ELLIOTT ACUPUNCTURE & CHINESE HERBAL MEDICINE

Date: ____ / ____ / _____

Name:		Sex:	Age:
Address:	City:	State:	Zip Code:
Home Phone #:	Other Phone #: Work Cell Other	Email: *check here to **NOT** receive newsletters via email _____	
Date of Birth:		City of Birth:	State of Birth:
Height:	Weight:	Relationship Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living w/partner ☐ Other :_____	
Employer:		Occupation:	
Physician:		Physician's Phone #:	
How did you hear of our clinic?:		Have you been treated by Acupuncture or Oriental Medicine Before? ☐ No ☐ Yes ____/____/____	

MAIN COMPLAINTS

Please write in your top 3 health complaints / concerns in order of importance to you. Circle the items that make it better or worse and mark on the scale from 1-10 the severity of the condition (1=no symptoms, 10=worst ever)

1 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

2 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

3 _____

When did this start? _____ago
Heat makes it: better no change worse
Cold makes it: better no change worse
Damp weather: better no change worse
Exercise / Activity: better no change worse

1 ——— 10

HEALTH HISTORY

Circle the 🧍 if you have / had the condition and note the year it started.
Circle the 👪 if there is a family history of the condition.

	YOU	Year	FAMILY
Cancer *type(s)?* _____	🧍	_____	👪
Diabetes	🧍	_____	👪
Hepatitis	🧍	_____	👪
High Blood Pressure	🧍	_____	👪
Heart Disease	🧍	_____	👪
Stroke	🧍	_____	👪
Seizure Disorder	🧍	_____	👪
Thyroid Disease	🧍	_____	👪
Asthma	🧍	_____	👪
Pacemaker	🧍		👪
Osteoporosis	🧍	_____	👪
Herpes	🧍	_____	👪
AIDS / HIV	🧍	_____	👪
Other STD	🧍	_____	👪
Rheumatic Fever	🧍	_____	👪
Alcoholism	🧍	_____	👪
Allergies	🧍	_____	👪
Mental Illness	🧍	_____	👪
Kidney Disease	🧍	_____	👪
Anemia	🧍	_____	👪
Other_____	🧍	_____	👪

HABITS

	Amount / Week	If Quit, Year?
Coffee / Tea	_____	_____
Soda	_____	_____
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____

EXERCISE

Do you exercise regularly? ☐ Yes ☐ No
If so, what and how often:
_____
_____
_____

DIET

Do you have a special diet now or in the past? (vegetarian, vegan, raw, Atkins, etc.)
Describe w/ dates:

MEDICATIONS

Please note what medications, herbs or supplements that you take regularly

_____
_____
_____

INJURIES & SURGURIES

Please note what happened to what body area and when it occurred (incl. dental)

_____
_____
_____

ELLIOTT ACUPUNCTURE & CHINESE HERBAL MEDICINE
HEALTH HISTORY FOR WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD ——— HOT

- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold "in the bones"
- ☐ Areas of numbness

Thirst for cold / hot drinks
- ☐ Thirst, no desire to drink
- ☐ Absence of thirst
- ☐ Excessive thirst

- ☐ Night sweats
- ☐ Unusual sweats
  When_____am / pm
  Where on body_____

- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Hot in afternoon
- ☐ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ☐ Dry skin
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry brittle nails

- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose / Nosebleeds

Where on your body?:
- ☐ Edema / Swelling _____
- ☐ Rashes _____
- ☐ Itching _____
- ☐ Dandruff

- ☐ Oily skin
- ☐ Oily hair
- ☐ Pimples
- ☐ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ☐ Y ☐ N
- ☐ Alternating diarrhea & constipation (IBS)
- ☐ Indigestion

- ☐ Gas
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite

- ☐ Nausea / Vomiting
- ☐ Bad breath
- ☐ Heartburn
- ☐ Excessive hunger

- ☐ Dry Stools
- ☐ Difficult to pass
- ☐ Tired after BM
- ☐ Foul smelling stools

ENERGY

LOW ——— HIGH

- ☐ Sudden energy drop
  Time of day: _____ am / pm
- ☐ Energy drop after eating
- ☐ Fatigue

