

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 dizziness. 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 intend 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

1900 L St. Suite 740 • Washington, DC 20036 • 202-783-9404

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)			
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> CONNECTIVE TISSUE DISEASE	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> THYROID DISEASE
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> DIABETES	<input type="checkbox"/> KIDNEY STONES	<input type="checkbox"/> VENEREAL DISEASE
<input type="checkbox"/> AUTOIMMUNE DISEASE	<input type="checkbox"/> GALLSTONES	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> AIDS	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> RUPTURED APPENDIX	_____
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> SEIZURES	_____



Washington Acupuncture & Traditional Chinese Medicine

1900 L St. Suite 740 • Washington, DC 20036 • 202-783-9404

Health History

CONFIDENTIAL

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> General | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Do not exercise | <input type="checkbox"/> Emotional |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Exercise regularly | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Recurrent bronchitis | <input type="checkbox"/> Exercise excessively | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Dizziness | | | <input type="checkbox"/> Often feel angry |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Weight | <input type="checkbox"/> Troubling dreams |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Underweight | <input type="checkbox"/> Cry uncontrollably |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Normal for height | <input type="checkbox"/> Feel sad a lot |
| <input type="checkbox"/> Excess thirst | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Overweight | <input type="checkbox"/> Forgetful |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Very overweight | <input type="checkbox"/> Mind not clear |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Dark urine | <input type="checkbox"/> Much fear |
| <input type="checkbox"/> Sweat spontaneously | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Unrestrained joy |
| <input type="checkbox"/> Night sweating | <input type="checkbox"/> Hypochondriac pain | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Terrors |
| <input type="checkbox"/> Lack of sweating | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Burning urination | <input type="checkbox"/> Difficulty expressing emotions |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Profuse urine | <input type="checkbox"/> Men Only |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Bloating | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Genital pain |
| <input type="checkbox"/> Aversion to heat | <input type="checkbox"/> Belching | <input type="checkbox"/> Poor bladder control | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Aversion to cold | <input type="checkbox"/> Gas | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Genital sores |
| <input type="checkbox"/> Head & Neck | <input type="checkbox"/> Constipation | <input type="checkbox"/> Skin | <input type="checkbox"/> Lump in testicles |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Diarrhea/loose stools | <input type="checkbox"/> Thin skin | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Phlegm in throat | <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Broken blood vessels | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Black stools | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Women Only |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Dark circles around eyes | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Bags under eyes | <input type="checkbox"/> Bleed between periods |
| <input type="checkbox"/> Eye pain/strain | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Lumps in groin | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Lumps under arms | <input type="checkbox"/> Heavy Periods |
| <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Stomachache | <input type="checkbox"/> Dry skin | <input type="checkbox"/> <25 day cycle |
| <input type="checkbox"/> Loss of sense of smell | <input type="checkbox"/> Nausea | <input type="checkbox"/> Acne | <input type="checkbox"/> >35 day cycle |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Brittle nails | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Diet/Lifestyle | <input type="checkbox"/> Premature gray hair | <input type="checkbox"/> Premenstrual tension |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Dry, brittle hair | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Balanced diet | <input type="checkbox"/> Hair falling out | <input type="checkbox"/> Contraceptives |
| <input type="checkbox"/> Red/inflamed eye | <input type="checkbox"/> Eat much fried foods | <input type="checkbox"/> Neurologic | <input type="checkbox"/> Sores on genitalia |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Eat much meat | <input type="checkbox"/> Fainting | <input type="checkbox"/> Change in vaginal discharge |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Smoke cigarettes | <input type="checkbox"/> Handwriting change | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Sores on lips | <input type="checkbox"/> Drink alcohol | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Menopausal |
| <input type="checkbox"/> Sores on tongue | <input type="checkbox"/> Drink coffee | <input type="checkbox"/> Stroke | <input type="checkbox"/> Facial hair |
| <input type="checkbox"/> Taste change | <input type="checkbox"/> Use drugs (illicit drug use) | <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of head hair |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Consume marijuana | <input type="checkbox"/> Vertigo | <input type="checkbox"/> May be pregnant |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Eat a lot of sweets | | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Take melatonin | | |
| <input type="checkbox"/> Hay fever | | | |

