Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. *~All information is strictly confidential*

General Patient Information:

Date:____/____/_____
Last Name:_____ First Name _____
Address:_____
City, State, Zip Code:_____
Home phone____/____/_____ Work ____/____/_____ Cell____/____/_____
E-mail_____
Age____ Date of Birth____/____/_____ Gender_____ Marital Status _____
Occupation_____ Employer_____
Guardian (if under 18)_____
Guardian phone number____/____/_____
At what phone number would you like to receive calls about appointments or other health care information _____
May we leave phone messages here with detailed information (please circle) Yes No

Please list persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):
Name_____ Phone #____/____/_____
Name_____ Phone #____/____/_____

Emergency Contact Information: (please check box if same as above)
Name_____ Phone #____/____/_____

How were you referred to this clinic? _____

Patient Intake Evaluation:

Major health complaint(s) in order of significance to you:

1. _____
2. _____
3. _____

How do these conditions interfere with your daily activities?

_____
_____
_____

Please list any medications or nutritional supplements you are currently taking:

1. _____ *2.* _____ *3.* _____
4. _____ *5.* _____ *6.* _____
7. _____ *8.* _____ *9.* _____

Please list any surgeries you have had and approximate dates:

1. _____ *2.* _____ *3.* _____

Patient Medical History:

Currently I am, or have the following:
Pregnant Using Recreational Drugs Pacemaker Hepatitis HIV/AIDS

How was your childhood health? _____
Habits or excessive usage: alcohol chocolate coffee drugs exercise food salt sugar sex

Recent Tests- (please indicate test results and date below)
Physical Blood Mammography Thermography Pap Smear Prostate Cholesterol HIV STD Hepatitis
Others_____ Test results and date: _____

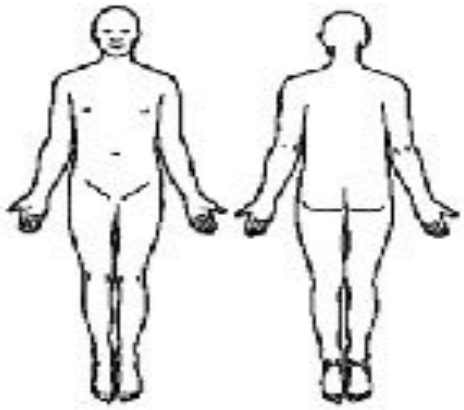
Check any you currently have, or have had in the past:
Allergies Asthma Alcoholism Auto-immune disease CVA(stroke)
Cancer Diabetes Drug abuse/use Epilepsy Heart Illness Hepatitis Hernia
High Blood psi. Kidney Illness Lung Illness
Liver Illness Mononucleosis Meningitis Organ transplant Paralysis Rheumatic Fever
Seizure STD Thyroid illness Tuberculosis Whooping cough Jaundice
Immunizations:_____
Any Adverse Reactions:_____

Patient Profile:
Please clearly mark any areas of pain and any scars with X's. Indicate which of these areas are scars in the margin next to the picture.
Is your pain?
sharp stabbing burning dull cramping aching moving fixed other_____

Do the following lessen the pain?
pressure heat cold movement rest
other_____

Do the following worsen the pain?
pressure heat cold movement rest
other_____

Does your pain limit your movement or flexibility?
yes no



Please check the following that currently pertain to you. If you have symptoms in the following categories it *may* indicate that you have an imbalance in that organ's function *as it is seen in Traditional Chinese Medicine*.

Overall Temperature- Kidney/Lung Function

- ☐ Cold hands or feet
- ☐ Sweaty hands or feet
- ☐ Afternoon flushes
- ☐ Night sweats
- ☐ Hot flashes any time of the day
- ☐ Heat in the hands, feet, or chest
- ☐ Take water to bed
- ☐ Hot body temperature (sensation)
- ☐ Cold body temperature (sensation)
- ☐ Thirsty
- ☐ Lack of thirst
- ☐ Craves ice cold drink
- ☐ Craves warm or hot drink
- ☐ Craves room temperature drink

Lung & Large Intestine Organ and Meridian system

- ☐ Asthma
- ☐ Frequent Yawning
- ☐ Hives, rashes, or itchy skin
- ☐ Pimples or acne
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Difficult Bowel movements
- ☐ Bowel movement has strong odor
- ☐ Gas/ Flatulence
- ☐ Grieving
- ☐ Overall achy feeling in Body
- ☐ Smoke Cigarettes: # per day-_____
- ☐ Loss of smell
- ☐ Allergies: to what_____
- ☐ Frequent nose Bleeds
- ☐ Incomplete Bowel movements
- ☐ Blood in stool or black stool
- ☐ Mucous in stool
- ☐ Burning sensation with bowel movement
- ☐ Sadness

