

Stuart Acupuncture

PATIENT INFORMATION	CONTACT INFORMATION
Date _____ Name _____ Address _____ City State Zip _____ Age _____ Birthdate _____ Occupation _____ Company name _____ Primary physician _____ Physician phone number _____ How did you hear about me? _____ _____	Home phone _____ Work phone _____ Other/cell phone _____ Email (required) _____ Another person we may contact if needed: Name _____ Relationship _____ Home phone _____ Work phone _____

HEALTH HISTORY	
What are your primary concerns for coming in for treatment? 1- _____ 2- _____ 3- _____ How is your sleep? _____ _____ How is your digestion? _____ _____ List medications or vitamin supplements you are taking. _____ _____ List serious illnesses, accidents or surgeries. _____ _____ Check illnesses that have occurred in blood relatives. <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> High blood pressure <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Heart disease <input type="checkbox"/> <input type="checkbox"/> Kidney disease	Check symptoms you have or have had in the last year: <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty in focusing <input type="checkbox"/> Dizziness <input type="checkbox"/> Easily startled <input type="checkbox"/> Excessive worry <input type="checkbox"/> Excessive anger <input type="checkbox"/> Excessive fear <input type="checkbox"/> Fatigue/tiredness <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep/poor sleep <input type="checkbox"/> Loss or gain of weight <input type="checkbox"/> Nervousness/irritability <input type="checkbox"/> Overwhelmed by life Check conditions you have or have had in the past: <input type="checkbox"/> AIDS <input type="checkbox"/> Allergies <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Breast lump <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes How long has it been since you have had a complete medical exam? _____

HEALTH HISTORY...CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- Tremors c Cramps
- Swollen joints
- Pain, weakness, numbness in:
 - Arms or Hips
 - Back Legs
 - Feet
 - Neck
 - Hands
 - Shoulders
 - Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature _____ Date _____

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or 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 working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. **I will notify the acupuncturist who is caring for me if I am or become pregnant.**

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about 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 for any future condition(s) for which I seek treatment.

Acupuncturist:	Signature:	Date:
Patient Name:	Signature:	Date:
Patient Representative (if under 18):	Signature:	Date:

Stuart Acupuncture's Missed Visit Agreement

As a patient, or guardian of a patient, of Stuart Acupuncture, I understand that I must give at least 24 hours notice if I am going to miss a visit. I understand I can cancel my appointment via text, phone or email or that I can go online to cancel my appointment on www.stuartacupuncture.com. **If I do not give 24 hours notice, I understand I will need to pay a \$10 missed visit fee at my next appointment.**

Exceptions to this rule are: 1) first missed visit will not be charged. 2) last minute cancellation due to ill family member, car breakdown, work crisis or similarly serious reason.

Please understand that Stuart Acupuncture is a high-volume clinic that relies on patients showing up for their appointments. If you cannot make your appointment, please free up the spot for another patient by canceling at least 24 hours in advance either online, via email or phone, or via text.

I have read and understand my responsibilities with regards to appointment cancellation:

Signature: _____ Date: _____