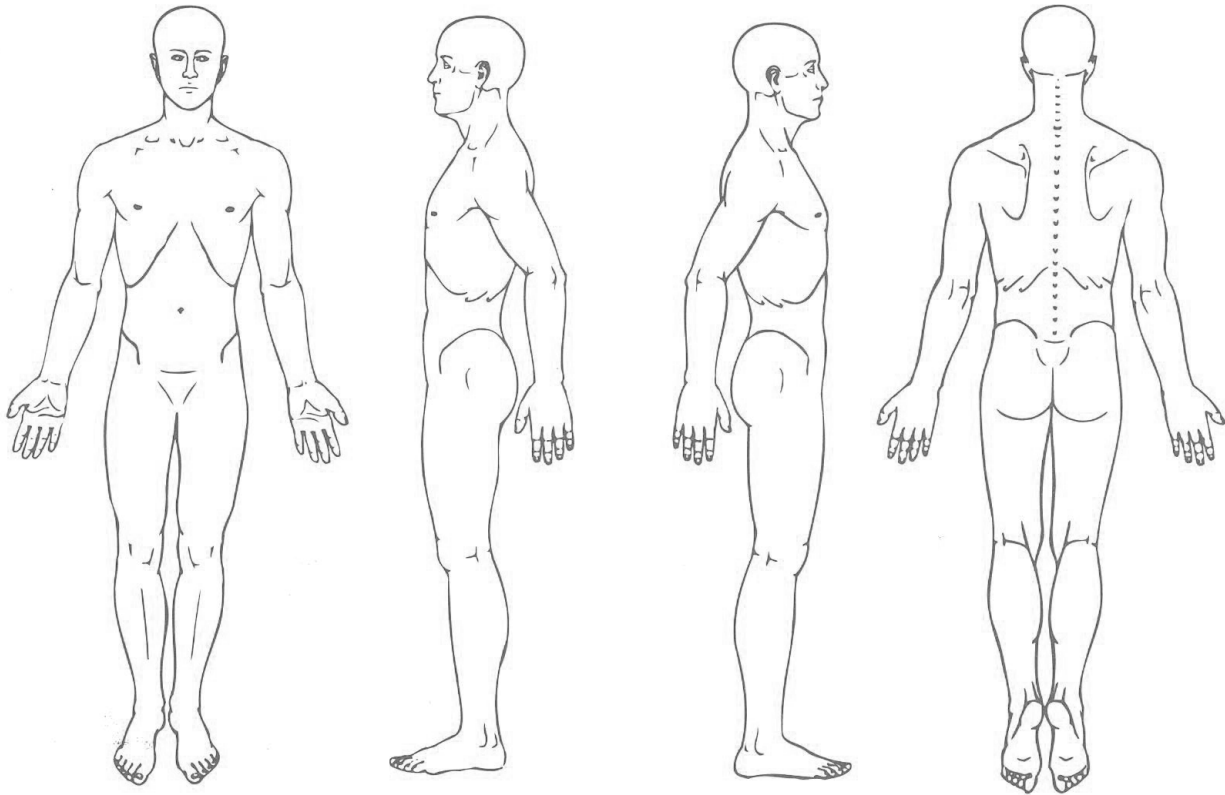


Washington Acupuncture & Traditional Chinese Medicine

1900 L St. Suite 740 • Washington, DC 20036 • 202-783-9404

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



Washington Acupuncture & Traditional Chinese Medicine

1900 L St. Suite 740 • Washington, DC 20036 • 202-783-9404

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 appreciate as much notice as possible.

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

Washington Acupuncture & Traditional Chinese Medicine
1900 L St. NW Suite 740
Washington, D.C. 20036
(202) 783-9404

Sign: _____ Date: _____

Print: _____



Washington Acupuncture & Traditional Chinese Medicine

1900 L St. Suite 740 • Washington, DC 20036 • 202-783-9404

MEN'S FERTILITY HISTORY

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)	DATE
----------------------------	------

HOW LONG HAVE YOU AND YOUR PARTNER BEEN TRYING TO CONCEIVE ? _____

HOW WOULD YOU DEFINE YOUR SEXUAL ENERGY ? BELOW NORMAL NORMAL

- | | YES | NO |
|---|--------------------------|--------------------------|
| DO YOU HAVE AN UNDESCENDED TESTES ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU EVER BEEN DIAGNOSED WITH A VARICOCELE ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU HAD ANY UROLOGIC SURGERIES ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU EXPERIENCED DIFFICULTY MAINTAINING ERECTION ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU EXPERIENCED DIFFICULTY EJACULATING ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU HAD EXPOSURE TO ANY KNOWN ENVIRONMENTAL TOXINS OR HORMONES ? | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU EXPERIENCED ANY PENILE DISCHARGE | <input type="checkbox"/> | <input type="checkbox"/> |
| DO YOU REGULARLY EXPERIENCE NOCTURNAL DISCHARGE ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU HAD A FERTILITY WORKUP ?..... | <input type="checkbox"/> | <input type="checkbox"/> |

IF YES , WHAT WAS YOUR SPERM COUNT ? BELOW NORMAL NORMAL NUMBER _____

WHAT WAS THE SPERM MOTILITY ? BELOW NORMAL NORMAL NOTES _____

WHAT WAS THE SPERM MORPHOLOGY ? ABNORMAL NORMAL NOTES _____

COMMENTS / NOTES :