- ☐ Dependence on caffeine / stimulants
- ☐ Wired / ungrounded feeling
- ☐ Body / Limbs feel heavy
- ☐ Body / Limbs feel weak

- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Blood pressure High / Low
- ☐ Bleed / Bruise easy

- ☐ Hard to concentrate
- ☐ Poor memory
- ☐ Dizziness / lightheaded
- ☐ Headaches _____x / week

SLEEP

hours per night _____
- ☐ Difficulty falling asleep
- ☐ Wake ___x/ night @_____am / pm
- ☐ Wake to urinate *How often?*_____
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ☐ Anger
- ☐ Irritability
- ☐ Anxiety
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Joy
- ☐ Fear
- ☐ Timid / shy
- ☐ Indecision

EYES, EARS NOSE THROAT

- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Sinus congestion
- ☐ Phlegm (*color*_____)
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess earwax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough

MENSES

Age at first menses: _____
Length of full cycle: _____ days
Length of menses: ____ days
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: ____ premature ____
# of abortions / miscarriages: ____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation (PMS)

- ☐ Cramps
  - ☐ Before bleeding
  - ☐ First day
  - ☐ During period
- ☐ Clots
- ☐ Breast tenderness

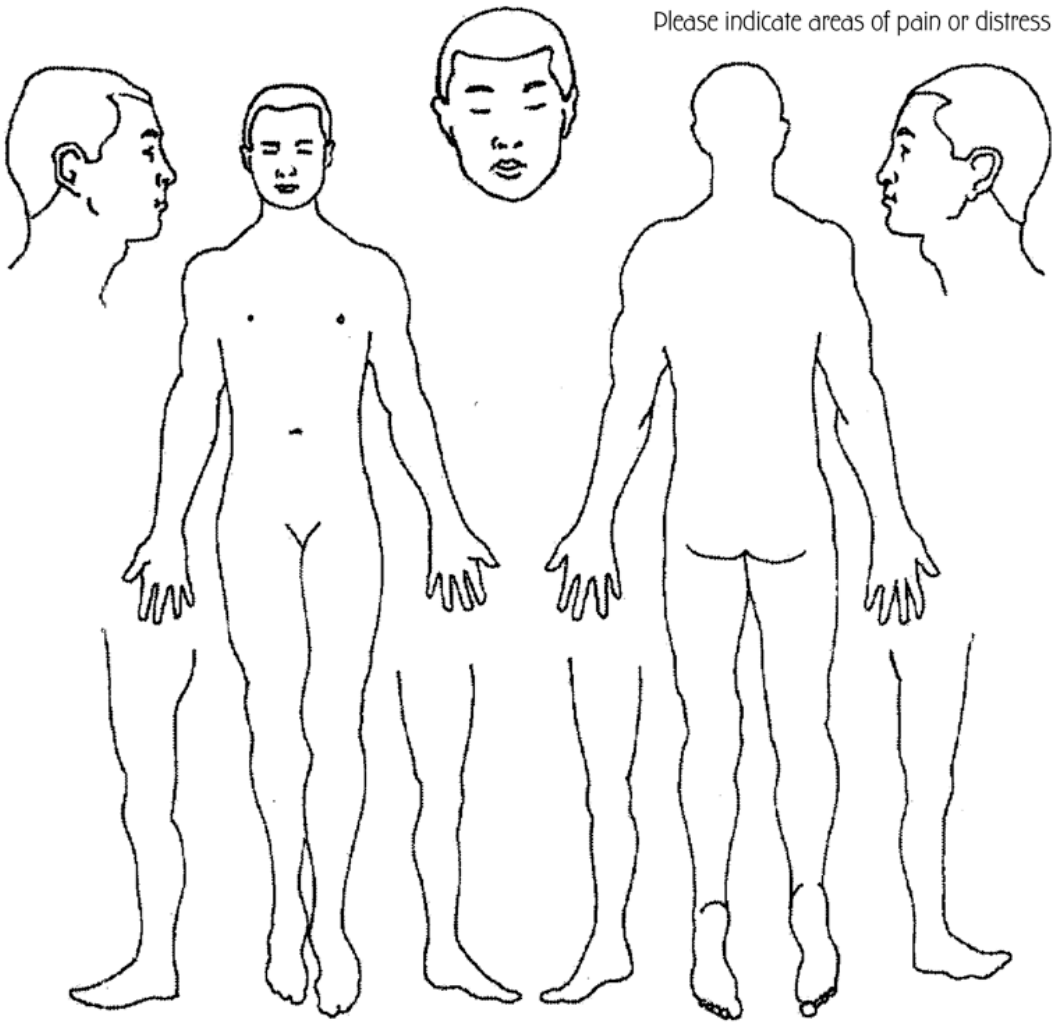
- ☐ Mood changes
- ☐ Fatigue w/ menses
- ☐ Digestive changes w/ menses
- ☐ Midcycle spotting
- ☐ Yeast infections
- ☐ Birth control pill (hormonal)

