Essence
ACUPUNCTURE

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NEW PATIENT FORMS

Please take the time to fill out this questionnaire completely and carefully to help us provide you with a complete health evaluation. We realize that some questions may seem irrelevant to your main problem, but they are significant in helping us to make an accurate diagnosis and formulate an appropriate treatment plan. All your answers are absolutely confidential. If you have any questions, please ask. Thank you.

Patient Name _____ Date _____

Address _____

_____

Date of Birth _____ Age _____ Height _____ Weight _____

Occupation _____ Marital Status _____

Preferred Contact Number: _____ Email _____

Primary Physician _____ Emergency Contact _____

Phone _____ Referred by _____

Main Complaint
(symptoms, diagnosis, duration, etc.)

Have you received acupuncture or Oriental medicine before? YES NO

What is your main complaint? _____

_____

_____

When did this problem first begin? How often does this bother you? _____

_____

_____

Severity of the problem on a scale of 0-10 (0 = best; 10 = worst) _____

If there is pain involved, what is the quality of the pain? (Circle all that apply)

Dull Achy Burning Sharp Stabbing Cold Numb Tingling Throbbing

What makes the problem feel better? (Circle all that apply)

Heat Cold Damp weather Wind Rest Work Other

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc)?

Have you been given a diagnosis for this problem? YES NO

What kinds of treatment have you tried?

Significant Trauma (physical or emotional)

Surgeries (please include date of procedure)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise: Length of workout, type of activity, days per week

Diet: meals per day, snacks, caffeinated drinks, alcohol per week

Personal History

Please circle any conditions or symptoms you have now or have had in the past.

Arthritis
High/Low Blood Pressure
Thyroid Imbalance
Cancer
Ulcer
Chronic Pain
Gastritis/Pancreatitis
Bleeding Tendency
Meningitis
Liver/Gall Bladder Disease
Hypo/Hyperglycemia
Diabetes
Respiratory Allergies
Impotence
Emphysema
Chronic Fatigue
Alcoholism
Hepatitis
Asthma
Migraines
Hepatitis
Heart Disease
High Cholesterol
Diverticulitis/IBS
Raynaud's Disease
Infertility
Nervous Disorders
Kidney Disease
Food Allergies/ Intolerance
Seizures
Anemia
Lyme Disease
HIV/AIDS
Syphilis
Other_____

Family Medical History

Diabetes	Seizures	Heart Disease	Stroke
High Blood Pressure	Allergies	Cancer	Asthma

Other_____

General

Please circle symptoms that you have experienced within the last year.

Poor Appetite	Poor Sleeping	Fatigue	Fevers
Chills	Night Sweats	Sweats Easily	Tremors
Cravings	Localized Weakness	Poor Balance	Change in Appetite
Bleed/Bruise Easily	Weight loss/gain	Peculiar tastes/smells	Dental/Gum Problems
Muscle Weakness/ Fatigue	Sudden Energy Drop	Strong Thirst	

Skin and Hair

Rashes	Ulcerations	Hives/Allergic	Itching
Eczema/Psoriasis	Dandruff	Dermatitis	Recent Moles
Skin discoloration	Acne	Loss of hair	Face Flushing
Dermatitis	Warts	Change in skin/hair texture	Weak or ridged
			Fungal Infection

Head, Eyes, Ears, Nose and Throat

Dizziness	Difficulty swallowing	Migraines	Glasses
Eye Strain	Eye pain	Poor vision	Night Blindness
Color Blindness	Cataracts	Blurred vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes	Sinus problems
Nose bleeds	Recurrent sore throats	Grinding teeth	Facial pain
Sores on lips/tongue	Recurrent colds	Jaw clicks/locks	Headaches
			Dental problems

Cardiovascular

Chest pain or pressure	Irregular heart beat	Palpitations at rest	Fainting
Cold hands/feet	Swelling of hands/feet	Blood clots	Phlebitis
Shortness of breath	Varicose/spider veins	Pressure in chest	Dizziness
Low blood pressure	High blood pressure	Spontaneous sweating	Raynaud's Disease

Respiratory

Cough/Wheezing
Pneumonia
Difficulty breathing when lying down
Coughing blood
Pain with deep inhalation
Asthma Bronchitis
Tight sensation in chest
Production of phlegm
Bronchitis
Tight sensation in chest
Difficult inhale/exhale

Gastrointestinal

Nausea
Gas
Indigestion
Bloating/Edema
Changes in appetite
Excessive appetite
Vomiting
Belching
Bad breath
Chronic laxative use
Acid reflux/GERD
Significant thirst
Diarrhea
Black stools
Rectal pain
Loose stools (>2 per day)
Hernia
IBS/Crohn's Disease
Constipation
Blood in stool
Hemorrhoids
Abdominal pain/cramps
Poor appetite

Genitourinary

Pain on urination
Unable to hold urine
Impotence
Premature ejaculation
Nocturnal emission
Night urination...
Frequent urination
Kidney stones
Sores on genitals
Decreased libido
Pain in testicles
Blood in urine
Scanty flow
Urinary tract infection
Prostatitis
Herpes
Excessive libido
Urgent urination
Copious flow
Burning urination
Dribbling after urination
Infections
Low libido

Gynecological/Reproductive (Women Only)

Difficult/Painful intercourse
Vaginal dryness/itching
Vaginal sores
Vaginal discharge
Polycystic Ovarian Syndrome
Infertility
Pregnancies
Miscarriages Ovarian Cysts
Endometriosis
Uterine Fibroids
Fibrocystic breast tissue
STD
Births
Painful menstruation
Irregular menstruation
PMS
Ectopic Pregnancy

