

Patient Information	Contact Information
<p>Date: _____</p> <p>Name: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Age: _____ Birthdate: _____</p> <p>Gender: _____ Occupation: _____</p> <p>How did you hear about me? _____</p> <p>First time getting acupuncture? _____</p>	<p>Phone number: _____</p> <p>Email: _____</p> <p>Best way to reach you? _____</p> <p><b>Emergency Contact Person</b></p> <p>Name: _____</p> <p>Phone number: _____</p> <p>Relationship: _____</p>
Health History	
<p>What are your primary reasons for coming in for treatment?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>4. _____</p> <p>Medications/Supplements you take:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Major illnesses/accidents/surgeries?</p> <p>_____</p> <p>_____</p> <p>Drugs (specify type) / Cigarettes / Alcohol quantity &amp; frequency:</p> <p>_____</p> <p>_____</p> <p>Would you like help cutting down or quitting?</p> <p>_____</p>	<p>Check illnesses that have occurred in family, S: Self, M: Mother, F: father, G: Grandparent, Si: Sibling: _____</p> <p>Diabetes _____ Gallbladder Issues _____</p> <p>_____ High blood pressure _____ Heart Disease _____</p> <p>_____ Stroke _____ Auto-Immune _____</p> <p>_____ Cancer (type: _____)</p> <p>Other: _____</p> <p>Check those you have or have had this year:</p> <p>___ Major life events (ie. Move, job loss, relationship change, loss of loved one)</p> <p>___ Major change in overall health</p> <p>What type of exercise do you do / how frequently?</p> <p>_____</p> <p>Do you have access to primary medical care? _____</p> <p>How long since last complete physical? _____</p> <p>Anything else you want me to know?</p> <p>_____</p> <p>_____</p> <p>Your Birth – Trauma / C-Section / Premature? Describe:</p> <p>_____</p> <p>_____</p>



**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

**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 - check symptoms experienced just before/during your menses:**

<input type="checkbox"/> stress	<input type="checkbox"/> insomnia
<input type="checkbox"/> irritability	<input type="checkbox"/> night sweats
<input type="checkbox"/> sadness	<input type="checkbox"/> fatigue
<input type="checkbox"/> mood swings	<input type="checkbox"/> cramps
<input type="checkbox"/> hypersensitivity	<input type="checkbox"/> constipation
<input type="checkbox"/> abdominal bloating	<input type="checkbox"/> diarrhea
<input type="checkbox"/> breast tenderness / swelling	<input type="checkbox"/> libido change
	<input type="checkbox"/> acne
	<input type="checkbox"/> temperature changes

Date of the 1st day of last period? \_\_\_\_\_  
 Could you be pregnant? \_\_\_\_\_  
 If so, what is your due date? \_\_\_\_\_

**MUSCLE/JOINT/BONES**

- C/P Tremors or Cramps or Muscle Spasms
- Locations: \_\_\_\_\_
- C/P Sciatica (Pain from low back / buttock down leg)
- Locations: left/right, back of leg, side of leg
- \_\_\_\_\_
- C/P Circle: Swollen/Painful joints/Arthritis
- Locations: \_\_\_\_\_
- \_\_\_\_\_

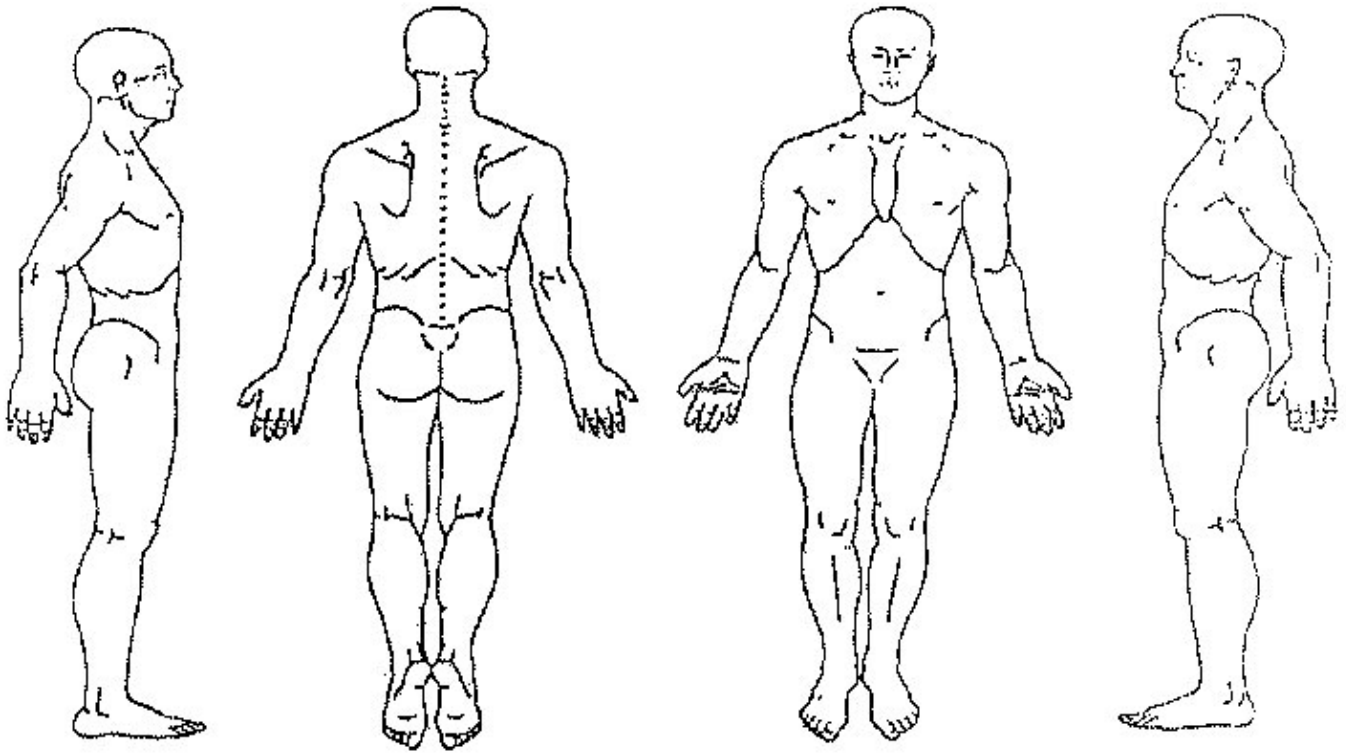
Indicate: Pain (Pa), Weakness (W), or Numbness (N)

- 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 – if yes for C/P, please indication location**

- C/P Boils
- C/P Lumps
- 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)

Pain Areas – Circle and Describe



## 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 (\$150). 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 (\$150) for the treatment being provided. If I arrive more than 15 minutes late and the practitioner cannot give or complete the treatment, I understand that I am liable for payment in full (\$150) for the allotted 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