julianakramer@gmail.com **Juliana Kramer, L.Ac.** *415-672-2036*

Patient Information	**Contact Information**
Date: _____ Name: _____ Address: _____ City, State, Zip: _____ Age: _____ Birthdate: _____ Gender: _____ Occupation: _____ How did you hear about us? _____ First time getting acupuncture? _____	Phone number: _____ Email: _____ Best way to reach you? _____ **Emergency Contact Person** Name: _____ Phone number: _____ Relationship: _____
Health History	
What are your primary reasons for coming in for treatment? 1. _____ 2. _____ 3. _____ Medications/Supplements you take: _____ _____ Major illnesses/accidents/surgeries? _____ _____ Drugs (specify type) / Cigarettes / Alcohol quantity & frequency: _____ _____ Do you want support in cutting back on any addictive habits? _____ _____	Check illnesses that have occurred in family, S: Self, M: Mother, F: father, G: Grandparent, Si:Sibling: _____ Diabetes _____ High blood pressure _____ Cancer (type: _____) _____ Heart Disease _____ Stroke _____ Auto-Immune Other: _____ Check those you have or have had this year: __ Major life events (ie. Move, job loss, relationship change, loss of loved one) __ Major change in overall health What type of exercise do you do / how frequently? _____ _____ Do you have access to primary medical care? ____ How long since last complete physical? _____ Anything else you want me to know? _____ _____

For the following please circle C for Current or P for Past:

CARDIOVASCULAR

- C/P Chest pain
- C/P High or low blood pressure
- C/P Pain over heart
- C/P Poor circulation
- C/P Previous heart attack
- C/P Rapid/irregular heart beat
- C/P Swelling of ankles
- C/P High Cholesterol

EYES/EAR/NOSE/THROAT/HEAD/RESPIRATORY

- C/P Asthma/wheezing
- C/P Blurred or failing vision
- C/P Difficulty breathing
- C/P Earache
- C/P Enlarged glands
- C/P Eye pain
- C/P Frequent colds
- C/P Hay fever (Allergies)
- C/P Gum trouble
- C/P Nose bleeds
- C/P Loss of hearing
- C/P Persistent cough
- C/P Ringing in ears
- C/P Sinus problems
- C/P Dizziness
- C/P Headaches / Migraine

GASTROINTESTINAL

- C/P Circle: Belching, gas or bloating
- C/P Colon trouble
- C/P Constipation
- C/P Circle: Diarrhea / loose stool
- C/P Difficulty swallowing
- C/P Excessive hunger
- C/P Excessive thirst
- C/P Gall bladder trouble
- C/P Hemorrhoids (piles)
- C/P Indigestion
- C/P Circle: Nausea / Vomiting
- C/P Pain over stomach
- C/P Poor appetite

EMOTIONAL HEALTH

- C/P Excessive sadness / grief
- C/P Excessive worry / overthinking
- C/P Excessive anger
- C/P Excessive fear
- C/P Excessive euphoria (mania)
- C/P Excessive fatigue
- C/P Circle: Loss of sleep/poor sleep
- C/P Loss or gain of weight
- C/P Easily startled
- C/P Difficulty Focusing

GENITO/URINARY

- C/P Blood/pus in urine
- C/P Frequent urination (fluids in < fluids out)
- C/P Inability to control urine
- C/P Decreased urination (fluids in > fluids out)
- C/P Painful urination
- C/P Kidney infection/stones
- C/P Lowered libido

MUSCLE/JOINT/BONES

- C/P Tremors or Cramps
- C/P Swollen joints, locations: _____

Indicate if there is Pain (Pa), Weakness (W), or Numbness (N):

- C/P Circle: Arms / Wrists
- C/P Circle: Legs / Hips / Knees
- C/P Back, Circle: Upper, Mid, Lower
- C/P Circle: Feet / Ankles
- C/P Circle: Hands / Wrists
- C/P Neck
- C/P Shoulders
- C/P Other _____

SKIN

- C/P Boils
- C/P Eczema
- C/P Bruise easily
- C/P Dry skin
- C/P Itching/rash
- C/P Sensitive skin
- C/P Sores that won't heal
- C/P Sweats (Circle: Day/Night)

FOR MEN ONLY

- C/P Erection difficulties
- C/P Penis discharge
- C/P Prostate trouble

FOR WOMEN ONLY

- C/P Bleeding between periods
- C/P Clots in menses
- C/P Excessive menstrual flow
- C/P Scanty menstrual flow
- C/P Extreme menstrual pain
- C/P Irregular cycle
- C/P Menopausal symptoms
- C/P Previous miscarriage
- C/P PMS (Circle symptoms experienced just before/during your menses: stress, irritability, sadness, mood swings, hypersensitivity, abdominal bloating, breast tenderness / swelling, insomnia, fatigue, cramps, constipation, diarrhea, libido change, acne)

