

Confidential Introductory Patient Information

Today's Date: _____

Name: _____ Home Phone: (____) _____ Cell Phone: (____) _____
Address: _____ Business Phone: (____) _____ Fax: (____) _____
City: _____ State: _____ Zip: _____ Email Address: _____
Birth date: _____ Gender: _____ Number of Children: ____ Ages: _____
Occupation: _____ Contact in emergencies: _____ Phone: _____
Referred by: _____

Insurance Information

Insurance Provider: _____
Provider's Address and Phone: _____
Social Security Number: _____ Member ID: _____ Group ID: _____
Employer (Name and Address): _____
Insured's Name and Date of Birth (if other than patient): _____

Primary complaint: _____
How long have you had this condition? _____
Secondary complaint: _____
How long have you had this condition? _____
Please list any medications, herbs, or supplements you are currently taking, whether prescription or non-prescription: _____

Serious Illnesses/Injuries/Surgeries/Hospitalizations	Dates	Outcome

<input checked="" type="checkbox"/>	Allergies/Sensitivities (please specify)	Typical Reaction
<input type="checkbox"/>	Pollen:	
<input type="checkbox"/>	Medications:	
<input type="checkbox"/>	Animal hair:	
<input type="checkbox"/>	Dust, molds:	
<input type="checkbox"/>	Food:	
<input type="checkbox"/>	Other:	

Please check all that apply to you:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Frequent childhood illness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Frequent colds or sore throat | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hot body temperature | <input type="checkbox"/> Eye pain, redness, dryness, or itching |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Seeing spots |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Ear pain |
| <input type="checkbox"/> Lymph nodes enlarged | <input type="checkbox"/> Urinary difficulty | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Lymph nodes removed | <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Hair dry or brittle | <input type="checkbox"/> Clogged/popping ears |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sugar cravings | <input type="checkbox"/> Premature greying | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Nails brittle | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Excess appetite | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Hypotension |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Reduced appetite | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Excess weight gain | <input type="checkbox"/> Sad/depressed | <input type="checkbox"/> Heart conditions, please specify: _____ |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Excess weight loss | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blood Pressure: _____/_____ |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Irritability | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Skin rashes | <input type="checkbox"/> Bloating | <input type="checkbox"/> Panic attacks | |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Constipation | <input type="checkbox"/> Rapid heartbeat or palpitations | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Water retention | |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Dry mouth | |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Excess thirst | <input type="checkbox"/> Cold sores | |
| <input type="checkbox"/> Venereal diseases | <input type="checkbox"/> Excess sweating | <input type="checkbox"/> Dental problems | |
| | <input type="checkbox"/> Numbness | | |
| | <input type="checkbox"/> Muscle spasms | | |
| | <input type="checkbox"/> Aches/pains | | |
| | <input type="checkbox"/> Cold hands/feet | | |

Men:

Check all that apply:

- Prostatitis Impotence
 Other, please specify: _____

Women:

At what age did you start menstruating? _____ Age at menopause (if applicable) _____

Number of days between cycles: _____

Number of days of flow: _____ Color: _____

Check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Hormone replacement | <input type="checkbox"/> Menopausal symptoms, please specify: _____ |
| <input type="checkbox"/> Light flow | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> No flow | <input type="checkbox"/> PMS symptoms, please specify: _____ | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Spotting between periods | _____ | _____ |
| <input type="checkbox"/> Discomfort or pain before period | <input type="checkbox"/> Birth control, please specify: _____ | |
| <input type="checkbox"/> Discomfort of pain during period | | |

Number of pregnancies: _____

Number of deliveries: _____

Family Medical History (Please list any significant family illnesses)

