South Philadelphia Community Acupuncture
Consent Form

Your treatment may include one or more of the following practices:
Acupuncture, Gua Sha, Moxibustion, Tui Na, Herbal Medicine, Diet Therapy, Oils and Liniments.

Purpose of Treatment: The purpose of treatment is to provide a health care service that is based on a traditional Chinese system of medical theory. Diagnosis and treatment based on these theories are used to promote health and to treat organic and functional disorders. TCM is not a replacement for conventional medical care.

Benefits of Treatment: Relief of presenting symptoms, improved circulation, optimizing the body's ability to heal itself, and wellness. These benefits may lead to prevention or elimination of the presenting problem, and strengthening of the patient's constitution. Of course, the practitioner cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Traditional Chinese medical practices have been shown to be relatively safe. However, there are some uncommon but potential risks. These potential risks may include:

1. Discomfort during the insertion of a needle.
2. Dizziness or fainting.
3. Minor bruising or temporary discoloration of the skin.
4. Minor burns with the usage of some types of moxa.
5. Possible temporary aggravation of symptoms that existed prior to treatment.
6. A broken needle (very rare with the use of disposable needles).
7. Infection (very rare with the use of disposable needles).
8. Gastro-intestinal upset with the use of Chinese herbs. (If this should occur, then please notify your practitioner).

Special Situations:** Some herbs and acupuncture points are contraindicative under certain situations. Please notify your practitioner **PRIOR TO TREATMENT** if you are **PREGNANT,** if you have **SEVERE BLEEDING DISORDERS,** or if you are wearing a **PACEMAKER** or **OTHER ELECTRONIC MEDICAL DEVICES. **

Cancellation Policy: Our clinic requires a **24 HOUR NOTICE OF CANCELLATION.** In respect for our intention to offer high quality health care at affordable rates, and for others in the community in need of treatment at specific times, we have a strict cancellation policy. All appointments that are rescheduled/cancelled with less than 24-hour advance notice, and appointments that are missed without notice, will be charged the regular fee for that appointment.

Silence is Golden: Please be mindful of the healing space we want to create for our community. By turning off your cell phones, speaking quietly in the clinic and waiting rooms, and keeping minimal conversation, we can continue to achieve a peaceful place for people to relax. Thank you!

I, _____ request and consent to receiving acupuncture and other traditional Chinese medical practices. I understand that I am free to withdraw my consent and that I may stop treatment at any time. I understand that my signature on this form indicates that I have read and comprehend the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask the treating practitioner.

I, _____
understand that there is a 24-hour cancellation policy and that if I do not adhere to the policy, I will be responsible for paying the regular fee for the missed appointment.

I, _____
release South Philadelphia Community Acupuncture and its practitioners from any and all liability that may occur in connection with the above-mentioned procedures.

Patient's Name (Please Print): _____

Patient's Signature _____

Date signed: _____

Name: _____ ***Date:*** _____ ***Age:*** _____

Home Address: _____

City: _____ ***State:*** _____ ***Zip:*** _____

Phone: _____ ***Email:*** _____

Birthdate: _____ ***Height:*** _____ ***Weight:*** _____

Relationship Status: _____ ***Number of Children:*** _____

Occupation: _____ ***Work Phone:*** _____

Emergency Contact _____

Who is your primary care physician? _____

When was your last acupuncture visit? _____ *With whom and why?* _____

Please list the MAIN REASONS why you are coming in for treatment today (include onset):

_____

_____

Please indicate the nature of your PAIN (onset, location, characteristics, what makes it feel better or worse):

_____

_____

Please rate your pain from 1 - 10 (10 is the worst): _____ Does the pain move or radiate? _____

Have you tried other therapies? _____

Other health problems? _____

Date of any accidents, surgeries or hospitalizations: _____

Are you involved in a legal case due to an accident? If so, please write date of accident: _____

Who should we thank for referring you to South Philly Community Acupuncture? _____

Please list any MEDICATIONS (including supplements and vitamins) you are taking. Continue on back if needed!

