Nature Acupuncture & Herbal Clinic
New Patient Consultation

First Name: Last Name:	Date:
Sex: M F Age: Date of Birth:	Marital Status: S M D W # of Children:
Email:	Address:
Contact Phone #:	In Emergency Notify: Emergency Contact #:
Do you have Health Insurance? Yes No	Name of Insurance Company:
Does your insurance cover acupuncture? Yes No	Have you ever been treated by acupuncture before?
Do you have any bleeding disorders (hemophelia etc.)? Yes(specify)_____No	Have you ever been treated by herbal medicine?
Are you taking any blood thinners (coumadin etc.)? Yes(specify)_____No	Are you allergic to any medicine?
Do you have any history of seizures or epilepsy? Yes No	If female: Are you pregnant or trying to conceive? Yes No
How did you hear about us?	

Main Problems? Reason for coming in _____

When did this problem begin?

What are the precipitating factors?

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment have you tried?

What makes this problem worse? What makes this problem better?

Remarks and additional information:_____

Please check if you have had (in the last 3 months) any of the following diseases or conditions.

General

Poor Appetite	Night Sweats	Poor Balance	Easily Bleed/Bruise
Poor Sleep	Sweats Easily	Weight Loss/Gain	Desire Hot/Cold Foods
Fatigue	Tremors	Peculiar Tastes	Sudden Energy Drop
Fevers/chills	Excessively Hungry	Strong Thirst	Dizziness

Musculoskeletal

Joint Disorders	Cold Hands/Feet	Paralysis	Swelling of Hands/feet
Muscle Weakness	Back Pain	Shoulder Pain	Difficulty Walking
Hand/Wrist Pain	Spinal Curvature	Cramping	Neck Tightness/Pain
Numbness	Hernia	Knee/Hip Pain	Whole Body Soreness

Skin/Hair

Rash	Itching	Dandruff	Loss of Hair
Ulcerations	Eczema	Dry Skin	Purpura
Hives	Pimples	Recent Moles	Other

Head/Eyes/Ear/Nose/Throat

Concussion	Eye Strain/Pain	Cataracts	Blurry Vision
Migraine	Night Blindness	Poor Vision	Difficulty Swallowing
Ringing In Ears	Poor Hearing	Sinus Problems	Spots in front of Eyes
Nosebleeds	Sore Throat	Grinding Teeth	Teeth Problems
Facial Pain	Jaw Clicking	Earaches	Sores on lips/tongue

Cardiovascular

Chest Pain	Palpitations	Fainting	High/Low BP
Phlebitis	Irregular Heartbeat	Varicose Veins	Slow/Fast Heartbeat

Respiratory

Cough	Bronchitis	Wheezing	Difficulty Breathing
Coughing Blood	Pneumonia	Chest Pain	Color of Phlegm___

Gastrointestinal

Nausea/Vomiting	Gallbladder Problems	Diarrhea	Constipation
Gas/Bloating	Belching	Black Stools	Blood in Stool
Indigestion	Bad Breath	Rectal Pain	Hemorrhoids
Parasites	Chronic Laxative Use	Ulcers	Abdominal Pain/Cramps

Neuro-Psychological

Concussion	Depression	Anxiety	Loss of Balance
Stress	Bad Temper	Bipolar	Lack of Coordination
ADD/ADHD	Schizophrenia	Addiction	Obsessive/Compulsive

Genito-Urinary

Pain on Urination	Blood in Urine	Urgent Urination	Frequent Urination
Kidney Stones	Dark Urine	Dribbling	Pause of Flow
Incontinence	Frequent UTI	Genital Pain	Genital Itching

Female

Pelvic Infection	Endometriosis	Fibroids	Frequent Vaginal Infection
Ovarian Cysts	Irregular Periods	Clotting	Vaginal Discharge
Hot Flashes	PMS	Fertility Problems	Pain/Cramps at Period
Mood Swings	Hysterectomy	Breast Lumps	Breast Tenderness

Number of pregnancies_____ Number of births_____ Miscarriages____ Abortions____

Age of first menses_____ Date of last periods_____

Duration of periods____days, cycle_____days

If on birth control pills, What type and for how long?_____

Male

Prostate Problems	Discharge	Impotence	Frequent Seminal Emissions
Painful Swollen Testicles	Lack of Sex Drive	Genital Pain	Ejaculation Problems

Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Ella Xu, L.Ac. or other acupuncturists who now, or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturists named, including those working at the clinic/office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese Herbal Medicine, and nutritional counseling.

I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some 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, organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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, animal, and mineral 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 will notify a clinical staff member who is caring for me if I am or become pregnant.

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

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 show that I have read, or have 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.

Patient Name (Print)_____ **Date**_____

Cancellation Policy

If I need to reschedule or cancel my appointment, in order to avoid a $45 cancellation fee, I must CALL the office with ***at least 24 hours advance notice***. Patients who do not arrive for their appointments and have not called ("no call/no show") will be charged the full price of the missed session, payable before the next appointment can be scheduled.

Patient Signature_____ **Date** _____