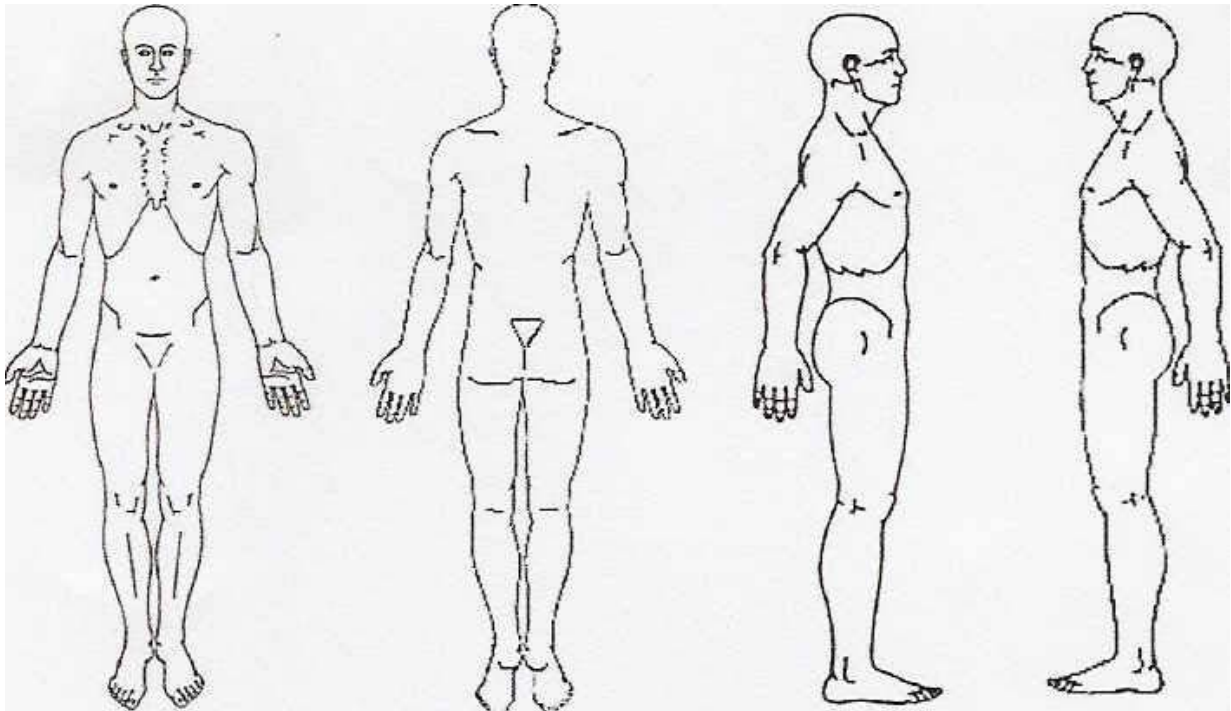
Mother _____

Father _____

Siblings _____

Grandparents _____

On the following drawing, please shade the areas that you would like addressed:



Please Note:

This office has a 24 hour cancellation policy. We ask that you notify us well in advance if you need to cancel or change your appointment. Payment in full will be due for all sessions cancelled with less than 24 hours. Monday appointments must be cancelled by Friday.

By signing here I agree to pay for any missed appointment when it is not cancelled with a minimum of 24 business hours notice.

Signed

Printed Name

Date: _____

Informed Consent

I consent to acupuncture treatments and related procedures associated with Oriental Medicine, by Janet Humphrey, L.Ac. and Carole Johnson, L.Ac. I understand that the methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, gua sha, tui-na, electrical stimulation, Chinese herbology and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have minor side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases, dizziness or fainting. This office uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of moxibustion. There may be some bruising after cupping and gua sha that may last a few days. There have been very rare instances reported of spontaneous miscarriage and pneumothorax. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements that are used are traditionally considered safe in the practice of Oriental Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs I will stop taking them and immediately inform the acupuncturist.

I will notify the acupuncturist should I become pregnant or if I am trying to become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the acupuncturist to exercise judgment during the course of treatment, and decide what she thinks is in my best interest, based upon the facts that are known at the time. I understand the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I have been informed 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 and for any future conditions for which I seek treatment.

Signature of Patient or Patient's Representative

Date