ACUPUNCTURE NEW PATIENT PAPERWORK

General Information:

Name:_____ Date:_____

DOB:_____ Age:_____ Phone (cell) :_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____

_____

Height:_____ Ft:_____ In Weight:_____ Gender: **M / F**_ Occupation:

_____

Emergency Contact Name:_____

Phone:_____

Is this your first time getting acupuncture? Yes or No (Circle)

Major Health Concerns and Date Symptoms Began:

_____
_____
_____
_____
_____

Are you experiencing pain at this time? **Yes or No**

Please rate your level of pain **1-10 (with 10 being the worst)**:

_____

How many days out of the week do you exercise?

_____

Share what your diet is like on an average day?

_____
_____

Medical History

Cancer type:_____ _____ _____
HIV: _____
Diabetes type:_____ _____ Mental Illness _____ Heart Disease
_____ Seizures _____ Hepatitis type:_____ _____
Stroke _____ High Blood Pressure _____ Thyroid Disease

_____ High Cholesterol _____ Other:_____

List any **major injuries** or **surgeries** with dates:

_____

_ _

_____

_ _

_____

_

List any **medications or supplements** you are currently taking:

_____

_ _

_____

_ _

_____

_ _

Do you have a pacemaker or any metal in your body? Yes or No

If metal present, please indicate location:

_____

Do you have a history of fainting? Yes or No

Family History

List immediate family members with any of the following conditions:

Family Member(s) Family Member(s)

Cancer (type?) _____ High Cholesterol _____ Diabetes _____ Mental Illness _____ Heart Disease _____ Stroke _____ High Blood Pressure _____ Alcoholism _____

How many hours per night do you sleep on average? _____ Do you wake rested: Yes / No
Nicotine Use: _____ Alcohol Use (#drinks/week and type):
_____

Please check all that apply.

Energy and Immunity Kidney/Urinary

Fatigue _____Painful Urination
_____Allergies (Specify):_____ _____Frequent Urinary Tract Infections
_____Anemia _____Frequent / Urgent Urination _____Chorionic Fatigue Syndrome
_____Edema / Swelling _____Thyroid Problems _____Tendency to catch colds

Musculoskeletal

_____Neck / Shoulder Pain
_____Muscle Spasms / Cramps / Weakness _____Finger Pain / Tingling / Numbness _____Upper Back Pain
_____Mid Back Pain
_____Low Back Pain
_____Headaches / Migraines
_____Leg / Knee Pain
_____Teeth Grinding / TMJ
_____Foot / Ankle Pain
_____Arm Pain
_____Hip / Pelvic Pain
_____Arthritis Neurological
_____Numbness / Tingling

Head, Eye, Ear, Nose and Throat _____Dry eyes
_____Blurry Vision
_____Poor Night Vision
_____Ear Ringing
_____Hearing Difficulties
_____Sore Throat
_____Chronic Sinus Congestion
_____Dry Mouth
_____Bad Breath
_____Mouth Sores / Bleeding
Gums _____ Vertigo / Dizziness
_____Increase in Thirst
_____Difficulty Concentrating / Poor Memory

Please check all that apply.

Emotions & Sleep

_____Mood Swings

_____Depressed
_____Irritable
_____Difficulty Making Decisions _____Stressed
_____Insomnia
_____Nightmares
_____Difficulty Falling or Staying Asleep

Respiratory & Cardiovascular

_____Shortness of Breath
_____Asthma
_____Chest Pain
_____Palpitations / Fluttering
_____Poor Circulation (cold hands / feet) _____Chronic Cough
_____Night Sweats
_____Unusual Sweating
_____Hot / Cold Intolerance

Gastrointestinal

_____Ulcers
_____Changes in Appetite
_____Nausea / Vomiting
_____Bloating / Pain
_____Gas
_____Heartburn / Acid Reflux

_____Belching
_____Diarrhea
_____Constipation
_____Sudden Weight Change
_____ Low/Excessive Appetite
_____Hemorrhoids

Skin

_____Rashes / Eczema / Hives / Psoriasis _____Dry Hair or Hair Loss
_____Changes in Skin Color
_____Easy Bruising
_____Acne
_____Dry / Itchy Skin

Female Health

When was the last start date of your menstrual cycle: _____

_____Irregular Cycle
_____Heavy Flow
_____Light Flow
_____Clots in Menstrual Blood
_____Menstrual Related Moodiness
_____Menstrual Related Breast Tenderness _____Menstrual Related Bloating
_____Bleeding Between Cycles
_____Painful Periods (Is Pain before, during or after Periods?_____
_____Hot Flashes
_____Vaginal Dryness
_____Breast Lumps / Cysts
_____Uterine Fibroids
_____Endometriosis
_____Ovarian Cysts
_____Unusual Vaginal Discharge Odor _____Frequent Yeast Infections
_____Decreased Libido

Male Health

_____Prostate Enlargement
_____Impotence
_____ Infertility
_____Premature Ejaculation
_____Decreased Libido
_____Groin Pain

Acupuncture & Oriental Medicine Informed Consent

I hereby authorize my licensed acupuncturist to assess and treat my condition according to the standards of Oriental Medicine. I extend this authority to treating any unexpected issues or reactions to treatment procedures. I understand the types of treatment under Acupuncture and Oriental Medicine may include, but are not limited to the following: acupuncture, electrical acupuncture, acupressure, Tui Na, moxibustion, cupping, heat lamps, gua sha, ear seeding, magnet therapy, herbal prescriptions, nutritional and lifestyle recommendations and breathing techniques and exercises pertaining to Oriental Medicine.

I understand that there are possible side effects to my treatment that may include, but are not limited to the following: pain, discomfort, swelling, bruising, sensations of heat or cold, numbness, tingling, slight bleeding or irritation at needle sites, digestive upset from herbs, burns from moxa, blisters or marks from cupping and gua sha, and fatigue. I understand that although rare, dizziness, fainting, broken needles, skin infections, pneumothorax, and other side effects may occur. I understand that there is no implied or stated promise or guarantee of the success or effectiveness of a specific treatment or series of treatments. I understand that I will be given the best treatment plan for my specific condition and other information necessary so that I am able to make educated decisions regarding the duration and appropriateness of continued care. I am fully aware that I can stop treatments at any time.

I understand that it is not within the scope of practice for acupuncturists to offer a Western Medicine diagnosis and that I am responsible to obtain such diagnosis elsewhere. I confirm that I have informed my acupuncturist of all known medical conditions and medications, and I will notify them of any changes. I assure that I will notify the acupuncturist as soon as I become **pregnant** or if I am **trying to get pregnant**. I give permission to the clinical and administrative staff, if needed, to review my medical records or provide them to my insurance company for billing purposes (if applicable), but am aware that all my records are confidential and will not be released without my written consent.

In signing this form, I agree that I have read this entire document. I understand that I am able to discuss any questions or concerns I may have with my licensed acupuncturist prior to signing. I also acknowledge that I am signing this document of my own free will.

Patient's Name (Print) _____

Patient's Signature _____ Date _____

If patient is under 18 years of age: Parent/Guardian Name (Print)_____

Parent/Guardian's Signature_____ Date_____

BASS CHIROPRACTIC

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 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, cupping, electrical stimulation, Tui-Na (Chinese massage), and nutritional counseling.

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. 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, 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.

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 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

Acupuncturist:

Patient Name: Patient Signature:

(or Patient Representative and relationship) Date: