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

Nature Acupuncture and Herbal Clinic Consent

INFORMED CONSENT FOR TREATMENT

I (print full name)_____hereby agree and consent to the performance of acupuncture and other Oriental Medicine procedures described below. I understand that such procedures may include, but are not limited to acupuncture, moxibustion, cupping, gua-sha, infrared heat lamp, breathing techniques, auricular therapy, exercise therapy, Tuina, Chinese or western herbal medicine and nutritional counseling based on traditional Chinese medical theory. I accept that no guarantee is made concerning the results of my treatments, and I have been informed that I may stop treatment at any time.

Acupuncture is a technique utilizing fine stainless steel, sterile, disposable needles inserted at specific points in the body to correct various ailments.

Moxibustion is the application of indirect head by burning a stick or cone of compressed Mugwort over acupuncture points. **TDP Lamp** is a decide that emits infrared heat by passing an electric current through a plate impregnated with minerals when electrically charged emit an infrared wavelength that penetrates deeply into the skin to improve circulation.

Cupping utilizes round suction cups over a large muscular area or joint to enhance blood circulation to the designated area.

Guasha technique works in a similar way to improve circulation but instead of using suction cups, the therapy scrapes the affected area with the edge of a rounded object such as a Chinese soup spoon.

Tuina is a form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally, there may be increased soreness at the sites of treatment on the day of, or day following treatment.

Auricular Therapy is the diagnosis and treatment of the body based on a theory of imaging the body to the ear. The ear contains hundreds of small acupoints that correspond to body systems. Small seeds from the Vaccaria plant are placed on a small band-aid or tape and applied to these acupoints. The seeds are then pressed routinely by the patients stimulating these acupoints to produce the desired effect.

I have been informed that the therapies stated above are safe methods of treatment, but may have side effects, including bruising, numbness or tingling, dizziness or fainting, exacerbation of pre-existing condition, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after treatment. I will immediately notify the physician of I experience any symptoms or problems. I understand that I should not make significant movement while the needles are being inserted, manipulated, retained or removed.

RELEASE OF INFORMATION

I (initial) _____ consent to the use and disclosure of my protected health I formation for treatment, payment, and clinic operations. Also, I have given my written consent that my health information be shared with the people, their addresses and/or contact numbers on the 'Intake/Referral' form. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

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.

Please sign and date below pertaining to above: Consent for Treatment, Release of Information and Notice of Privacy Practices and Patient Rights.

_____

Patient's Signature **Date Signed**

_____

Guardian's Signature **Date Signed**