Medication	***Dosage***	***Reason***	***Duration***	***Physician***	**Date**

*Did you have any severe **CHILDHOOD ILLNESSES** or immunization injuries? If yes, please explain:*

_____

_____

Are you HYPERSENSITIVE or ALLERGIC to:

Any Drugs? _____

Any Foods? _____

Environmental factors? _____

Symptom Profile

If you have experienced ANY of these symptoms, please use the following symbol or corresponding date:

CURRENTLY: please select box PAST: please provide date

SKIN:

- ☐ Acne _____
- ☐ Acute Hair Loss _____
- ☐ Itching _____
- ☐ Boils _____
- ☐ Pigment Change _____
- ☐ Hives _____
- ☐ Brittle Nails _____
- ☐ Psoriasis _____
- ☐ Rash _____
- ☐ Nail Fungus _____

RESPIRATORY:

- ☐ Bronchitis _____
- ☐ Chronic Cough _____
- ☐ Acute Cough _____
- ☐ Sinus Congestion _____
- ☐ Chronic Asthma _____
- ☐ Emphysema _____
- ☐ Pain in Breathing _____
- ☐ Shortness of Breath _____
- ☐ Spitting up Blood _____
- ☐ Tuberculosis _____
- ☐ Pleurisy _____
- ☐ Seasonal Allergies _____

MENTAL/EMOTIONAL:

- ☐ Anxiety _____
- ☐ Obsessive Worry _____
- ☐ Mood Swings _____
- ☐ Depression _____
- ☐ Irritability _____
- ☐ Anger/Rage _____
- ☐ Increased Fears _____
- ☐ Attempted Suicide _____
- ☐ Mental Illness _____

HEAD / EARS / EYES / NOSE / MOUTH:

- ☐ Headache _____
- ☐ Migraine _____
- ☐ Head Injury _____
- ☐ Hay Fever _____
- ☐ Earache _____
- ☐ Ear Ringing _____
- ☐ Impaired Hearing _____
- ☐ Thirst _____
- ☐ Sore Throat _____

HEAD / EARS / EYES / NOSE / MOUTH CONT'D:

- ☐ Swollen Glands _____
- ☐ Nose Bleeds _____
- ☐ Loss of Smell _____
- ☐ Bleeding Gums _____
- ☐ Mouth Ulcers/Sores _____
- ☐ Dental Cavities _____
- ☐ Teeth Grinding _____
- ☐ Jaw Problems/TMJ _____
- ☐ Oral Thrush _____
- ☐ Hoarseness _____
- ☐ Trouble Swallowing _____
- ☐ Dizziness _____
- ☐ Vertigo _____
- ☐ Eye Pain _____
- ☐ Night Blindness _____
- ☐ Eye Tearing _____
- ☐ Eye Drying _____
- ☐ Cataracts _____
- ☐ Phlegm Congestion _____

DIGESTION:

- ☐ Nausea _____
- ☐ Vomiting _____
- ☐ Loss of Appetite _____
- ☐ Excess Appetite _____
- ☐ Gas/Flatulent _____
- ☐ Bloating _____
- ☐ Cramping _____
- ☐ Constipation _____
- ☐ Hemorrhoids _____
- ☐ Diarrhea _____
- ☐ Ulcer _____

BM per day: _____

CARDIOVASCULAR:

- ☐ Heart Disease _____
- ☐ Endocarditis _____
- ☐ Chest Pain _____
- ☐ Heart Murmur _____
- ☐ Low Blood Pressure _____
- ☐ Phlebitis _____
- ☐ Blood Clots _____
- ☐ Ankle Swelling _____
- ☐ High Blood Pressure _____
- ☐ Palpitations _____
- ☐ Fainting _____
- ☐ High Cholesterol _____

