PATIENT INFORMATION AND CONSENT FORM

Name: ____

Date of Birth: ____

Place of Birth: ____

Mailing Address: ______________________________________

How did you hear about our practice? ______________________

We often send text message reminders for appointments. What is the best number to reach you?

Phone Number: ______________________

Email Address: ______________________

Have you had acupuncture before? YES NO

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 Washington Acupuncture & Traditional Chinese Medicine.

I understand that Traditional Chinese medicine includes various modalities including Acupuncture, herbal medicine, TuiNa massage, Guasha (a dermal friction technique), Moxibustion, Acupressure and other types of hands-on techniques. While very effective, these techniques are not necessarily a substitute for conventional care.
I understand the risks of receiving treatment include bruising, numbness near the needling sites and sometimes dizzi-ness. Bruising is a common side effect of cupping. Extremely rare side effects of acupuncture include nerve damage and organ puncture, particularly lung puncture (pneumothorax). Burns and scarring are a potential side effect of moxibustion and cupping.

I understand that the herbs and nutritional supplements are generally considered safe when prescribed by a licensed practitioner of Chinese medicine. Some possible side effects of taking herbs or supplements include nausea, gas, headache, rashes and diarrhea.

I will report any side effects to the office and I wish to rely on the clinical staff to exercise judgment during the course of treatment, based upon the facts then known that is in my best interest. I understand that while the clinical staff may review my patient records and lab reports, all my records will be kept confidential and will not be released without my written consent.

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 the 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 been told about the risks and benefits of acupuncture and other procedures. I intent this consent form to cover the entire course of treatment for my present condition as well as any future conditions for which I seek treatment. Payment is due at the time services are rendered. Herbal medicine fees are additional to visit costs.

Patient Signature (or Patient Representative) ________________________ Date ______________

Washington Acupuncture & Traditional Chinese Medicine

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Medical History

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)	DATE
WHAT IS THE PRIMARY REASON FOR YOUR VISIT?	
HOW DID THIS CONDITION DEVELOP?	
HOW LONG HAS IT PERSISTED?	
IS THERE ANYTHING THAT MAKES IT BETTER?	
IS THERE ANYTHING THAT MAKES IT WORSE?	
HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION?	IF YES, WHEN?
WHERE?	BY WHOM?
WHAT WAS THE DIAGNOSIS?	WHAT KINDS OF TREATMENT?
DO YOU HAVE ANY SECONDARY CONCERNS?	
LIST ANY SUBSTANCES YOU ARE ALLERGIC TO:	

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION	STRENGTH	HOW MANY PER DAY	FOR HOW LONG
____________________	____________	____________	____________
____________________	____________	____________	____________
____________________	____________	____________	____________

LIST ANY SUPPLEMENTS YOU ARE CURRENTLY TAKING:

____

____

LIST ANY MAJOR SURGERIES OR ACCIDENTS YOU HAVE HAD:

____

____

____

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

ARTHRITIS	CONNECTIVE TISSUE DISEASE	HYPERTENSION	THYROID DISEASE
ASTHMA	DIABETES	KIDNEY STONES	VENEREAL DISEASE
AUTOIMMUNE DISEASE	GALLSTONES	RHEUMATIC FEVER	OTHER:____________________
AIDS	HEART DISEASE	RUPTURED APPENDIX	______________________
CANCER	HEPATITIS	SEIZURES	______________________

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Health History

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Please check any current symptoms, or those you have experienced in the past 6 months.

General
- Chills
- Low energy
- Dizziness
- Allergies
- Fatigue
- Fevers
- Excess thirst
- Insomnia
- Nervousness
- Numbness
- Sweat spontaneously
- Night sweating
- Lack of sweating
- Weight loss
- Weight gain
- Aversion to heat
- Aversion to cold

Head & Neck
- Headache
- Phlegm in throat
- Cataract
- Double vision
- Earache
- Eye pain/strain
- Blurred vision
- Nasal discharge
- Loss of sense of smell
- Hearing loss
- Hoarseness
- Nosebleeds
- Recurrent sore throat
- Red/inflamed eye
- Ringing in ears
- Sinus problems
- Sores on lips
- Sores on tongue
- Taste change
- Teeth problems

Respiratory
- Asthma
- Hay fever
- Persistent cough
- Shortness of breath
- Recurrent bronchitis

Cardiovascular
- Chest pain
- High blood pressure
- Low blood pressure
- Irregular heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins
- Hypochondriac pain

Gastrointestinal
- Abdominal pain
- Bloating
- Belching
- Gas
- Constipation
- Diarrhea/loose stools
- Bloody stools
- Black stools
- Poor appetite
- Heartburn/reflux
- Hemorrhoids
- Indigestion
- Stomachache
- Nausea
- Vomiting

