Acupuncture Internal Medicine

Penny Harris L.Ac. Dipl.OM.

First Name:	Last Name:	Male/Female
Address:		
City:	State:	Zip:
Phone:		
Email:		
Date of birth:	Age:	
Marital status:		
Emergency contact:	Relationship:	Phone:
Referred by:		
Insurance Info (if using Insurance to pay for visits): Policy Holder's Name: Insurance Company:	Policy Number:	

Please describe the main reason for your visit today:

Please indicate if you have any of the following:

- ❑ Cardiac pacemaker
- ❑ Seizure disorder
- ❑ Bleeding disorder/ Blood thinners
- ❑ Fainting disorders
- ❑ High blood pressure
- ❑ Believe you are or may be pregnant
- ❑ HIV/AIDS positive
- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ Other:_____

List all major childhood and adult illnesses:

Have you had any surgeries, major accidents or injuries, please explain:

List any major disease or illness in your immediate family and indicate family member:

List all medications or supplements, including herbs and vitamins you are currently taking:

Occupation: _____

Do you have a regular exercise program? _____ Please describe. _____

Are you on a restricted diet? _____ What kind? _____

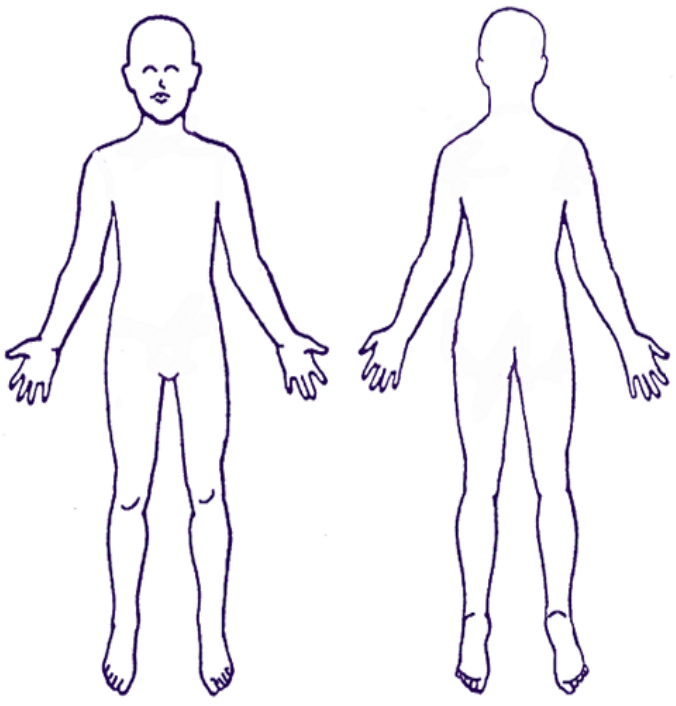
How many packs of cigarettes do you smoke per week?

How much coffee, tea, or cola do you drink per week?

How much alcohol do you drink per week?

Do you do any drugs? How often?

Indicate painful or distressed areas. Please rate pain on a scale of 1 (No pain) to 10 (Worst pain).



Name: _____

PATIENT MEDICAL HISTORY

Please check off all symptoms that pertain to you

- ☐ cold hands/feet
- ☐ fatigue
- ☐ feverish in the afternoon
- ☐ heat sensation in hands, feet, chest
- ☐ night sweats
- ☐ catch colds easily
- ☐ sweat easily
- ☐ dizziness
- ☐ see floating black spots

- ☐ palpitations
- ☐ sores on tip of tongue
- ☐ restlessness
- ☐ anxiety
- ☐ chest pain radiating to shoulder
- ☐ insomnia

- ☐ cough
- ☐ sinus congestion
- ☐ dry mouth, throat, nose or skin
- ☐ allergies
- ☐ chills alternating with fever
- ☐ stiff neck/shoulders
- ☐ sore throat
- ☐ difficult breathing

- ☐ low appetite
- ☐ loose stools
- ☐ constipation
- ☐ abdominal bloating and/or gas after eating
- ☐ feeling tired after eating
- ☐ prolapsed organs (previously diagnosed)
- ☐ bruise easily
- ☐ general feeling of heaviness in body
- ☐ mental heaviness, sluggishness or fogginess
- ☐ swollen hands/feet
- ☐ burning sensation after eating
- ☐ large appetite
- ☐ bad breath
- ☐ mouth (canker) sores
- ☐ bleeding, swollen, painful gums
- ☐ heartburn/belching
- ☐ vomiting

- ☐ diarrhea alternating with constipation
- ☐ tight feeling in chest
- ☐ bitter taste in mouth
- ☐ blood shot/dry eyes
- ☐ anger easily
- ☐ skin rashes
- ☐ headaches
- ☐ numbness of hands/feet
- ☐ muscle spasms, twitching, cramping
- ☐ seizures/convulsions

- ☐ sore, cold or weak knees
- ☐ low back pain/soreness
- ☐ frequent urination
- ☐ get up more than once per night to urinate
- ☐ lack of bladder control
- ☐ memory problems
- ☐ hair loss
- ☐ ringing in ears

Urine is:

- ☐ normal color
- ☐ clear
- ☐ dark yellow
- ☐ reddish
- ☐ cloudy
- ☐ scanty
- ☐ has odor
- ☐ burning
- ☐ painful
- ☐ difficult
- ☐ urgent

Libido (sex drive) is:

- ☐ normal
- ☐ low
- ☐ high

Name: _____

WOMEN ONLY

Please answer each question or check the appropriate response

1. Are you pregnant now? ☐ Yes ☐ No
2. Number of children: _____
3. Number of pregnancies: _____
4. Age of first period: _____
5. Age of menopause (if applicable): _____
6. Is your mentrual cycle regular? _____
   a) Average number of days of flow: _____
   b) The flow is: ☐ normal ☐ heavy ☐ light
   c) The color is: ☐ normal ☐ dark ☐ purple ☐ light brown ☐ brown
   d) Do you have the following menstruation related signs/symptoms?
      - ☐ blood clots
      - ☐ cramps
      - ☐ nausea
      - ☐ breast distension
      - ☐ PMS
      - ☐ bleeding between periods
      - ☐ heavy vaginal discharge between periods

MEN ONLY

Please check off all symptoms that pertain to you

- ☐ Feeling of coldness or numbness in external genitalia
- ☐ Pain or swelling of testicles
- ☐ Premature ejaculation
- ☐ Impotence/erectile dysfunction

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for who I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or 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, Tiu-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 be an unpleasant smell or taste. I will immediately notify a member of 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 and 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 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.

PATIENT SIGNATURE **X** _____ Date _____
(Or Patient Representative; Indicate Relationship If Signing For Patient)