraines
___ Stiff neck
___ Dizziness
___ Fainting
___ Swollen glands
___ Other (describe)
_____

Ears
___ Ringing
___ Hearing loss
___ Hearing aids
___ Infections
___ Earache
___ Vertigo
___ Other (describe)
_____

Eyes
___ Glasses/contacts
___ Blurred vision
___ Poor night vision
___ Spots or floaters
___ Eye inflammation
___ Double vision
___ Glaucoma
___ Cataracts
___ "Lazy" eye
___ Other (describe)
_____

Nose, Throat & Mouth
___ Sinus Infection
___ Hay fever/allergies
___ Frequent sore throat
___ Difficulty swallowing
___ Mouth/tongue ulcers
___ Frequent colds
___ Nosebleeds
___ Dry nose
___ Nasal congestion
___ Loss of voice
___ Thirst
___ Excessive phlegm
___ TMJ
___ Facial pain
___ Gum problems
___ Dental problems (last visit)
_____
___ Other (describe)
_____

Skin
___ Hives
___ Rashes
___ Eczema/psoriasis
___ Night sweating
___ Excess sweating
___ Dry skin
___ Easily bruised
___ Changes in moles/lumps
___ Itching
___ Other (describe)
_____

Respiratory
___ Difficulty breathing
___ Difficult breathing reclining
___ Wheezing
___ Asthma
___ Chronic cough
___ Wet cough
___ Dry cough
___ Coughing up phlegm
___ Coughing up blood
___ Shortness of breath
___ Tight chest
___ Pneumonia
___ Other _____

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Chest pain/tightness
___ Palpitations
___ Rapid heart beat
___ Irregular heart beat
___ Poor circulation
___ Swollen ankles
___ Phlebitis (vein inflammation)
___ Anemia
___ History of heart disease
___ Heart murmur
___ Night sweats
___ Tendency to be cold
___ Tendency to be warm
___ Other (describe)
_____

Gastrointestinal
___ Nausea
___ Indigestion
___ Stomach pain
___ Diarrhea
___ Constipation
___ Poor appetite
___ Excessive hunger
___ Vomiting
___ Gas
___ Hiccups
___ Acid regurgitation
___ Bloating
___ Laxative use
___ Bloody stool
___ Other (describe)
_____

Musculoskeletal
___ Joint pain/swelling
___ Sore muscles
___ Weak muscles
___ Difficulty walking
___ Limited range of motion
___ Pain (describe)
_____
_____

Neurological

___ Seizures
___ Tremors
___ Numbness/tingling
___ Pain (describe)

_____

___ Paralysis
___ Poor coordination
___ Other (describe)

_____

Mental/Emotional

___ Depression

___ Mood swings
___ Irritability
___ Difficulty relaxing
___ Loneliness
___ Sensitive
___ Shyness
___ Frequent crying
___ Worries frequently
___ Compulsive behaviors
___ Difficulty focusing
___ Hopeless outlook
___ Suicidal thoughts
___ Lose temper
___ Frustration
___ Other (describe

_____

Urinary

___ Pain on urination
___ Frequent urination
___ Urgent urination
___ Blood in urine
___ Incontinence
___ Incomplete urination
___ Bedwetting
___ Wake to urinate
___ History of UTI
___ Kidney (specify)

_____

_____

___ Other (describe)

_____

Male Genital

___ Impotence
___ Premature ejaculation
___ Nocturnal emission
___ Pain/itching of genitalia
___ Lumps in testicles
___ Increased libido
___ Decreased libido
___ Breast checked
___ Other (describe

_____

Infection Screening (circle self/other)

___ HIV risk: self or partner
___ TB: self or household
___ Hepatitis risk: self or partner
___ History of sexually transmitted disease: self or partner (specify)

_____

_____

___ Other (describe)

_____

Trauma (list)

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Other information

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Patient Signature

_____

Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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, including those working at the clinic or office listed below or any other office or clinic, 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, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: Earnest Cook, L.A.c

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

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PATIENT NAME:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)