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 _____

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Medical History

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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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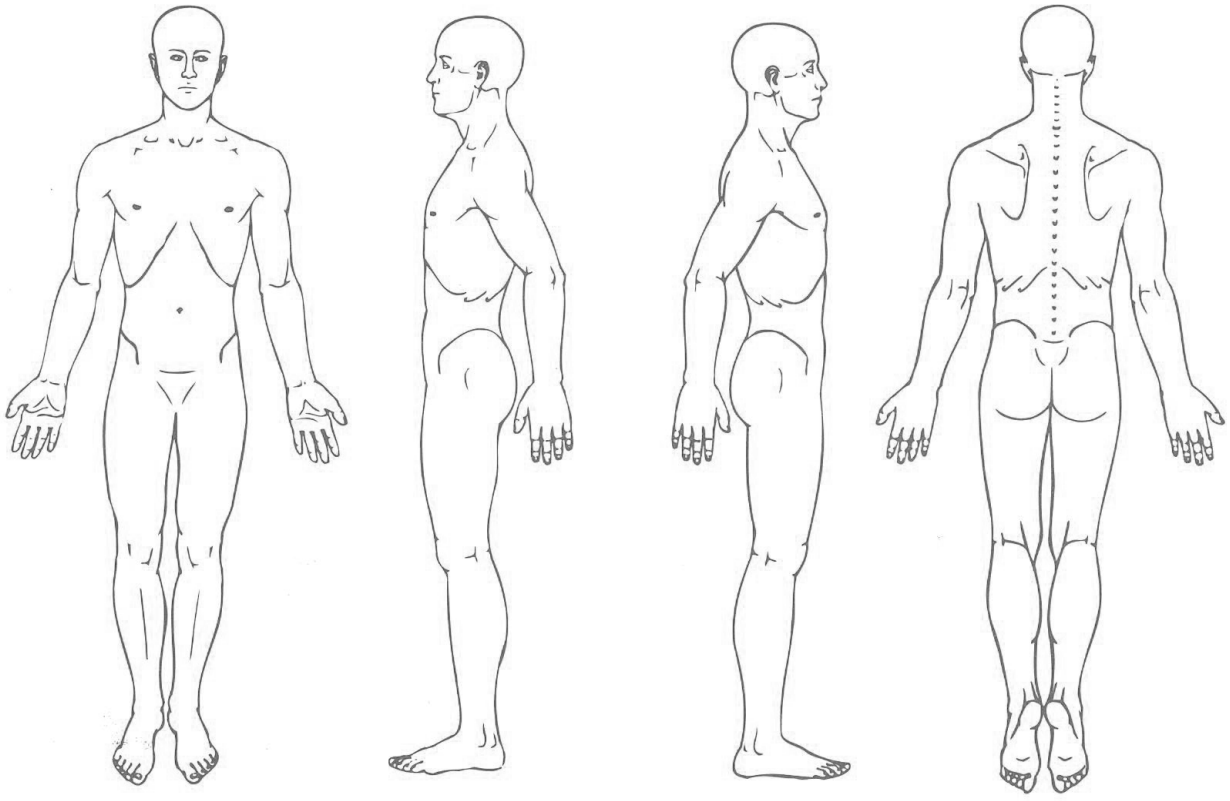
Pain Assessment

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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Sign: _____ Date: _____

Print: _____