ACUPUNCTURE INFORMED CONSENT TO TREAT

Please read and sign below if the practitioner you are seeing has an acupuncture license.

I understand that acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. I understand that my care providers will appropriately assume I am under the care of a primary care physician or medical specialist; that if I am pregnant or nursing, I am being managed by an appropriate healthcare professional; and that if I have cancer, I am under the care of an oncologist.

I have been informed that there are risks to acupuncture and other care techniques practiced at the Clinic, including, but not limited to: infection; bruising; numbness or tingling near the needling sites that may last a few days; nerve damage; organ puncture; and dizziness or fainting. Burns and/or scarring are potential risks of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping.

I understand that the herbs used or recommended in my course of care may need to be prepared and the teas consumed according to the instructions provided. Some herbs may have an unpleasant odor or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects that may occur. I understand that herbs and nutritional that may be recommended may be toxic in large doses. I also understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above 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.

______________________________	______________________________	____________
Printed Name of Patient/Guardian/Guarantor	**Signature of Patient/Guardian/Guarantor**	**Date**

Patient Health Questionnaire

Holistic Health and preventative care are only possible when the provider has complete understanding of the patient physically, mentally, and emotionally. Please complete this form as thoroughly as possible. Thank you.

Health Concerns

Please list your concerns, in order of importance, including what brings you in today.

1 ______________________________ 2 ______________________________

3 ______________________________ 4 ______________________________

5 ______________________________ 6 ______________________________

Prior treatment and response? ______________________________

What do you think caused your symptoms? ______________________________

What positive attributes can you describe about your health? List as many as you can.

____

Allergies and reactions: Please list all known reactions to food, drugs, environment, or other allergies.

____

____

Please list all prescriptions medications, over the counter medications, vitamins, supplements, and herbs you have taken in the past 2 months, with dosages.

____

____

Hospitalizations, surgeries, and major injuries: please list type and when they occurred.

____

____

Any other significant traumas? ______________________________

Occupational stressors (chemical, physical, psychological)? ______________________________

Imaging and special studies (Xray, MRI, CT, PET, EKG, EEG, U/S): Please list type and date performed.

____

____

Birth History Birth history is not known ☐

Age of parents at conception: Mother __________ Father __________ Birth order __________ of __________

Brief birth history (trauma, c-section, parental drug use, forceps, breech, etc.) ______________________________

Health in childhood ______________________________

Major or chronic childhood illness (earaches, asthma, measles, etc.) ______________________________

Vaccination history unknown ☐ All normal childhood vaccines ☐ Did not receive childhood vaccines ☐

Vaccines as an adult ☐ Any reactions to vaccines? ______________________________

Family History Family medical history is not known ☐ Are you of Ashkenazi Jewish descent? Y☐ N☐

Please list age or (age at death/cause): Mother __________ Father __________ Siblings __________

Family Cancer history: Are you concerned about your personal or family history of cancer Y☐ N☐

Relationship __________ Type/location __________ Age at diagnosis __________

Relationship __________ Type/location __________ Age at diagnosis __________

Family History continued…

Any close relatives with:

☐ Allergies/Hay Fever
☐ Alzheimer's/Dementia
☐ Arthritis
☐ Asthma
☐ Autoimmune
☐ Bleeding Disorder
☐ Depression/Anxiety
☐ Diabetes
☐ Eczema/Psoriasis
☐ Food Intolerances
☐ Heart Disease
☐ High Blood Pressure
☐ Genetic Disease
☐ Kidney Disease
☐ Mental Illness
☐Osteoporosis/Osteopenia
☐ Seizures
☐ Sickle Cell (SCD, SCT)
☐ Stroke
☐ Thyroid Disorder
☐ Other:______________

Diet and Lifestyle

Are you currently pregnant? Y☐ N☐ Due date ______________ Do you enjoy your work/daily activities? Y☐ N☐

Do you sleep well? Y☐ N☐ Do you wake rested? Y☐ N☐ Average number of hours of sleep? ______________

Do you exercise? Y☐ N☐ How often/what kind? ____

After exercise do you feel: More fatigued ☐ More energized ☐ Neither ☐

Have you experienced an eating disorder or disordered eating? Y☐ N☐ Not sure☐ When ______________________

Tobacco use? Y☐ N☐ Past☐ Quantity/type ____

Alcohol use? Y☐ N☐ Past☐ Quantity/type ____

Treated for addiction/alcoholism? Y☐ N☐ When? ____

Cannabis? Y☐ N☐ Caffeine? Y☐ N☐ Soda? Y☐ N☐ Sugar? Y☐ N☐

How much vacation do you take? ______________________________ How much screen time a day? _______________