Diet/Lifestyle
- Vegetarian
- Balanced diet
- Eat much fried foods
- Eat much meat
- Smoke cigarettes
- Drink alcohol
- Drink coffee
- Use drugs (illicit drug use)
- Consume marijuana
- Eat a lot of sweets
- Take melatonin
- Do not exercise
- Exercise regularly
- Exercise excessively

Weight
- Underweight
- Normal for height
- Overweight
- Very overweight

Genitourinary
- Dark urine
- Blood in urine
- Cloudy urine
- Burning urination
- Profuse urine
- Frequent urination
- Poor bladder control
- Urgency to urinate

Skin
- Thin skin
- Broken blood vessels
- Bruise easily
- Dark circles around eyes
- Bags under eyes
- Lumps in groin
- Lumps under arms
- Dry skin
- Acne
- Brittle nails
- Premature gray hair
- Dry, brittle hair
- Hair falling out

Neurologic
- Fainting
- Handwriting change
- Paralysis
- Stroke
- Seizures
- Vertigo

Emotional
- Insomnia
- Irritability
- Often feel angry
- Troubling dreams
- Cry uncontrollably
- Feel sad a lot
- Forgetful
- Mind not clear
- Anxiety
- Much fear
- Unrestrained joy
- Terrors
- Difficulty expressing emotions

Men Only
- Genital pain
- Impotence
- Genital sores
- Lump in testicles
- Nocturnal emission
- Low libido

Women Only
- Abnormal pap smear
- Bleed between periods
- Irregular periods
- Heavy Periods
- <25 day cycle
- >35 day cycle
- Painful periods
- Premenstrual tension
- Breast lumps
- Contraceptives
- Sores on genitalia
- Change in vaginal discharge
- Low libido
- Menopausal
- Facial hair
- Loss of head hair
- May be pregnant
- Currently pregnant

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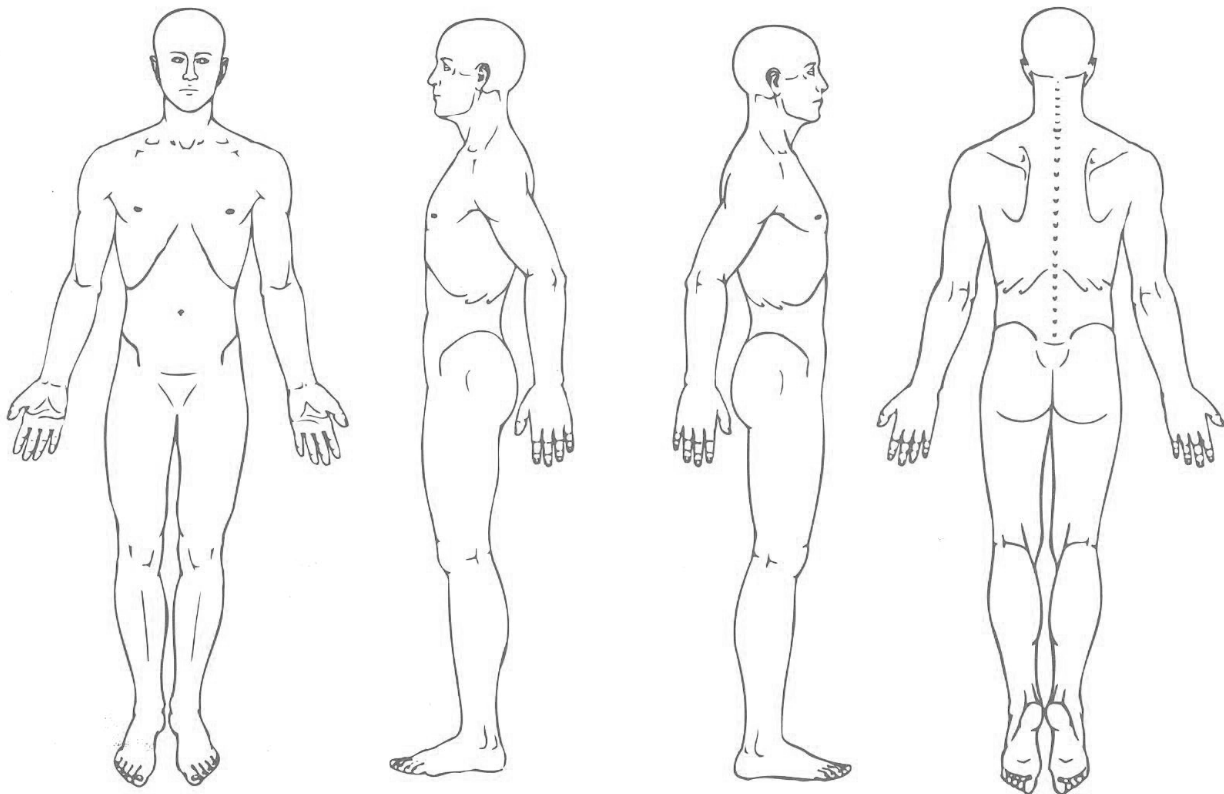
Pain Assessment