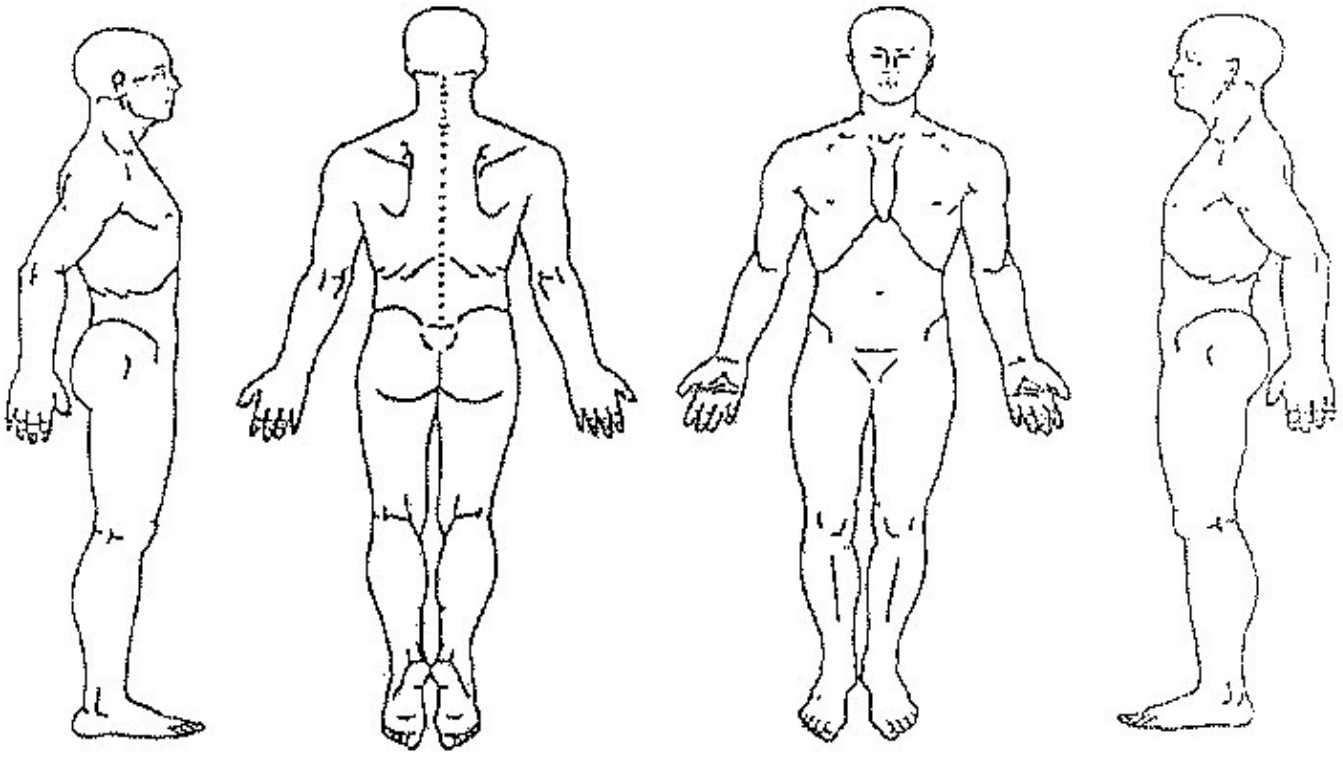
Date of the 1st day of last period? _____

Could you be pregnant? _____

If so, what is your due date? _____

PAIN AREAS:

Circle and Describe



Please check any of the following that apply to you:

__ Headaches

__ Grating in Neck

__ Sinus Pain

__ Painful or Swollen Joints

__ Arthritis

__ Degenerative Disc

__ Osteoporosis

__ Bulging disc

__ Torn Muscles

__ Scoliosis

__ Pinched Nerves

__ Recent Fracture

__ Pregnant Mo. _____

__ Cold Hands

__ Cold Feet

__ Pins and Needles (extremities)

__ Swollen Ankles

__ Dizziness

__ Fainting

__ Diabetes

__ Cancer

__ Chest Pains

__ Heart Condition

__ High Blood Pressure

__ Low Blood Pressure

__ Hypertension

__ Aneurysms

__ Phlebitis

__ Bone, Muscle or Skin Disease

__ Infectious Disease

Juliana Kramer, Licensed Acupuncturist (L.Ac.)

INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Juliana Kramer, L.Ac.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. 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 acupuncturist below uses sterile, disposable, single-use needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

I understand that methods of treatment may include, but are not limited to, acupuncture, electrostimulation, gua sha, cupping, Tui Na, massage, and Chinese and Western herbal remedies, supplements, and nutritional counseling.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that may be recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that the herbs need to be prepared and consumed according to the instructions provided orally and in writing. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will keep the clinic practitioner informed of my current medications and allergies and understand that I am responsible for obtaining appropriate primary medical care, which is not provided by this clinic. I understand that some herbs and acupuncture treatments are contraindicated during pregnancy. I will notify the clinic practitioner if I am or intend to become pregnant.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I also understand that results are not guaranteed. I do not expect Juliana Kramer, L.Ac. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named clinic to exercise judgment during the course of treatment which they think at the time, based upon facts then known, is in my best interests. I understand that I may refuse or stop any treatment.

I understand that I am expected to pay for services at the time of treatment. **Cancellation policy: late cancellation is within twenty-four (24) hours of a booked appointment. If I cancel with less than twenty-four hours notice, or if I miss a booked appointment, I understand that I will be charged the full rate of the appointment.**

If I am using health insurance and have a late cancellation I understand that I am liable for the full amount of the non-insurance rate of all treatments being provided. Non-insurance rates for follow-up acupuncture visits are One Hundred ($100) per hour. If I arrive late and the practitioner cannot complete the quantity of time for treatment intended, I understand that I am liable for payment in full for the alotted time.

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.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name