# Acupuncture

Date:________________

## Patient Information

Patient Name:_________________________________ Date of Birth:_________________

Preferred Name: ______________ Marital Status: S M D W DP Sex: M F NB

Pronouns: She / Her He / Him They / Them

Address:______________________________________________________________________
Street City State Zip Code

Home Number:___________________________ Cell Number:_____________________

Email Address:______________________________________________________________

Emergency Contact:_________________________ Relationship to Patient:____________

Emergency Contact Phone Number:____________________________________________

Primary Care Physician (PCP):________________________ PCP Phone:________________

Date of last medical examination:_______________________________________________

Occupation:__________________________________________________________________

How did you hear about us?___________________________________________________

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## Health History

I. Have you received acupuncture treatment before? YES NO

II. Please describe your primary problem or health concern

III. How long have you had this problem and was the onset sudden or gradual? Was there any significant event that led to it?

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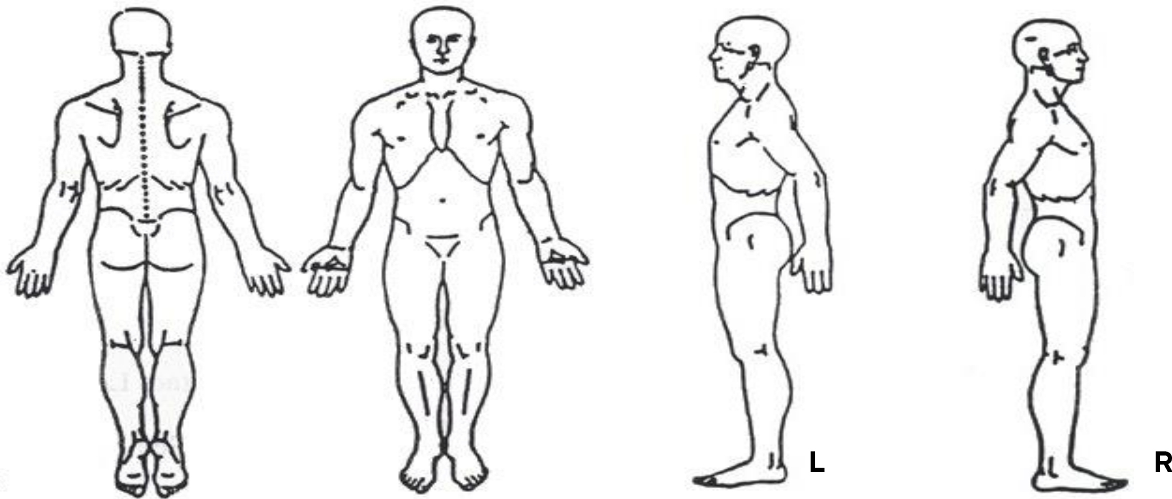
- Have you had a medical evaluation for your problem(s)? If yes, when and what diagnosis did you receive?

- Other Care: What other therapies are you doing/have you done to manage for your condition, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

Are you in pain? Y N if yes, where?_____________________________________

Severity on a scale: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain imaginable**

Please indicate any areas of discomfort with X's



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**Medications, Supplements and Herbs**

Please list all medications, prescriptions, over-the-counter drugs and/or herbs you are currently taking:

| Medications, supplements or herbs: | For what problem or concern: |
| --- | --- |
| 1.______________________ | 1.______________________ |
| 2.______________________ | 2.______________________ |
| 3.______________________ | 3.______________________ |
| 4.______________________ | 4.______________________ |
| 5.______________________ | 5.______________________ |
| 6.______________________ | 6.______________________ |
| 7.______________________ | 7.______________________ |

List any allergies (to medications, supplements, herbs, foods):

______________________________________________________________

**Personal Medical History**

I. Birth: Describe anything significant/traumatic about your birth:

II. Vaccination History: Any unusual reaction? Any unusual vaccination?

III. Childhood Illness (0-12 years): Any surgery, accidents and/or major illnesses? Please list in chronological order and indicate duration of illnesses

Age:__________ ______________________________

Age:__________ ______________________________

Age:__________ ______________________________

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IV. Adolescence Illness (13-17 years): Any surgery, accidents and/or major illnesses? Please list in chronological order and indicate duration of illnesses

Age:____________ ______________________________________________

Age:____________ ______________________________________________

Age:____________ ______________________________________________

V. Adulthood Illness (18-35 years): Any surgery, accidents and/or major illnesses? Please list in chronological order and indicate duration of illnesses

Age:____________ ______________________________________________

Age:____________ ______________________________________________

Age:____________ ______________________________________________

VI. Adulthood Illness (36 & up): Any surgery, accidents and/or major illnesses? Please list in chronological order and indicate duration of illnesses

Age:____________ ______________________________________________

Age:____________ ______________________________________________

Age:____________ ______________________________________________

VII. Family Medical History: Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

Mother:__________________________________________________________________

Father:__________________________________________________________________

Siblings:________________________________________________________________

Maternal Grandparents:__________________________________________________

Paternal Grandparents:__________________________________________________

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VIII. Symptom Overview by System: Please check all symptoms that you are currently experiencing and/or experience frequently

### Musculoskeletal
□ Joint clicking
□ Limitation of movement
□ Pain or Stiffness
□ Spasms or cramps
□ Swelling
□ Weakness
(Where?)______________________

### Eyes, Ears, Nose, & Throat
□ Loss of vision, eye pain, tearing
□ Ear pain, loss of hearing, ringing

### Eyes, Ears, Nose, & Throat Cont.
□ Problems with balance (vertigo)
□ Olfaction (sense of smell) impaired
□ Nose stuffiness, nosebleeds, sinus pain
□ Other: (Please list)