1. Is this your initial visit or a follow-up visit?

2. Please mark or shade the areas of your body where you feel pain, numbness, or weakness.

3. Do you feel a sensation of heat or cold with your discomfort?



4. Next to each area marked above, please note the intensity of pain.

No pain	Minimal		Tolerable, but hinders activities		High- 50% of activities impaired		Extreme- most activities impaired		Unbearable
0	1	2	3	4	5	6	7	8	9

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PRACTICE POLICIES

We have a 48 hour minimum cancelation policy. Please be aware that it is difficult to fill your appointment even with 48 hours notice. We appreaciate as much notice as possible.

We reserve your appointment time especially for you. We do not double or triple book appointment times. The allows us to spend more time with each individual patient and manage our time effectively so as not to invoncenience you.

Policies aside, we know that life often intervenes at the last moment and some situations cannot be avoided.

We will work with you and appreciate your attentiveness to this matter.

We ask for payment to be made at the time of your visit. We will provide you with duplicate copies of your superbill (including diagnosis and fees) so that you may keep a copy for your records and turn in a copy to your insurance company, if you so choose.

Our bank charges us a $15.00 fee for any bounced checks. Therefore, if you bounce a check, please be prepared to pay that fee.

Thank you for your understanding and cooperation.

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1900 L St. NW Suite 740
Washington, D.C. 20036
(202) 783-9404

Sign: ____ Date: ____________________________

Print: ____

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Women's Fertility History

Confidential

Age at which menses began: ________
Are your periods painful? | Yes | No
How many days does the pain last? _______
How many days do you normally bleed? _______
How heavy is the bleeding? | Light | Normal | Heavy
What color is the blood? | Light Red | Red | Dark Red | Purple | Brown | Black
Is there clotting? | Yes | No
Do you have premenstrual tension? | Yes | No
Does your face break out before or during your period? | Yes | No
Do you bleed or spot between periods? | Yes | No
Are your menstrual cycles spaced irregularly? | Yes | No
How many days are there from one period to the next? _______
Date of last menstrual period: _____________

	Number	Years
How many pregnancies have you had?	______	______
How many children do you have?	______	______
How many abortions have you had?	______	______
How many miscarriages have you had?	______	______
How many times has D&C been performed?	______	______

Have you ever had an abnormal pap smear? | Yes | No
Have you ever had a cervical biopsy, operation, cauterization, or conization? | Yes | No
Have you ever had a sexually transmitted infection? | Yes | No
Do you get yeast infections regularly? | Yes | No
Have you ever been diagnosed with chlamydia? | Yes | No
Do you have chronic vaginal discharge? | Yes | No
Do you have any sores on your genitalia? | Yes | No
Date of last Pap smear: ____________
Have you ever been diagnosed with uterine fibroids or polyps? | Yes | No
Have you ever been diagnosed with endometriosis? | Yes | No

Have you been diagnosed with pelvic adhesions? | Yes | No
Have you been diagnosed with pelvic abnormalities? | Yes | No
Have you taken any medications for gynecological conditions other than contraceptives? | Yes | No

Medication	Reason	How long?
_______________	_______________	_______________
_______________	_______________	_______________

Have your cycle changed since they began? | Yes | No
How?
____
____

Do you ovulate on your own? | Yes | No
On what day of your cycle? __________
Do your breasts get tender at/during ovulation? | Yes | No
Do you get premenstrual low back pain? | Yes | No
Do your bowel movements become loose at the beginning of your period? | Yes | No
Have you ever had fertility treatments? | Yes | No
If yes, by whom, and where?
____
____

What types of treatment? ________________________________
Have you taken medication to help you ovulate? | Yes | No
When? __________
How long? __________
Have your fallopian tubes been evaluated medically? | Yes | No What were the results? ________________________________ Have you had any tubal operations? | Yes | No
Have you had any hormone laboratory tests performed? | Yes | No
What were the results? _______________________________

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Women's Fertility History (pg 2)

Confidential

Do you have a single partner with whom you have been trying to conceive? | Yes | No

How long have you been married or living together? __________

If your partner is male, has he had a fertility workup? | Yes | No | N/A

If yes, what were the results?

