

Confidential Introductory Patient Information

Today's Date: _____

Name: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Business Phone: (____) _____

City: _____ State: _____ Zip: _____ Email Address: _____

Birthdate: ____/____/____ Age: _____ Gender: Male Female Occupation: _____

Marital Status: _____ Number of Children: _____ Ages: _____

Contact in emergencies: _____ Phone: _____

Referred by: _____ Name of Primary Care Physician: _____

What would you like treated with Acupuncture? _____

How long have you had this condition? _____ The onset was Sudden Gradual

What medical diagnosis have you received? _____

What other treatments you have received for this and/or other conditions? (chiropractic, physical therapy, massage, etc.) _____

In general, do you feel hot or cold? _____ Do you have chills or fever? _____

Please list any medications, herbs, or supplements you are currently taking, whether prescription or nonprescription:

Names of Medications/Supplements	For what condition(s)?

FAMILY HISTORY: Place an X in the box indicating any illness that your family members have ever had.

	Father	Mother	Brother	Sister	Children
Allergies					
Blood Disorders/Anemia					
Diabetes					
Cancer or Tumors					
Seizures					
High Blood Pressure					
Drug Abuse					
Tuberculosis					
Heart Disorder					
Stroke					
Other _____					

Please check all that apply to you. Please *circle* any conditions that you have *currently*:

IMMUNE SYSTEM

- Frequent Childhood Illnesses
- Frequent colds or sore throats
- Allergies / Hay Fever
- Sinusitis
- Lymph nodes enlarged
- Other _____

RESPIRATORY

- Shortness of breath
- Asthma
- Chronic Cough
- Coughing Blood
- Difficulty Breathing
- Other _____

EARS

- Ringing in ears
- Clogged ears/Popping ears
- Hearing loss
- Other _____

NOSE, THROAT & MOUTH

- Nose bleeds
- Sinus Infection
- Sore throat
- Hoarseness
- Difficulty swallowing
- Changes in taste
- Changes in smell
- Tooth pain
- Other _____

GENERAL

- Insomnia
- Frequent Dreams/Nightmares
- Depression
- Anxiety
- Fatigue
- Numbness/Tingling
- Neck stiffness
- General body pain
- Frequent Headaches
- Back pain
- Muscle pain
- Difficulty walking
- Urinary difficulty
- Frequent Urination
- Nighttime Urination
- Blurry vision
- Aversion to Cold
- Aversion to Heat
- Other _____

MEDICAL CONDITIONS

- Migraine Headaches
- Convulsions/Seizures
- HIV/Aids
- Tuberculosis
- Hepatitis A/B/C
- STD: _____
- Diabetes
- Hypoglycemia
- High Cholesterol

GASTROINTESTINAL

- Nausea
- Indigestion
- Stomach pain
- Excess gas/bloating
- Constipation
- Diarrhea
- Excess appetite
- Reduced appetite
- Vomiting blood
- Blood in stools/ Black Stools
- Recent weight change
- Other _____

SKIN

- Itching
- Hives
- Eczema
- Acne
- Skin Rashes
- Dry skin
- Night sweating
- Excess sweating
- Bruise easily
- Other _____

CARDIOVASCULAR

- Palpitations
- Chest pain or tightness
- Rapid heart beat
- High blood pressure Rate: _____
- Poor circulation
- Ankle swelling
- Phlebitis / Vascular problems

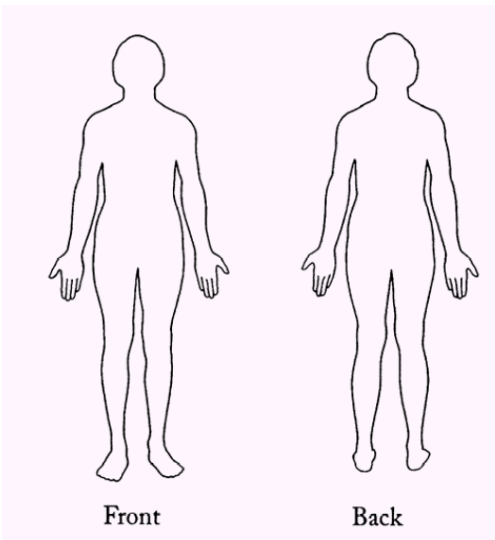
FEMALE REPRODUCTIVE SYSTEM

- Urinary Tract Infections
- Vaginal infections
- Pain/itching of genitalia
- Vaginal lesions/discharge
- Pelvic Inflammatory Disease
- Abnormal pap smears
- Irregular menstrual periods
- Painful menstrual periods
- PMS
- Abnormal bleeding
- Menopause symptoms/Hot flashes
- Other _____

MALE REPRODUCTIVE SYSTEM

- Pain/Itching of genitalia
- Genital lesions/discharge
- Impotence
- Weak urinary stream
- Prostatitis
- Injury/Lumps in Testicles
- Other _____

Please shade in the area which you feel needs to be addressed.



Patient Advisory to Consult a Physician

We, the undersigned, do affirm that _____ (patient) has been advised by Tricia Smith, L.Ac., (licensed acupuncturist), to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

Informed Consent to Acupuncture Treatment

I consent to acupuncture treatments and other techniques associated with Traditional Oriental Medicine. I am aware that acupuncture is performed by the insertion of pre-sterilized disposable needles. The techniques used along with acupuncture may include moxibustion, cupping, gua sha and electrical stimulation.

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. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture including lung puncture (pneumothorax).

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.

Signature of Patient or Patient's Representative

Date

Print Name of Patient