MENOPAUSE

Age at last menses : _____
Year changes began: _____

- ☐ Hot flashes _____x / day
- ☐ Night sweats _____x / week
- ☐ Vaginal dryness
- ☐ Loss of sex drive

Please indicate areas of pain or distress



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 whom 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, 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. Marking 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 substances (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 on 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.

CLINIC NAME: Elliott Acupuncture & Chinese Herbal Medicine
ACUPUNCTURIST NAME: Andrea Elliott, L.Ac.

PATIENT SIGNATURE (or patient representative)	**(indicate relationship if signing for patient)**	**DATE**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Elliott Acupuncture & Chinese Herbal Medicine is in compliance with HIPAA regulations assuring your medical privacy. We never release medical records without permission. Your records are available to you upon request. The staff of Elliott Acupuncture & Chinese Herbal Medicine, such as receptionists and therapists who have access to your records, obtain only the information they need to perform their jobs. They are aware of HIPAA regulations and understand the importance of patient confidentiality.

Please read and sign the following so that we may remain in compliance with the HIPAA regulations. Thank you very much for your cooperation.

****

I understand that:

my medical records are kept confidential, and are sent to third parties, such as attorneys, insurance companies, or doctors, only upon my consent to release.

no consultation concerning my case will be made with any other party, including members of my family, without my written permission.

unless I request otherwise, Elliott Acupuncture & Chinese Herbal Medicine staff may contact me at any of the phone numbers or addresses I provide for them. Phone messages for me may be left either on an answering machine or with whomever answers the phone.

Elliott Acupuncture & Chinese Herbal Medicine has permission to release my records and discuss my case with representatives of the third party responsible for payment, such as my health insurance company.

Please be aware that cell phone and cordless conversations are not as secure as landline calls. Please let us know if this is a problem for you.

_____ _____ _____

printed name *signature* *date*

We want you to know:

Chinese Medicine is a system of medicine based on traditional Asian principles and methods and *is not meant to replace Western medical treatment.*

It is not necessary to discontinue Western medical therapies in order to receive Acupuncture or Chinese herbs. Adjusting the dosages of prescribed pharmaceutical medications must be done under the advice of the prescribing physician.

No claims are made about curing your condition.

Any Western medical diagnosis must be performed by a licensed physician. You will be advised to seek more appropriate treatment when necessary. In that event you assume full responsibility for consulting with your physician.

Cancellation Policy: Elliott Acupuncture & Chinese Herbal Medicine is a specialized practice with time set aside for individualized care and attention for each client. Appointments must be canceled 24 hours in advance, or you will be billed for the missed appointment.

Payment is expected at time of service, unless other arrangements are made in advance. We accept payment by personal check, cash or credit card. *I understand that I am responsible for payment of all fees.*

There is a **$25.00 charge** (or more if the bank charges us more) for any check returned to our office by the bank, payable at once, in addition to the face amount of the check.

****

I have read and understand all the information stated above.

I hereby certify that all information I have given on these forms is true and complete, to the best of my knowledge. In addition, *I will advise my Acupuncturist of any changes in my medical condition.*

_____	_____	_____
printed name	*signature*	*date*