____

____

Is your partner supportive of your wish to conceive? | Yes | No

Have you taken oral contraceptives? | Yes | No

How long? __________

Have you ever had an IUD? | Yes | No

When? __________

How long? __________

How long have you been trying to conceive? __________

Have you had a diagnosis related to infertility? | Yes | No

What was it?

____

How is your sexual energy? | Low | Normal | High

Are you more than 20% over your ideal body weight? | Yes | No Are you more than 20% below your ideal body weight? | Yes | No Do you have a stressful occupation? | Yes | No

Do you exercise regularly? | Yes | No

Have you been exposed to any environmental toxins or hormones? | Yes | No

Are you presently taking steroids? | Yes | No

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent YES answers for more than one diagnostic category.

DIAGNOSIS

KIDNEY YIN DEFICIENCY (Ki Yi-)

Do you have lower back weakness, soreness, or pain, or knee problems? ☐Yes ☐No

Do you have ringing in your ears or dizziness? ☐Yes ☐No

Does your hair prematurely gray? ☐Yes ☐No

Do you have vaginal dryness? ☐Yes ☐No

Is your midcycle fertile cervical mucus scanty or missing? ☐Yes ☐No

Do you have dark circles around or under your eyes? ☐Yes ☐No

Do you have night sweats? ☐Yes ☐No

Are you prone to hot flashes? ☐Yes ☐No

Would you describe yourself as fearful? ☐Yes ☐No

DIAGNOSIS

KIDNEY YANG DEFICIENCY (Ki Yan-) ☐Yes ☐No

Do you have lower back premenstrually? ☐Yes ☐No

Is your low back sore or weak? ☐Yes ☐No

Are your feet cold, especially at night? ☐Yes ☐No

Are you typically colder than those around you? ☐Yes ☐No

Is your libido low? ☐Yes ☐No

Are you often fearful? ☐Yes ☐No

Do you wake up at night or early in the morning because you have to urinate? ☐Yes ☐No

Do you urinate frequently, and is the urine diluted and/or profuse? ☐Yes ☐No

Do you have early morning loose, urgent stools? ☐Yes ☐No

Do you have profuse vaginal discharge? ☐Yes ☐No

Does your menstrual blood tend to be dull in color? ☐Yes ☐No

Do you feel cold cramps during your period that respond to a heating pad? ☐Yes ☐No

DIAGNOSIS

SPLEEN QI DEFICIENCY (Sp-)

Are you often fatigued?	☐Yes ☐No
Do you have poor appetite?	☐Yes ☐No
Is you energy lower after a meal?	☐Yes ☐No
Do you feel bloated after eating?	☐Yes ☐No
Do you crave sweets?	☐Yes ☐No
Do you have loose stools, abdominal pain, or digestive problems?	☐Yes ☐No
Are you hands and feet cold?	☐Yes ☐No
Is your nose cold?	☐Yes ☐No
Are you prone to feeling heavy or sluggish?	☐Yes ☐No
Are you prone to feeling heaviness or grogginess in the head?	☐Yes ☐No
Do you bruise easily?	☐Yes ☐No
Do you think you have poor circulation?	☐Yes ☐No
Do you have varicose veins?	☐Yes ☐No
Are you lacking strength in your arms and legs?	☐Yes ☐No
Are you lacking in exercise?	☐Yes ☐No
Are you prone to worry?	☐Yes ☐No
Have you been diagnosed with low blood pressure?	☐Yes ☐No
Do you sweat a lot without exerting yourself?	☐Yes ☐No
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	☐Yes ☐No
Are you more tired around ovulation or menstruation?	☐Yes ☐No
Do you ever spot a few days or more before your period comes?	☐Yes ☐No
Have you ever been diagnosed with uterine prolapse?	☐Yes ☐No
uterus?Are you often sick, or do you have allergies?	☐Yes ☐No
Have you been diagnosed with hypothyroid or anemia?	☐Yes ☐No
Do you have hemorrhoids or polyps?	☐Yes ☐No

DIAGNOSIS

BLOOD DEFICIENCY (BI-) (not necessarily equated with anemia)

Are your menses scanty and/or late?	☐Yes ☐No
Do you have dry, flaky skin?	☐Yes ☐No
Are you prone to getting chapped lips?	☐Yes ☐No
Are your fingernails or toenails brittle?	☐Yes ☐No
Are you losing hair on your head (not in patches, but all over)?	☐Yes ☐No
Is your hair brittle or dry?	☐Yes ☐No
Do you have diminished nighttime vision?	☐Yes ☐No
Do you get dizzy or light-headed around your period?	☐Yes ☐No