__________________________________

### Respiratory
□ Chest Pain, tightness
□ Coughing up blood (hemoptysis)
□ Shortness of breath (dyspnea)
□ Sore throat
□ Sputum production
□ Wheezing
□ Other: (please list)__________________

### Cardiovascular
□ Chest pain/ pressure
□ Edema
□ Fainting
□ Fatigue

### Urogenital
□ Difficulty with urine flow
□ Incontinence
□ Painful urination, pelvic pain
□ Rashes
□ Red Urine
□ Urinary Tract Infection (UTI)
□ Other:___________________________

### Neurological
□ Change in consciousness
□ Confusion

### Neurological Cont.
□ Difficulty concentrating
□ Dysphasia (impaired ability to speak)
□ Gait disturbance, balance issues
□ Headache
Frequency:_____ Severity 1-10:____
□ Migraine
Frequency:_____ Severity 1-10:____
□ Numbness and/or tightness
□ Loss of Consciousness
□ Paralysis
□ Post Shingles pain
□ Problems coordinating movements
□ Severe forgetfulness
□ Tremor
□ Visual disturbance
□ Weakness
□ Other: (Please list)_________________

### Integumentary (Skin)
□ Changes in hair

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- ☐ Palpitations
- ☐ Skin Ulceration
- ☐ Swelling of the ankles/legs
- ☐ Other: (Please list)________________

## Digestive

- ☐ Abdominal distention/bloating
- ☐ Abdominal mass
- ☐ Abdominal pain
- ☐ Acid regurgitation/Heartburn
- ☐ Alternating constipation/diarrhea
- ☐ Rectal bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Eating Disorder
- ☐ Indigestion
- ☐ Jaundice (yellow tint to skin/eyes)
- ☐ Nausea
- ☐ Vomiting
- ☐ Other: (Please list)________________

## Sleep

- ☐ Difficulty falling asleep
- ☐ Dream disturbed sleep
- ☐ Wake up & cannot fall back asleep
- ☐ Other: (Please list)________________

## Miscellaneous

- ☐ Extremely low energy/fatigue
- ☐ Other: (Please list)________________

## For Men Only

- ☐ Fertility Concerns
- ☐ Prostate problems
- ☐ Sexual dysfunction
- ☐ Unusual discharge

- ☐ Changes in nails
- ☐ Changes in skin color
- ☐ Itching (prurites)
- ☐ Never sweat
- ☐ Rash and/or skin lesion
- ☐ Unusual sweating
- ☐ Wounds that will not heal
- ☐ Other: (please list)________________

## Psychological

- ☐ Feelings of grief
- ☐ Feelings of sadness
- ☐ Feeling fearful/anxious/nervous
- ☐ Difficulty managing anger
- ☐ Feeling manic
- ☐ Feeling worried or overly pensive
- ☐ Feelings of panic
- ☐ Feeling overwhelmed
- ☐ Extreme mood swings
- ☐ Extreme lack of emotion
- ☐ Other: (Please list)________________

## For Women Only

- ☐ Abnormal vaginal bleeding
- ☐ Changes in hair distribution
- ☐ Fertility Concerns
- ☐ Irregular menstruation
- ☐ Menopausal symptoms
- ☐ No menses
- ☐ Pain with menses
- ☐ Pain during or after sexual relations
- ☐ Pelvic pain
- ☐ Premenstrual symptoms
- ☐ Sexual dysfunction
- ☐ Unusual discharge

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**For Women Only**

Are you pregnant OR trying to become pregnant? YES NO

Have you ever been pregnant? YES NO

If yes, how many pregnancies _____________ # births________ # miscarriages_________

IX. Medical Diseases/Conditions: What medical diseases/conditions have been diagnosed?

Heart

Lung

Digestive System

GI Tract

Urinary System

Bones and Joints

Skin

Face and Head

Neck and Thyroid

Upper Extremities

Lower Extremities

X. Lifestyle Information:

Energy Level , Sleep and Exercise

- Do you have any problems with your energy level? If yes, please briefly describe:
- Do you have any problems with sleep? What are you hours of sleep per night? If yes, please briefly describe:
- Do you exercise? How frequent?
- Do you have any problems with your sexual drive? If yes, please briefly describe:
- Please describe your self-care routines:

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Smoking, Alcohol & Drugs

- Do you smoke tobacco? YES NO

  Do you have a history of smoking tobacco? If yes, ___years.
  When did you quit?________________

- Do you drink alcohol? YES NO If yes, do you believe that this is a problem for you?

- Do you use recreational drugs and/or prescription medications that your physician does not know about? YES NO if yes, do you believe that this is a problem for you?

Diet and Nutrition

- If applicable, briefly describe any problems you think you have with your eating habits and appetite. Do you believe your diet has any impact on you complaint? YES NO

  # of meals eaten in a day______________ fluid intake: # of glasses a day_____________

- Are you concerned about your weight and/or appetite (under or overweight, too much or too little appetite)? YES NO

Spiritual Practice

- Please describe:

# Acupuncture

## Acupuncture & Chinese Medicine
### INFORMED CONSENT

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 whom I am legally responsible) by the acupuncturist indicated 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 Milan Center 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 instruction 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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 agree to notify my acupuncturist if I experience any of these or other symptoms. I will notify a clinical staff member who is caring for me if I am or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during 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'S PRINTED NAME: ___________________________________

PATIENT SIGNATURE: _______________________________________DATE: _______________
(Or Patient Representative, please indicate relationship if signing for patient)

Acupuncturist: Rain Lanning, LAc