Stomach & Spleen Organ and Meridian system

- ☐ Indigestion
- ☐ Heartburn
- ☐ Acid reflux
- ☐ Burning sensation in Stomach
- ☐ Diabetes
- ☐ Poor appetite
- ☐ Hungry, but don't want to eat
- ☐ Large appetite
- ☐ Bruises easily or varicose veins
- ☐ Gurgling noise in stomach
- ☐ Nausea or vomiting
- ☐ Sensation of heaviness in the body or head
- ☐ General weakness of limbs or muscles
- ☐ Mouth (Canker) Sores
- ☐ Prolapsed organ-diagnosed:_____
- ☐ Over-thinker, pensive
- ☐ Worry
- ☐ Burping/ belching
- ☐ Hiccups
- ☐ Stomach ulcer- diagnosed
- ☐ Abdominal bloating
- ☐ Lower abdominal pain
- ☐ Upper abdominal pain
- ☐ Unable to stay focused
- ☐ Poor long-term memory
- ☐ Low energy
- ☐ fatigue & lassitude
- ☐ Fatigue after eating
- ☐ Headaches on the forehead
- ☐ Bad Breath
- ☐ Bleeding, swollen or painful gums
- ☐ Undigested food in stool
- ☐ Loose stool or diarrhea
- ☐ Hemorrhoids

Heart & Small Intestine Organ and Meridian system

- [ ] palpitations
- [ ] irregular heart beat
- [ ] heart problems
- [ ] chest pain/discomfort
- [ ] chest fullness, tightness or pressure
- [ ] arm numbness or tingling
- [ ] tongue or speech problems
- [ ] sores on tongue
- [ ] lack of joy/ humor
- [ ] fidgety
- [ ] talkative
- [ ] insomnia
- [ ] trouble falling asleep
- [ ] trouble staying asleep
- [ ] wake un-refreshed
- [ ] dreams disturb sleeping
- [ ] vivid dreams
- [ ] anxiety/dread
- [ ] mental restlessness
- [ ] mental confusion, "foggy", or unclear thinking
- [ ] poor short term memory
- [ ] intestinal hernia

Kidney & Urinary Bladder Organ and Meridian system

- [ ] Frequent Cavities
- [ ] Arthritis
- [ ] Bone problems
- [ ] Bones break easy
- [ ] Sore or weak Knees
- [ ] Cold sensation in Knees
- [ ] Decreased libido
- [ ] Excessive libido
- [ ] Memory Problems, forgetfulness
- [ ] Water Retention/ Edema
- [ ] Wake During Night to Urinate
- [ ] Infertility/Sterility
- [ ] Low-Pitched Ringing in Ears
- [ ] Hearing loss
- [ ] Ear problems
- [ ] Kidney Stones
- [ ] Bladder Infections
- [ ] Bladder control weakness
- [ ] Low back pain
- [ ] Headaches at base of skull or back of head
- [ ] Premature gray hair
- [ ] Hair Loss
- [ ] Fear or easily startled
- [ ] Lack of Willpower

Urination

- [ ] Yellow or Pale Yellow
- [ ] Dark Yellow
- [ ] Clear
- [ ] Reddish
- [ ] Visible blood
- [ ] Cloudy
- [ ] Dribbling or weak stream
- [ ] fluids consumed are less than urine output
- [ ] Discharge
- [ ] Painful
- [ ] Difficult
- [ ] Frequency
- [ ] Urgency
- [ ] Scanty
- [ ] Profuse
- [ ] Strong Odor

- [ ] fluids consumed are more than urine output

Liver & Gallbladder Organ and Meridian system

- [ ] Tenderness on sides of ribcage
- [ ] Headaches on top of head, sides of head or behind the eyes
- [ ] Dizziness
- [ ] Alternating constipation and diarrhea
- [ ] High pitched ringing in the ears
- [ ] Bitter Taste in the Mouth
- [ ] Anger/Frustration
- [ ] Resentment
- [ ] Depression/ “feel down”
- [ ] Irritable
- [ ] Stressed
- [ ] Indecisive
- [ ] Brittle/coarse nails or hair
- [ ] Muscle Twitching, cramping or spasms
- [ ] Tendon problems
- [ ] Frequent sighing
- [ ] Anemia (of any type)
- [ ] Seizures or convulsions
- [ ] Gall stones
- [ ] sensation of a Lump in the throat
- [ ] Itchy, gritty, or red eyes
- [ ] blurry vision
- [ ] decreased night vision
- [ ] seeing spots/floaters
- [ ] other eye problems
- [ ] High blood pressure

For Women Only:

No. of pregnancies____

No. of live births____

No. of premature births____

No. of miscarriages___

No. of abortions____

Age at 1st menses_____

Average length of period _____ Days of heavy flow_____

☐ early cycle (less than 21 days) ☐ late cycle (more than 35 days)

Number of days between cycles _____

Menstrual Color: ☐ bright red ☐ scarlet ☐ dk. red ☐ dk. purple ☐ brown

Menses clot size: ☐ dime size ☐ quarter size ☐ larger ☐ no clots

In General Menses Is: ☐ light ☐ mod. ☐ heavy ☐ very heavy

Menstrual Pain/Cramps: ☐ before ☐ during ☐ after menses

☐ No cramping

☐ Fertility concerns

☐ body change w/period ☐ mood swing w/period

☐ Ovarian cysts

Are you in Menopause? _____ Age at menopause (if applicable)____

☐ Fibroids

Vaginal Discharge: ☐ clear ☐ wt. ☐ yellow ☐ green ☐ pink/red

☐ Endometriosis how often_____

Breast

☐ Tenderness with Menses ☐ General tenderness or pain ☐ Lumps/masses ☐ discharge

☐ History of breast cancer (self) ☐ Family history of breast cancer

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture and traditional Chinese medicine on me (or patient named below, for whom I am legally responsible) by the acupuncture practitioner named below and/or other licensed acupuncture practitioner serving as back-up for practitioner, whether signatories to this form or not.

