Patient Information and Health History

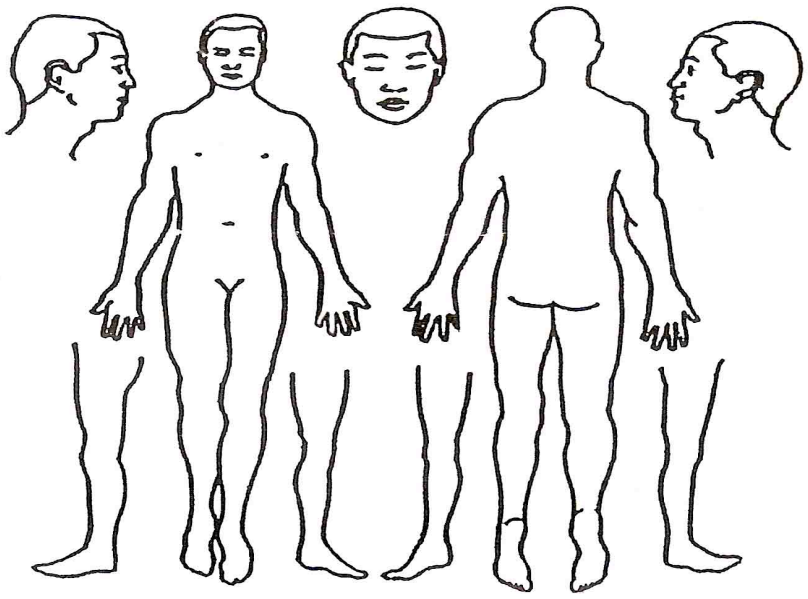
Name:	Age:	Sex:	Date of Birth:
Cell phone:	Height:	Weight:	Marital Status:
Email (kept private):			Occupation:

Please list main concern(s). How long ago did each begin?	Have you had acupuncture before? How recently? From whom did you hear about us?

Current medications:

What do you do for exercise? How often?

Please mark any areas of pain or discomfort



Please rate how often you experience each symptom:

(leave blank if never) 1 = occasionally, 2 = often, 3 = always

General

allergies 1 2 3
teeth clenching/ grinding 1 2 3
frequent colds/flus 1 2 3
shortness of breath 1 2 3
nausea/vomiting 1 2 3
how often do you have a bowel movement? _____
hemorrhoids 1 2 3

Sleep

how much sleep do you get? _____
difficulty falling asleep 1 2 3
waking often 1 2 3
difficulty falling back asleep (after waking) 1 2 3
vivid/disturbing dreams 1 2 3
night sweats 1 2 3

Psychological

racing thoughts 1 2 3
easily startled 1 2 3
anxiety 1 2 3
depression 1 2 3
irritability 1 2 3
other:

Please continue on back →

For women

Ob-Gyn

Could you be pregnant? Y N

age of first period: _____

duration of typical period: ____

duration of typical cycle: _____

date of last period: _____

painful periods 1 2 3

bleeding between periods 1 2 3

clots in menstrual flow 1 2 3

cramping 1 2 3

pregnancies: _____

abortions: _____

miscarriages: _____

live births (when?): _____

Are you taking birth control?

premenstrual & menstrual symptoms

(circle ones you have, write in others)

bloating breast tenderness

irritability mood swings

fatigue loose stool

other:

menopause symptoms:

(circle ones you have, write in others)

hot flashes night sweats

Irritability mood swings

fatigue

other:

menopause – age you started? _____

Additional comments: *Please list any other issues you would like to discuss.*

Acupuncture Informed Consent to Treat

I, the undersigned, hereby consent to acupuncture treatment on me (or on the patient named below, for whom I am legally responsible). I have been informed that acupuncture is generally a 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. Rare risks include spontaneous miscarriage, nerve damage and organ puncture, including pneumothorax (lung puncture). 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 or treatment, other side effects and risks may occur.

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. I will rely on the clinical staff to exercise judgment to determine the best treatment for me, based upon the facts known at the time of treatment. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been informed of 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.

Patient Signature **X** _____ Date: _____
(or patient representative – indicate relationship if signing for patient)

Financial Policy

DCAC makes every attempt to make acupuncture available to as many people as possible, at the most affordable rates. In respect for our intention to offer high-quality health care at affordable prices, we ask for **24-hour advance notice** if it is necessary to cancel or reschedule an appointment.

All appointments that are missed, or cancelled or rescheduled with less than 24-hour advance notice will be charged the bottom of the sliding scale for that appointment unless we are able to fill the spot. If appointments have been purchased in a package, the missed or cancelled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding.

Patient Signature **X** _____ Date: _____
(or patient representative – indicate relationship if signing for patient)