Name: _____Birthdate:_____

How did you hear about us?_____

E-mail(required)_____

Phone:_____

Address:_____

City:_____State:_____Zip:_

Have you had acupuncture before?_____

Chief Complaints

1)_____

2)_____

3)_____

How long have you had this condition? _____

Do you have any diagnoses? _____

Allergies/Medications:_____

Does anything Help the condition? _____

(Circle) Pregnant Pacemaker HIV AIDS Hepatitis

Frequency of pain: 25% 50% 75% 100% of the time

Digestion(circle): Constipation Diarrhea gas upset stomach

Chronic medical conditions: diabetes, Heart disease or high blood pressure?_____

Energy(circle): Great Ok Poor

Sleep(circle): Great Ok Poor

Emotions(circle): Stress Irritable Anger Frustration Sadness Greif Worry Anxiety Panic Restless

Mental Illness

I tend to feel(circle): Hot Cold

Sex drive: Great Ok Needs Help

<u>Womens Health</u>

[]Endometriosis []Fibroids []Ovarian Cysts []Breast Cysts []Hormone Replacement Therapy []Hysterectomy []Menopause []I do not have a period

On Menstrual Period, I experience: []Bloating []Swollen Breasts []Tender Breasts []Clots []Back Pain []Upset Stomach []Mood change(circle): Before/during/after

[]Cramps(circle): Before/during/after

Physician notes: Age chronic/acute intermittent/constant

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Chinese Herbs/supplements: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation oSf symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Clinic as soon as possible.*

Acupressure/TuiNa Massage/Cupping: I understand that I may also be given acupressure/tuina massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Injection: I understand that I may be given an injection of an herb, homeopathic, or vitamin, and, as with all injections, it may cause pain, or redness at the site of injection, though this is rare.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature **Date**