URINARY TRACT:

- ☐ Frequent Infection _____
- ☐ Incontinence _____
- ☐ Night Time Frequency _____
- ☐ Burning/Pain _____
- ☐ Frequent Urination _____
- ☐ Scanty Amount _____
- ☐ Dribbling _____
- ☐ Kidney Stones _____
- ☐ Blood in Urine _____

MUSCULOSKELETAL:

- ☐ Muscle Spasm _____
- ☐ Weakness _____
- ☐ Sciatica _____
- ☐ Fibromyalgia _____
- ☐ Joint Pain _____
- ☐ Stiffness _____
- ☐ Swelling _____

MISCELLANEOUS:

- ☐ Bleed/Bruise Easily _____
- ☐ Varicose Veins _____
- ☐ Anemia _____
- ☐ Chronic Infections _____
- ☐ Hypoglycemia _____
- ☐ HIV + _____
- ☐ Hyperthyroid _____
- ☐ Cancer _____
- ☐ Chronic Fatigue Syndrome _____
- ☐ Cold Intolerance _____
- ☐ Heat Intolerance _____
- ☐ Cold Hands/Feet _____
- ☐ Hepatitis (A/B/C) _____
- ☐ Herpes Genital _____
- ☐ Herpes Oral _____
- ☐ Diabetes (I/II) _____
- ☐ Sudden Weight Loss _____
- ☐ Kidney Disease _____
- ☐ Spontaneous Sweats _____
- ☐ Night Sweats _____
- ☐ Fatigue _____
- ☐ Low Energy _____
- ☐ Jaundice _____
- ☐ Gall Bladder Disease _____
- ☐ Testicular Pain _____
- ☐ Prostate Disease _____
- ☐ Nighttime Urination _____
- ☐ Premature Ejaculation _____
- ☐ Impotence _____

Last Prostate Exam: _____

OB/GYN:

Are You Pregnant?		**# of Days in Menstrual Cycle (ex. 28 days)**		**Are you Sexually Active?**	
# of Pregnancies		**# of Days of Blood Flow (ex. 2-7 days)**		**Sexual Difficulties**	
# of Miscarriages		**Age at First Menses**		**Decreased Libido**	
# of Abortions		**Color of Blood (red/purple/brown)**		**Method of Birth Control**	
# of IUI		**Amount of Blood (excess/moderate/light)**		**Cervical Dysplasia**	
# of IVF		**Blood Consistency (thick/medium/thin)**		**Fibroids**	
Breast Lumps		**Clots? (size, frequency)**		**Ovarian Cysts**	
Breast Tenderness		**Vaginal Discharge**		**Endometriosis**	
Fibrocystic Breasts		**Pain or Cramps (type/ location)**		**Polycystic Ovarian Syndrome (PCOS)**	
Date of Last PAP Smear		**Day of Ovulation**		**Lichen Sclerosis**	
PAP results		**Quality of Cervical Fluid During Ovulation**		**Yeast Infections**	

LIFESTYLE:

*Do you **SLEEP** well? _____*
*What **time** of day is your **ENERGY** at its best? _____*
*What **time** of day is your **ENERGY** at its worst? ____*

*Do You **EXERCISE**? If yes, what kind and how often?*
_____
_____

What do you generally have for the following meals?
BREAKFAST _____
LUNCH _____
DINNER _____
SNACK _____
*Do you **RESTRICT** certain foods from your diet?*
_____

Do you have a history of psychological, physical or sexual abuse? _____

Is there anything you feel is important for us to know regarding your answer?
_____
_____
_____

How much do you typically consume of the following?
SODA _____
ALCOHOL _____
CAFFEINE _____
TOBACCO _____
RECREATIONAL DRUGS _____
ETC _____

Please rate how you FEEL about these areas in your life:

	Great	*Good*	*Fair*	*Poor*	*Bad*	*Comments:*
Partner						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spirituality						