CASE HISTORY FORM

Name _____ Birth Date ___/___/_____ Age _____

Address _____ Height _____ Weight _____

City _____ State ____ Zip _____ Marital Status: M S W D

Phone (____) _____-_____ Is this a mobil #: Yes / No # of Children _____

E-mail _____ Are you using insurance? _____

Emergency contact _____ Occupation_____

Relation _____ Phone _____ Employer _____

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture. The methods of treatment may include but are not limited to: acupuncture, electrical stimulation, manual therapies, cupping, moxibustion, tui-na, gua-sha, nutritional counseling, Chinese herbal medicine and supplements. I will immediately notify my acupuncturist of any unpleasant effects associated with the consumption of herbs or supplements.

I'm aware acupuncture is generally a safe method of treatment, but that occasionally there may be some dizziness, bruising, soreness, pain or tingling near the needle insertion sites that could last for several days. Unusual risks of acupuncture include nerve damage and organ puncture (this is extremely rare). I am aware that cupping & gua-sha procedures will leave visual marks on the skin that resemble bruising, and that these marks may last for up to 7-10 days. I understand that while this document describes major risks of treatment, other side effects and risks may occur.

CANCELATION POLICY

Your treatment plan is designed for optimal results, missed appointments will hinder your progress.

A $75.00 fee will be charged for missed/ "no show" appointments. If a treatment package has been purchased, one session will removed from your package for every missed appointment.

A $50 fee will be charged for cancellations within 24 hours of your appointment.

By voluntarily signing below, I show that I have read, understand & agree to the Informed Consent for Treatment and Cancelation Policy listed above. I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient Signature _____ **Date** _____

Please continue to next page

HEALTH HISTORY

Please identify the chief concerns that you would like to address today
1. _____
2. _____
3. _____

How did this condition develop? (what caused it / how did it start)
_____
_____
_____

How long have you had this condition? _____ Date symptoms began: ___ /___ /_____

Overall, my condition has been getting (circle best choice): Better / Worse / Staying the same

Have you had any of the following (circle all that apply): X-ray MRI CAT EEG EMG ECG

Recent lab tests: _____ When where these taken? _____

Have you ever been diagnosed with COVID? Yes / No If so, when? _____

Do you have any infectious diseases? Yes / No

If yes, please identify:_____

List any substances you are allergic to: _____

_____

What was your most recent blood pressure reading? ____ /____ Date taken: _____

FOR WOMEN ONLY:

Are you pregnant? Yes / No Are you nursing? Yes / No

Date of last menstrual cycle: _____

Age of menopause (if applicable): _____

Circle all that apply: irregular cycles / heavy cycles / scanty cycles / PMS / clotting / spotting

Age of first menses: _____ **|** Length of cycles: _____ **|** # of days of menstrual bleeding: _____

Are you on birth control? Yes / No If yes, what kind? _____

# of pregnancies _____ # of live births _____ # of miscarriages _____ # of abortions ____

PAIN ASSESMENT

List your current symptoms in order of severity.
On the scale below, circle the number that demonstrates your level of pain or discomfort.

Area of Symptoms **Severity:** 0= no pain, discomfort / 10= worst pain imaginable

1. _____ |----------| 0 1 2 3 4 5 6 7 8 9 10

2. _____ |----------| 0 1 2 3 4 5 6 7 8 9 10

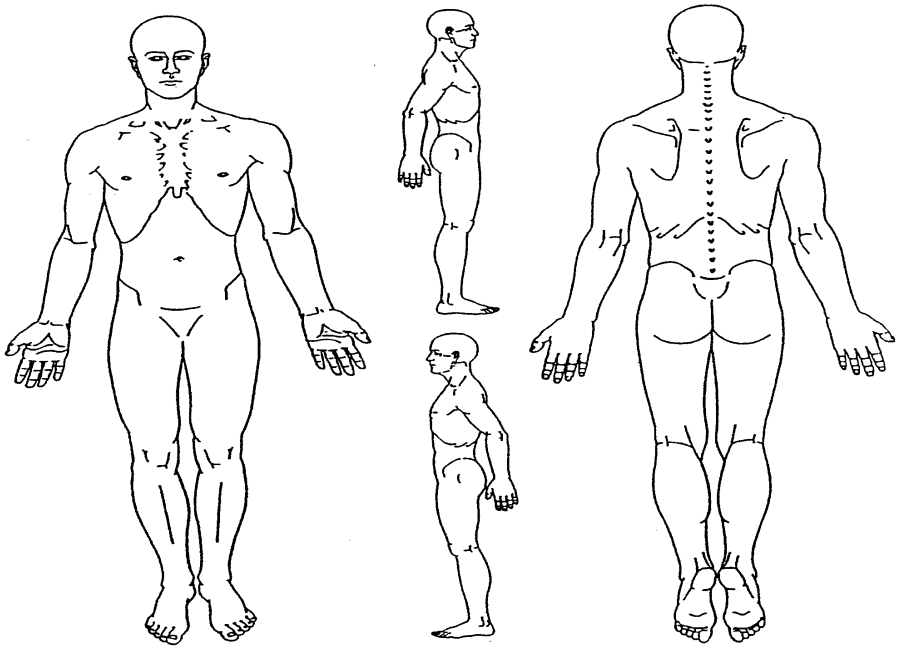
3. _____ |----------| 0 1 2 3 4 5 6 7 8 9 10

Does your pain interfere with any of the following? (circle all that apply):
work / sleep / daily routines / sports / recreation / Other: _____

Is your pain constant? Yes / No | Does your pain come & go? ? Yes / No
Is your pain getting: better / worse / staying the same
Have you had this or a similar condition before? Yes / No
If yes, please explain? _____

Type of Pain (circle all that apply):
Sharp / Dull / Achy / Throbbing / Stabbing / Shooting / Burning / Tingling / Cramping
Stiffness / Numbness / Pins & Needles / Other:_____

Mark your areas of pain with an 'X':



Patient Initials: _____ Please continue to next page

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you ever had acupuncture? Yes / No
2. Do you experience dizziness? Yes / No
3. Do you bruise easily? Yes / No
4. Do you bleed easily? Yes / No
5. Do you have a fear of needles? Yes / No
6. Do you experience fatigue? Yes / No
7. Do you have issues with digestion? Yes / No
8. How many hours of sleep do you get? _____

INSURANCE INFORMATION

Will you be using group, union, or personal health insurance? Yes / No

Name of Insurance Company _____ HMO / PPO / EPO / HSA

Member ID# _____ Group # _____

Is you injury work-related? Yes / No Where you involved in an automobile accident? Yes / No

If using insurance please provide a copy of the front and back of your health insurance card.

By way of my signature below, I acknowledge the above information to be correct to the best of my knowledge. Additionally, I give the treating provider my authorization and consent to review and disclose my health care information to other health care professionals for the purpose of treatment and heath care operations.

Patient Signature _____ Date _____

Your all done!

Please arrive 5 minutes early to your appointments,
it's beneficial to have a few minutes to sit and relax before being treated.

Do not come to an appointment hungry,
it's best to have eaten within 1-2 hours of your appointment.

Wear loose and comfortable clothing whenever possible.

PLEASE SILENCE YOUR CELL PHONE WHEN IN THE OFFICE