New You Acupuncture Wellness Center

Oriental Medicine - Acupuncture - Herbs - Homeopathy

Patient Contact Information Form

Your privacy is being protected per HIPPA guidelines. No information will be given out without your expressed consent.

Please indicate any of the following methods of communication approved by you by circling one of the following:

Home Work Cell Phone Email

Name_____Date_____

Date of Birth_____ Age_____

Gender_____Marital Status:_____

Address_____City_____State_____ Zip_____

Email Address_____Home Phone_____Cell Phone_____

Occupation_____Work Phone_____

Emergency Contact Information

Primary Care Physcian Name_____Phone_____

Nearest Relative/Friend (Not living with you)_____

Relationship_____ Home/Work Phone_____Cell Phone_____

Emergency Contact Name_____ Phone_____

Address_____City_____State_____ Zip_____

Who can we thank for referring you? _____

Have you previously had: **Acupuncture/Chinese Herbs** Yes No **Homeopathic remedies** Yes No

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Patient Health History Form

Name:_____**Date:**_____

Reason for your visit today:

What are your main heathcare concerns? (please list in order of importance)

1 _____

2 _____

3 _____

How long have you had this (or these) condition (s)?_____

_____

What was the initial cause or causes?_____

_____

What makes the symptoms better or worse?_____

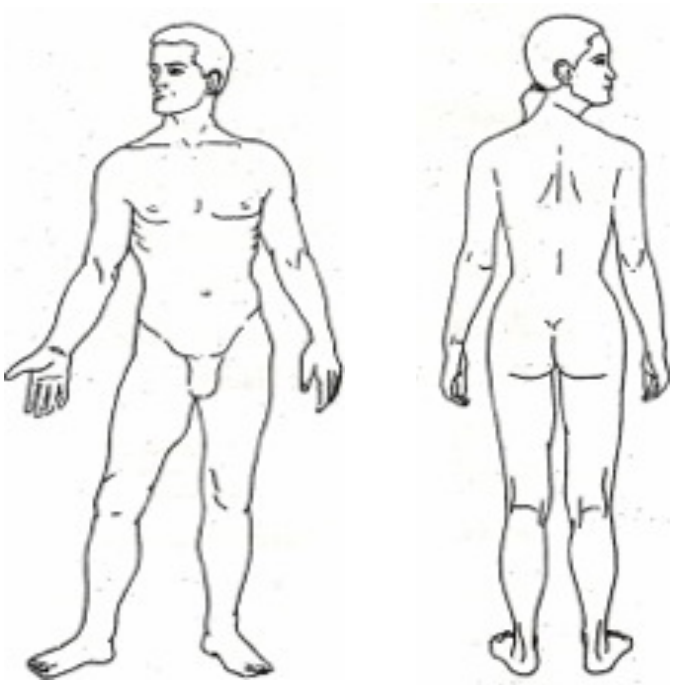
_____

Are you presently under the care of a physician? Yes No (circle one)

If yes, for what?_____

Who is your treating physician?_____

Indicate affected area (s) on diagrams:



List any therapies, dates and length of treatment you have done for any conditions in the last year:_____

_____

_____

_____

List any supplements or medications and the dosages you are taking for any conditions:_____

_____

_____

_____

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Patient Health History Form

Name:_____Date:_____

List any major injuries/ traumas or accidents and their dates_____

_____

List any surgeries or operations you have had and the dates_____

_____

Age_____ Height_____ Weight_____ Baseline Blood Pressure_____

Your Past Medical History

Check any of the following conditions you currently have, or have had in the past

☐ AIDs/HIV	☐ Diabetes	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Typhoid Fever
☐ Allergies	☐ Epilepsy	☐ Pacemaker	☐ Ulcers
☐ Appendicitis	☐ Goiter	☐ Pleurisy	☐ Venereal Disease
☐ Arteriosclerosis	☐ Gout	☐ Pneumonia	☐ Whooping Cough
☐ Asthma	☐ Heart Disease	☐ Polio	☐ Other (Specify)
☐ Birth Trauma	☐ Hepatitis	☐ Rheumatic Fever	☐ _____
(your own birth)	☐ Herpes	☐ Scarlet Fever	☐ _____
☐ Cancer	☐ High Blood Pressure	☐ Seizures	☐ _____
☐ Chicken Pox	☐ Measles	☐ Stroke	☐ _____

Your Family Medical History

☐ Allergies	☐ Arteriosclerosis	☐ Cancer	☐ Diabetes
_____	☐ Asthma	_____	☐ Heart Disease
_____	☐ Alcoholism	_____	☐ High Blood Pressure
_____	☐ Stroke	_____	☐ Seizures

Diet and Nutrition

Appetite	Thirst		
☐ High	water per day	_____oz	☐ Artificial Sweeteners
☐ Low	Coffee/ tea per day	_____oz	☐ Sugar/Honey etc
☐ # Meals per day _____	Soft drinks per day	_____oz	☐ Salty food/ table salt

Average Daily Diet

Breakfast	Lunch	Dinner

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Name:_____ Date:_____

Patient Health History Form

Lifestyle

- ☐ Alcohol freq. per week_____
- ☐ Tobacco Pks/day_____
- ☐ Marijuana
- ☐ Recreational drugs
- ☐ Stress
- ☐ Occupational Hazards
- ☐ Regular Exercise Type/Frq_____