How much time do you spend outdoors? ____

What are the current stressors in your life? ____

What do you do for self-care? ____

Height _________ Current Weight _________ Lowest weight/When ____________ Max Weight/When ___________

How many meals do you eat a day? ______ Any food avoids? ____

Morning meal ____

Afternoon meal ____

Evening meal ____

Current Musculoskeletal Pain

Primary area of pain? ____

Other areas of pain? ____

When and how did pain start? ____

Intensity of pain, scale of 1-10? Currently ________ Worst this week ________ Best this week ________

Qualities of pain? Constant ☐ Intermittent ☐ Sharp ☐ Radiating ☐ Numbness/tingling ☐

Since onset, is the pain? Improving ☐ Getting worse ☐ Unchanged ☐

Have you ever had this pain before? Y☐ N☐ When? ____

What activities are limited by pain? ____

Body Systems Please check any symptoms that you currently experience (C) or have had in the past (P)

Head and Neck/EENT

C☐ P☐ Headaches
C☐ P☐ Migraines
C☐ P☐ Changes in vision
C☐ P☐ Spots/blurry/double vision
C☐ P☐ Cataracts
C☐ P☐ Impaired vision
C☐ P☐ Glaucoma
C☐ P☐ Eye pain/strain
C☐ P☐ Tears or dry eyes
C☐ P☐ Ear ringing/tinnitus
C☐ P☐ Earaches
C☐ P☐ Impaired hearing
C☐ P☐ Nose bleeds
C☐ P☐ Stuffy nose
C☐ P☐ Dry mouth/throat
C☐ P☐ Hay fever
C☐ P☐ Sinus problems
C☐ P☐ Loss of smell
C☐ P☐ Neck lump/goiter
C☐ P☐ Swollen glands
C☐ P☐ Neck pain/stiffness
C☐ P☐ Jaw clicks/pain/TMJ
C☐ P☐ Dental work
C☐ P☐ Frequent sore throat
C☐ P☐ Gum problems
C☐ P☐ Copious saliva
C☐ P☐ Teeth grinding
C☐ P☐ Tongue/lip sores

Cardiovascular

C☐ P☐ Cold hands/feet
C☐ P☐ High blood pressure
C☐ P☐ Low blood pressure
C☐ P☐ Anemia
C☐ P☐ Swelling in hands/feet
C☐ P☐ Palpitations/fluttering
C☐ P☐ Fainting
C☐ P☐ Easy bleeding/bruising
C☐ P☐ Murmurs
C☐ P☐ Irregular heartbeat
C☐ P☐ Varicose veins
C☐ P☐ Blood clots
C☐ P☐ Deep leg pain
C☐ P☐ Phlebitis
C☐ P☐ Heart disease
C☐ P☐ Chest pain
C☐ P☐ Angina
C☐ P☐ Atherosclerosis
C☐ P☐ Congestive heart failure

Gastrointestinal

C☐ P☐ Strong thirst
C☐ P☐ Poor appetite
C☐ P☐ Heavy appetite
C☐ P☐ Changes in appetite
C☐ P☐ Cravings
C☐ P☐ Bad breath
C☐ P☐ Gas or burping
C☐ P☐ Heartburn
C☐ P☐ Nausea/vomiting
C☐ P☐ Foul smelling stools
C☐ P☐ Diarrhea
C☐ P☐ Hemorrhoids
C☐ P☐ Constipation
C☐ P☐ Laxative use
C☐ P☐ Ulcer
C☐ P☐ Pain or cramps
C☐ P☐ Rectal pain
C☐ P☐ Trouble swallowing
C☐ P☐ Blood in stool
C☐ P☐ Black stools
C☐ P☐ Gall Bladder disease
C☐ P☐ Liver disease
C☐ P☐ Jaundice
C☐ P☐ Appendicitis

Bowel movements: Frequency ____________________ Color _______________ Texture/shape ________________________

Respiratory

C☐ P☐ Cough
C☐ P☐ Tight chest
C☐ P☐ Shortness of breath
C☐ P☐ Difficult/painful breathing
C☐ P☐ Allergies/hay fever
C☐ P☐ Asthma/wheezing
C☐ P☐ Bronchitis
C☐ P☐ Pneumonia
C☐ P☐ Coughing blood
C☐ P☐ Emphysema
C☐ P☐ COPD
C☐ P☐ Tuberculosis