I understand that the methods of treatment may include but are not limited to acupuncture, electrical stimulation, moxibustion, cupping, Tui-Na (Chinese Medical Massage), Oriental herbs and or Western nutritional supplements to promote health and well being, dietary and lifestyle counseling.

I have been informed that acupuncture is generally a safe method of treatment, but may have some side effects, including minor bruising, numbness or tingling near the sites that may last a few days, dizziness or fainting, a broken needle, or may produce temporary flare-up symptoms. Bruising is a common side effect of cupping. Fainting can most easily be avoided if patient takes care not to come to treatment when he or she is exhausted or hungry. To avoid needle breakage, patients must limit their movement while on the table. With sterile disposable needles there is no risk of HIV or hepatitis from the needles. Unusual risks of acupuncture are rare but include pneumothorax (lung puncture), nerve damage, organ puncture, and spontaneous miscarriage.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The acupuncture practitioner must be advised if the patient has a pacemaker, cardiac condition, bleeding disorder, history of seizures, is or may be pregnant.

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment, which based on the facts then known is in my best interest. While there are a number of alternatives that exist, the prognosis for treatment depends on the patient's condition, the duration and frequency of treatment and the responsiveness of the patient to both the treatment and the treatment plan. I understand that results are not guaranteed.

I understand that the practitioner and/or clinical 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 to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Printed Name _____

Patient Signature _____ Date _____
Patient Parent Guardian

Witness Signature _____ Date _____

PATIENT AND CLIENT RIGHTS
Mutual Understandings in the Therapeutic Relationship

YOUR RIGHTS AS A PATIENT OR CLIENT:
The practice of both licensed and non-licensed persons in the health care fields are regulated by their respective state regulatory boards.

You are entitled to receive information about methods of care, techniques used, duration of care if known, and fee structure. You have the right to know the risks as well as the benefits of any therapy, procedure performed, medicinal agent, healing supplement, herb or other recommendations made by a health practitioner. All invasive procedures require documented informed consent. You are also to be informed of the health care provider's degrees, credentials, and licenses.

You have the right to seek a second opinion from another health care provider or terminate care at any time. Understand that by law, "No practitioner may guarantee the outcome or cure."

You should know that in a professional relationship, sexual intimacy is never appropriate and should be reported to your state Medical Grievance Board.

It is important that you understand that information provided by you during care is confidential except in certain circumstances of which you should be informed.

CONFIDENTIALITY:
Matters regarding your care will be kept confidential except in the following circumstances: you sign a release of information giving permission to release information to a specific individual or agency; child abuse; patient or client is in imminent danger to self or others; subpoena of records.*

FEES AND PAYMENTS:
Charges are $120.00 for all first visits , $70.00 for regular follow-up visits, $90 for follow-up with cupping and $80.00 for facial rejuvenation follow-up visits. Payment is due at time of service. Check, Cash, and all major credit cards accepted as well as some HSA and FSA cards.

AVAILABILITY AND ANSWERING SERVICE:
I am available to receive your calls during most normal business hours. If I am providing care, you may get the receptionist or an answering machine. I pick up messages regularly. If you have a major emergency and cannot reach me please call 911.

CONTINUITY OF CARE/TERMINATION OF CARE:
Your responsibility in a therapeutic relationship is to keep your appointments and follow through with a practitioner's guidance and recommendations in a way that both takes reasonable steps toward the goal of health and is in your highest interest. It is always your right to terminate care at any time. However, I strongly encourage you to talk about this decision with me. It has been my experience, that particularly in a therapeutic relationship of any length, termination is a very important process. If I see you as approaching readiness to leave care, I will certainly discuss this with you. I will also discuss your progress and status with you on an ongoing basis. This is a cooperative process, so please feel free to talk about your needs and concerns with me.

*In addition it may be appropriate to consult with your primary care medical doctor particularly in circumstances where physical symptoms are being monitored by a medical doctor or a change in medication may be needed. In this circumstance your signature below constitutes your giving your health care practitioner in this office permission for such consultations.
I state that I understand my rights and my responsibilities in the therapeutic relationship.

_____	_____	_____
Printed Name	Signature	Date

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and full future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

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This consent was signed by: _____

(patient or guardian signature)

Relationship to patient (if other than patient): _____

Date:_____

Witness:_____

(practice representative signature)

Date:_____