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Recent weight loss/gain
- ☐ Peculiar taste (describe)
- ☐ Poor sleep
- ☐ Heavy sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Shortness of Breath
- ☐ Fever
- ☐ Bleed or bruise easily
- ☐ Chills
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Muscle cramps
- ☐ Vertigo or dizziness

Head, Eyes, Ears, Nose, Throat

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Other head/ neck problems
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ Grinding teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- _____
- ☐ Migraines
- ☐ Concussions
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive saliva
- ☐ Sinus problems
- ☐ Excessive phlegm
- ☐ Color of phlegm
- _____
- ☐ Headaches
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches

Respiratory

- ☐ Tight chest
- ☐ Asthma/wheezing
- ☐ Pneumonia
- ☐ Difficulty breathing
- ☐ when lying down?
- ☐ Shortness of breath
- ☐ Coughing blood
- ☐ Cough
- ☐ Wet or Dry?

Color of Phlegm

Thick or Thin?_____

Musculoskeletal

- ☐ Neck/shoulder pain
- ☐ Muscle pain
- ☐ Other _____
- ☐ Joint Pain
- ☐ Rib pain
- ☐ Limited range of motion
- ☐ Limited use
- ☐ Upper back pain
- ☐ Low back pain

Skin and Hair

- ☐ Change in hair/skin texture
- ☐ Fungal infections
- ☐ Itching
- ☐ Dandruff
- ☐ Hair loss
- ☐ Ulcerations
- ☐ Rashes
- ☐ Hives
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other _____

Neuropsychological

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor memory
- ☐ Depression
- ☐ Anxiety
- ☐ Considered/attempted
- ☐ suicide
- ☐ Seeing a therapist
- ☐ Irritability
- ☐ Easily stressed
- ☐ Abuse survivor

Genito-urinary

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urgent urination
- ☐ Date of last UTI_____
- ☐ Increased libido
- ☐ Decreased libido
- ☐ Kidney stone
- ☐ Wake to urinate
- ☐ Nocturnal emission
- ☐ Blood in urine
- ☐ Unable to hold urine
- ☐ Incomplete urination
- ☐ Impotence
- ☐ Premature ejaculation
- ☐ Venereal disease
- ☐ Bedwetting

Gynecology

Date last period began_____

Length of cycle (day 1 to day 1)_____

Duration of flow_____

Age of Menopause_____

- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Vaginal infections
- ☐ Yeast Infections
- ☐ Breast Lumps

Date of last Mammogram_____

NEW YOU ACUPUNCTURE WELLNESS CENTER

CONSENT FOR TREATMENT

PLEASE INITIAL EACH PARAGRAPH AFTER READING. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR ACUPUNCTURE PHYSICIAN BEFORE INITIALING.

You have chosen to undergo Acupuncture, Moxibustion, Cupping, Gua Sha, Tui Na, Electrical Stimulation, Chinese Herbal Therapy, Acupuncture Injection Therapy and Homeopathic Remedies by New You Acupuncture Wellness Center. Such treatments are quite common in Acupuncture and Chinese Medicine and are considered safe procedures. Nevertheless, any treatment is not without some risks. Please review the following before you consent to its use.

_____1. Discomfort, swelling and/or bruising can occur at the site where the needles or modalities are placed.
_____2. Moxibustion consists of the use of indirect heat; supplied by burning an herb or combination of herbs. This procedure is known as moxibustion. I understand that this treatment may leave some redness and in some cases a small blister at the moxibustion site.
_____3. Chinese techniques called Gua Sha, Tui Na and cupping may be used in certain cases. These procedures may produce a deep redness of the skin, which can remain for varying periods of time. For some people, bruising and tenderness may persist for several days following the treatment.
_____4. In some cases Chinese herbal therapy and oral homeopathic remedies may be used. Side effects such as digestive upset, bowel movement irregularities, skin irritations and headaches may occur. In all cases of unexpected side effects, patients are instructed to stop treatments, make contact with the acupuncture physician's office and follow instructions given. In the majority of cases side affect symptoms will resolve within twenty-four (24) to forty-eight (48) hours.
_____5. Acupuncture injection therapy may be used in certain cases. Acupuncture injection therapy is a technique that injects homeopathic remedies and/or nutritional supplements intra-dermally, subcutaneously or intramuscularly. Discomfort, swelling, or bruising at the injection site can occur. In all cases of unexpected side effects patients are instructed to stop treatments and contact their acupuncture physician's office and follow instructions given. In the majority of cases side affects will resolve within twenty-four (24) to forty-eight (48) hours.

YOUR OBLIGATION
_____1. If an adverse reaction is encountered, it is imperative that you immediately report it to your healthcare provider, and follow all instructions carefully for remedy of the adverse reaction.
_____2. Other:
_____

_____

I have read and understand the above paragraphs and realize that Acupuncture, Moxibustion, Cupping, Gua Sha, Tui Na, Electrical Stimulation, Chinese Herbal Therapy, Acupuncture Injection Therapy, Homeopathic Remedies carry with it certain possible risks. I request that these procedures be used for my treatment. All my questions have been answered fully to my satisfaction regarding this consent and I fully understand the risks involved. I also state that I speak, read and write English.

_____
Printed Name

_____
PATIENT'S (OR LEGAL GUARDIAN'S) SIGNATURE DATE