Birth control medications and duration of use _____

_____

Men's Health

Swollen testes
Testicular pain
Enlarged prostate
Premature Ejaculation
Impotence
Cancer (prostate or testicular)
Feeling of coldness or numbness in external genitalia
Difficult urination (weak stream or dribbling)
Sexually transmitted disease

Musculoskeletal

- Neck pain
- Knee pain
- Hip pain
- Back pain
- Soreness/weakness in lower body
- Shoulder pain
- Muscle pain
- Sprains/Strains
- Hand/wrist pain
- Sciatica
- Muscle weakness
- Bursitis
- Carpal Tunnel
- Foot/ankle pain
- Tendonitis
- Rotator Cuff

Neuropsychological

- Seizures
- Lack of coordination
- Anxiety/Panic attacks
- Nervousness
- Loss of balance Poor memory
- Bad temper/irritable
- ADD/ADHD
- Vertigo/Dizziness
- Concussion
- Easily susceptible to stress
- Manic Depression
- Areas of numbness
- Depression
- Seasonal Affective Disorder
- Other _____

Have you ever been treated for emotional problems? YES NO

Have you ever considered or attempted suicide? YES NO

Have you ever been treated for substance abuse? YES NO

Comments Please inform me of any other problems you would like to discuss.

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary health care services I may need.

Patient Signature: _____ Date: _____

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INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other Oriental medicine procedures on me (or on the patient named below, for which I am legally responsible) by the above named licensed acupuncturist. I understand that methods or treatments may include but are not limited to acupuncture, moxibustion, cupping, intra-dermal needles, ear press-balls, bloodletting, electrical stimulation, Tui Na (Chinese massage), Gua Sha, Chinese herbal medicine, and nutritional counseling.

Heat therapy using moxa (Artemisia), a dried herb, that is lit and burned on the needles or on the skin, or the use of a heat lamp in conjunction with needle therapy. Moxa is not burned directly on the skin, but on top of a burn ointment which will conduct the heat and prevent burns. On rare occasions, a blister may occur. The practitioner will explain the procedure as it is done and the patient is asked to let them know the status of the heat at all times.
Application of stainless steel press-balls onto various points in the ear. These are applied with adhesive tape and may be left in the ear for up to 7 days or as suggested by the practitioner.
Electrical stimulation of the needles using a battery operated machine to create a current through the needles may be used. This creates a constant vibration through the needles that would be adjusted according to patient comfort.
Cupping is a technique used to resolve muscle tightness or help clear the lungs in respiratory conditions. A glass cup is applied to the skin and then a pump suctions the skin and muscle into the cup. The amount of suction is adjusted according to patient comfort. Depending on how tight the muscles are and the amount of restricted blood flow, the cups can leave a reddish or purplish mark on the skin that clears up in a few days, similar to a bruise.
Gua sha is a technique similar to cupping where a flat tool is used to scrape the skin to relieve muscle tension and congested blood flow. It leaves a similar bruise-like "rash" that lasts for a few days.
Herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine. I understand the same herbs may be inappropriate during pregnancy and will inform my practitioner immediately of pregnancy status. If experience any gastrointestinal reactions to the herbs I will inform the acupuncturist immediately.

I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I also understand there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I also understand that any evaluation given to me in no way replaces western (allopathic) medical evaluation diagnosis and treatment.

INITIAL _____

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above. INITIAL _____

I agree to pay the full charge for any missed or forgotten appointments without 24-hour notice of cancellation.
INITIAL _____

Patient's Printed Name _____

Patient's Signature _____ DATE _____

Are you pregnant? YES NO

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation and will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information: _____

_____ _____

Patient's Signature _____ DATE _____

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OFFICE POLICIES

The following policies and procedures are in place to insure that your care is as efficient and effective as possible.

APPOINTMENTS: We make every effort to remain on schedule. We believe that respect between patient and practitioner includes respect for each other's time. If you are late, your remaining time may not be sufficient for a full treatment, so treatment will be tailored to fit within the time available or you have the option to reschedule. Occasionally, there are situations that arise that cause us to run over. If we are late, it will not effect the time of your treatment. If you have time constraints, please let us know.

It is recommended that you wear loose fitting clothing to appointments for your comfort and to make acupuncture points accessible. You may bring a pair of shorts or loose undershirt to change into.

CANCELLATION/LATE ARRIVAL POLICY:
Your appointment time is reserved solely for you, consequently, a 24-hour cancellation policy applies to your appointment. You may leave a message on our voice mail system at any time of day to cancel your appointment, and it will date and time stamp your call. If you are unable to cancel your appointment 24-hours in advance, a cancellation charge for the full treatment fee will apply. (If you must cancel due to an emergency, please explain to the clinic.)
Please do your best to arrive on time for your appointment. If you find that you are running late, please call the clinic to let your practitioner know and we will do our best to accommodate you, depending on schedule availability.

CONFIDENTIALITY: All information gathered within the context of treatment is held in strict confidence and will NOT be released without your written consent. However, if your insurance is covering your treatments, they have the right to request copies of all records pertaining to your treatment.

PAYMENT: Payment is expected at the time of the visit unless other arrangements have been made in advance. We accept cash, check, and PayPal. Acupuncture is covered by worker's compensation, auto insurance and a number of private insurance policies. Should you have coverage, we can discuss the procedure for billing and payment.

I have read and agree to the policies outlined above.

Signature of Patient: _____ Date: _____