Urinary

C☐ P☐ Frequent urination
C☐ P☐ Nighttime urination
C☐ P☐ Urinary urgency
C☐ P☐ Leakage/incontinence
C☐ P☐ Painful urination
C☐ P☐ Frequent infections
C☐ P☐ Blood in urine
C☐ P☐ Kidney stones

Immune

C☐ P☐ Frequent colds
C☐ P☐ Slow wound healing
C☐ P☐ Chronic fatigue
C☐ P☐ Chronic infections
C☐ P☐ Chronic swollen glands
C☐ P☐ Chronic/contagious disease
C☐ P☐ HIV/AIDS

COVID diagnosis (dates, effects) ____

Neurologic

C☐ P☐ Poor balance
C☐ P☐ Poor coordination
C☐ P☐ Poor memory
C☐ P☐ Brain fog
C☐ P☐ Numbness or Tingling
C☐ P☐ Vertigo or dizziness
C☐ P☐ Neurodivergent
C☐ P☐ Seizures
C☐ P☐ Tremors
C☐ P☐ Paralysis
C☐ P☐ Head injury

Concussion (date/s, effects) ____________________

Endocrine

C☐ P☐ Insomnia/poor sleep
C☐ P☐ Heavy sleep
C☐ P☐ Fevers
C☐ P☐ Chills
C☐ P☐ Changes in body temp
C☐ P☐ Hyperthyroid
C☐ P☐ Hypothyroid
C☐ P☐ Hypoglycemia
C☐ P☐ Diabetes
C☐ P☐ Fatigue
C☐ P☐ Unexpected weight gain/loss
C☐ P☐ Excessive/changes to thirst
C☐ P☐ Heat/cold intolerance

Sudden energy drop at ____________ Peculiar tastes/smells ____________

Musculoskeletal

C☐ P☐ Muscle spasms/cramp
C☐ P☐ Muscle weakness
C☐ P☐ Sciatica
C☐ P☐ Joint or bone pain
C☐ P☐ Foot trouble
C☐ P☐ Neck pain
C☐ P☐ Low back pain
C☐ P☐ Jaw pain
C☐ P☐ Arthritis
C☐ P☐ Hernia
C☐ P☐ Fibromyalgia
C☐ P☐ Orthotics

Old injuries/dates ____________________

Skin

C☐ P☐ Rashes/hives
C☐ P☐ Itching
C☐ P☐ Acne/pimples/boils
C☐ P☐ Rosacea
C☐ P☐ Eczema
C☐ P☐ Cold sores/ulcers
C☐ P☐ Changes in hair/skin
C☐ P☐ Unusual hair loss
C☐ P☐ Unusual sweats
C☐ P☐ Lack of sweat
C☐ P☐ Night sweats

Emotional/psychological

C☐ P☐ Depression
C☐ P☐ Seasonal depression
C☐ P☐ Anxiety
C☐ P☐ Short temper
C☐ P☐ Easily stressed
C☐ P☐ History of abuse
C☐ P☐ Thoughts of suicide
C☐ P☐ Mental health diagnosis
C☐ P☐ Treatment for emotional/psychological problems

Sexual health

Are you sexually active? __________ Sexual orientation? __________ Birth control? __________

Difficulties/changes in desire or function? __________ Fertility issues? __________

Do you have a menstrual history? Y☐ N☐ Age at first menses __________ Most recent menses __________

Length of cycle, one to the next __________ Days of flow __________ Date of last PAP __________

Menopause? Y☐ N☐ Hot flashes/night sweats Y☐ N☐ Other menopausal symptoms Y☐ N☐

Number of pregnancies __________ Number of live births __________ History of lactation Y☐ N☐

C☐ P☐ Irregular cycles
C☐ P☐ Bleeding between cycles
C☐ P☐ Heavy flow
C☐ P☐ Clots
C☐ P☐ Painful menses
C☐ P☐ PMS
C☐ P☐ Abnormal PAP
C☐ P☐ Endometriosis
C☐ P☐ Ovarian Cysts
C☐ P☐ Breast pain/tenderness
C☐ P☐ Breast lumps
C☐ P☐ Nipple discharge
C☐ P☐ Breast self-exams
C☐ P☐ Testicular mass
C☐ P☐ Testicular pain
C☐ P☐ Prostate problems
C☐ P☐ Unusual discharge
C☐ P☐ Genital sores
C☐ P☐ Herpes
C☐ P☐ Genital warts
C☐ P☐ Pain with sexual activity
C☐ P☐ Hernia
C☐ P☐ Other sexually transmitted infection