

Patient Information and Health History

| | | | |
|-----------------------|-----------------|-------------|-------------|
| Name: | Age: | Sex/Gender: | Cell phone: |
| Full address: | Date of Birth: | | Home phone: |
| | Marital Status: | | Work phone: |
| Email (kept private): | Height: | Weight: | Occupation: |

Please list main concern(s). How long ago did each begin?

Have you seen a physician?
Did you receive a diagnosis? What?

Have you had acupuncture before?
How recently?

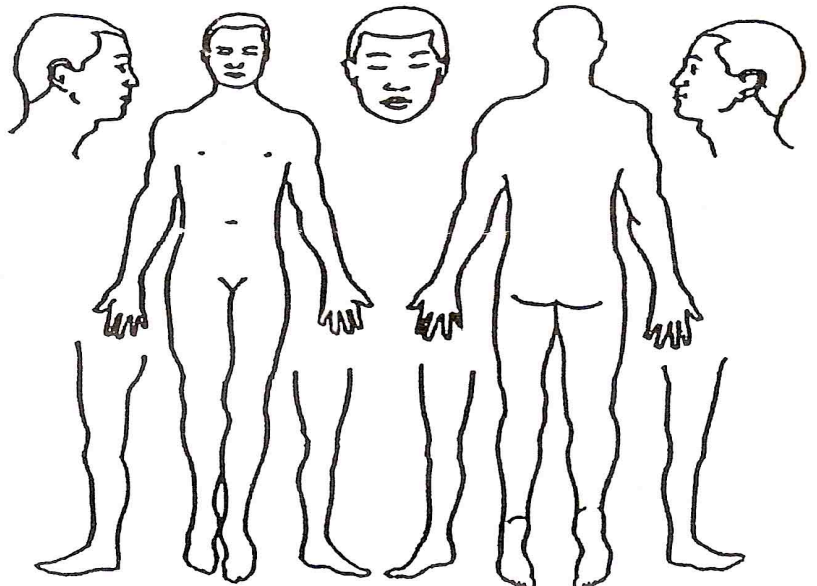
Current medications and supplements:

Please list any allergies (*medications, foods, chemicals, etc.*)

What do you do for exercise? How often?

Do you restrict your diet in any way? (*vegetarian, no red meat, organic, etc.*)

Please mark any areas of pain or discomfort



Please rate how often you experience each symptom:

(leave blank if never) 1 = occasionally, 2 = often, 3 = always

Head, Eyes, Ears, Nose, Throat

allergies 1 2 3
 sinus problems 1 2 3
 sores on lips/gums/tongue 1 2 3
 teeth clenching/ grinding 1 2 3
 jaw clicking/pain 1 2 3
 other:

Respiratory

recurrent sore throats 1 2 3
 frequent colds/flu 1 2 3
 phlegm – color: _____ 1 2 3
 asthma/wheezing 1 2 3
 shortness of breath 1 2 3
 other:

Digestion

nausea/vomiting 1 2 3
 poor appetite 1 2 3
 excessive hunger 1 2 3
 fatigue after meals 1 2 3
 cravings (for specific foods, other) _____ 1 2 3
 belching/burping 1 2 3
 gas/bloating 1 2 3
 abdominal pain/cramps 1 2 3
 indigestion/heartburn 1 2 3
 how often do you have a bowel movement? _____
 hemorrhoids 1 2 3
 other:

Ob-Gyn

Could you be pregnant? Y N
 age of first period: _____
 duration of typical cycle: _____
 duration of typical period: _____
 date of last period: _____
 painful periods 1 2 3
 bleeding between periods 1 2 3
 heavy menstrual flow 1 2 3
 light menstrual flow 1 2 3
 clots in menstrual flow 1 2 3
 cramping 1 2 3
 # pregnancies: _____
 # abortions: _____
 # miscarriages: _____
 # live births (when?): _____

Are you taking birth control?

premenstrual & menstrual symptoms
 (circle ones you have, write in others)

bloating breast tenderness
 irritability mood swings
 fatigue poor coordination
 loose stool acne
 other:

menopause symptoms:

(circle ones you have, write in others)
 hot flashes night sweats
 Irritability mood swings
 fatigue
 other:

menopause – age you started? _____

Skin, Hair and Nails

sensitive scars 1 2 3
 acne 1 2 3
 itching 1 2 3
 loss of hair 1 2 3
 brittle or weak nails 1 2 3
 other:

Sleep

how much sleep do you get? _____
 difficulty falling asleep 1 2 3
 waking often 1 2 3
 difficulty falling back asleep (after waking) 1 2 3
 vivid/disturbing dreams 1 2 3
 night sweats 1 2 3

Psychological/Neurological

excessive worry 1 2 3
 excessive sadness 1 2 3
 excessive anger 1 2 3
 excessive fear 1 2 3
 racing thoughts 1 2 3
 easily startled 1 2 3
 nervousness 1 2 3
 anxiety 1 2 3
 depression 1 2 3
 irritability 1 2 3
 overwhelmed 1 2 3
 stress 1 2 3
 difficulty concentrating 1 2 3
 other:

Comments: Please list any other issues you would like to discuss.

Acupuncture Informed Consent to Treat

I, (printed name) _____ 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 named 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, massage, Chinese herbal medicine and nutritional counseling. I understand that the herbs may need to be consumed according to the instructions provided. 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 have been informed that acupuncture is generally a 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. Bruising is common with cupping. Rare risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax (lung puncture). Infection is another possible risk, although the clinic uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (of plant, animal, and mineral origin) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although (as with pharmaceuticals) some are toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, 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.**

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 chart, but all my records will be kept confidential and will not be released without written consent. The exception to this is that patients wishing to have their insurance pay for part of the treatment do hereby consent to have all relevant information shared with their insurance provider only insofar as needed for the office to receive reimbursement.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been informed of 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 any future condition(s) for which I seek treatment.

Patient Signature **X** _____
(or patient representative – indicate relationship if signing for patient)



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Financial Policy

DCAC makes every attempt to make alternative health care, as acupuncture and Chinese medicine, available to as many people as possible, at the most affordable rates.

In respect for our intention to offer high-quality health care at affordable prices, we ask for 24-hour advance notice if it is necessary to cancel an appointment.

All appointments that are cancelled with less than 24-hour advance notice, and appointments missed without notice, will be charged \$15 for that appointment. If appointments have been purchased in a package, the missed or cancelled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding,

Davis Community Acupuncture Clinic Staff

SIGNATURE _____ DATE ____/____/____

PRINTED NAME _____