DIAGNOSIS

BLOOD STASIS

Is your menstrual flow ever brown or black in color?	☐Yes ☐No
Do you feel midcycle pain around your ovaries?	☐Yes ☐No
Do you have painful breast lumps?	☐Yes ☐No
Do you experience periodic numbness of your hands and feet (especially at night)?	☐Yes ☐No
Do you have varicose or spider veins?	☐Yes ☐No
Do you have red hemangiomas (cherry red spots) on your skin?	☐Yes ☐No
Do you have hemorrhoids?	☐Yes ☐No
Does your menstrual blood contain clots?	☐Yes ☐No
Have you been diagnosed with endometriosis or uterine fibroids?	☐Yes ☐No
Is your lower abdomen tender to palpation (resisting touch)?	☐Yes ☐No
Can you feel any abnormal lumps in your lower abdomen?	☐Yes ☐No
Do you have piercing or stabbing menstrual cramps?	☐Yes ☐No
Do you have dark spots in your eyes?	☐Yes ☐No
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	☐Yes ☐No

DIAGNOSIS

LIVER QI STAGNATION

Are you prone to emotional depression? ☐Yes ☐No

Are you prone to anger quickly? ☐Yes ☐No

Do you become irritable premenstrually? ☐Yes ☐No

Do you feel bloated or irritable around ovulation? ☐Yes ☐No

Does it feel as if your ovulation lasts longer than it should? ☐Yes ☐No

Are your breasts sensitive/sore at ovulation? ☐Yes ☐No

Do you experience nipple pain or discharge? ☐Yes ☐No

Do you have a lot of premenstrual breast distension or pain? ☐Yes ☐No

Have you been diagnosed with elevated prolactin levels? ☐Yes ☐No

Do you become bloated premenstrually? ☐Yes ☐No

Are your pupils usually dilated and large? ☐Yes ☐No

Do you have difficulty falling asleep at night? ☐Yes ☐No

Do you experience heartburn or wake up with a bitter taste in your mouth? ☐Yes ☐No

Are your menses painful? ☐Yes ☐No

Do you feel your menstrual cramps in the external genital area? ☐Yes ☐No

Is your menstrual blood thick and dark, or purplish in color? ☐Yes ☐No

DIAGNOSIS

HEART DEFICIENCY (Ht-) (*often associated with heat*)

Do you wake up early in the morning and have trouble getting back to sleep? ☐Yes ☐No

Do you have heart palpitations, especially when anxious? ☐Yes ☐No

Do you have nightmares? ☐Yes ☐No

Do you seem low in spirit or lacking in vitality? ☐Yes ☐No

Are you prone to agitation or extreme restlessness? ☐Yes ☐No

Do you fidget? ☐Yes ☐No

Do you sweat excessively, especially on your chest? ☐Yes ☐No

DIAGNOSIS

EXCESS HEAT (^H)

Is your pulse rate rapid?	☐Yes ☐No
Is your mouth and throat usually dry?	☐Yes ☐No
Are you thirsty for cold drinks most of the time?	☐Yes ☐No
Do you often feel warmer than those around you?	☐Yes ☐No
Do you wake up sweating or have hot flashes?	☐Yes ☐No
Do you break out with red acne (especially premenstrually)?	☐Yes ☐No
Do you have a short menstrual cycle?	☐Yes ☐No
Do you have vaginal irritation or rashes?	☐Yes ☐No

DIAGNOSIS

DAMPNESS (D)

Do you feel tired and sluggish after a meal?	☐Yes ☐No
Do you have fibrocystic breasts?	☐Yes ☐No
Do you have cystic or pustular acne?	☐Yes ☐No
Do you have urgent, bright, or foul-smelling stools?	☐Yes ☐No
Does your menstrual blood contain stringy tissue or mucus?	☐Yes ☐No
Are you prone to yeast infections and vaginal itching?	☐Yes ☐No
Do your joints ache, especially with movement?	☐Yes ☐No
Are you overweight?	☐Yes ☐No

DIAGNOSIS

DAMP HEAT (DH)

Do you have signs of heat and/or dampness as indicated above?	☐Yes ☐No
Do you have foul-smelling, yellow, or greenish vaginal discharge?	☐Yes ☐No
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?	☐Yes ☐No

DIAGNOSIS

COLD UTERUS (CW)

Do you fit the Kidney Yang deficiency (Ki Yan-) category?	☐Yes ☐No
Do you fall into the Blood stasis pattern?	☐Yes ☐No
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	☐Yes ☐No