Patient Information

Name:_____ Date: _____

Address: _____ Phone: _____

_____ Gender: _____

Birth Date: _____ Age: _____

Email address (optional) _____

Referred here by: _____

Emergency Contact: _____ Telephone #: _____

Relationship: _____

Have you ever had acupuncture before? Y / N

What health issue(s) would you like to be addressed? _____

_____

Are you presently being treating for any medical conditions? Please describe. _____

_____

Please briefly describe any chronic pain. _____

What treatment have you been using for relief of this pain? _____

_____

Do you have other health concerns? _____

Are you a vegetarian / vegan? **Y / N**

Do you drink coffee? **Y** Frequency _____ **N**

Please list any food or drug allergies: _____

Do you exercise regularly? **Y** Type of exercise _____ **N**

Please list any vitamins, herbs, or medications you are currently taking:_____

_____

_____

Previous Pregnancies

Living_____ Ectopic_____ Miscarriages_____ Induced Abortions_____ Total_____

Head and Neck

Past	current	
☐	☐	Blurred vision
☐	☐	Visual changes
☐	☐	Poor night vision
☐	☐	Visual spots
☐	☐	Cataracts
☐	☐	Eye discharge
☐	☐	Nose bleeds
☐	☐	Sinus infection
☐	☐	Nasal allergies
☐	☐	Sore throat
☐	☐	Swollen glands
☐	☐	Teeth grinding
☐	☐	Ear infection
☐	☐	Ringing of ears
☐	☐	Poor hearing

Gastro-Intestinal

Past	current	
☐	☐	Bad breath
☐	☐	Belching
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Indigestion
☐	☐	Pain/cramps
☐	☐	Gas/bloating
☐	☐	Gallbladder disorder
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Rectal Pain
☐	☐	Diarrhea
☐	☐	Bloody stools

Cardiovascular

Past	current	
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Blood clots
☐	☐	Palpitations
☐	☐	Chest Pain
☐	☐	Irreg. heart beat
☐	☐	Edema
☐	☐	Valve prolapse
☐	☐	Pacemaker

Respiratory

Past	current	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Frequent colds
☐	☐	Pneumonia
☐	☐	Cough
☐	☐	Short of breath
☐	☐	COPD
☐	☐	Tuberculosis

Genito-Urinary

Past	current	
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Bloody urine
☐	☐	Urgency
☐	☐	Frequent UTI
☐	☐	Kidney stones
☐	☐	Kidney disease
☐	☐	Leaky bladder

Ortho-Neuromuscular

Past	current	
☐	☐	Pain/tightness
☐	☐	Numbness
☐	☐	Seizures
☐	☐	Tremors
☐	☐	Paralysis

Skin

Past	current	
☐	☐	Rashes/hives
☐	☐	Itching
☐	☐	Dryness
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Tumors/lumps

Use history

Past	current	
☐	☐	Tobacco
☐	☐	Marijuana
☐	☐	Alcohol
☐	☐	Cocaine/crack
☐	☐	Speed
☐	☐	Heroin
☐	☐	Pain meds

Female

Past	current	
☐	☐	Vaginal infection
☐	☐	Genital pain/itch
☐	☐	Genital lesions
☐	☐	Genital discharge
☐	☐	PID
☐	☐	Abnormal PAP
☐	☐	Irregular menses
☐	☐	Painful menses
☐	☐	PMS
☐	☐	Abnormal bleeding
☐	☐	Breast lumps

Male

☐	☐	Genital lesions
☐	☐	Genital pain/itch
☐	☐	Genital discharge
☐	☐	Impotence

Psychological

Past	current	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Insomnia
☐	☐	Bipolar disorder
☐	☐	Stress
☐	☐	Irritability
☐	☐	Substance abuse
☐	☐	Eating disorder
☐	☐	Sexual abuse
☐	☐	Physical abuse

Positive Test Results for:

Past	current	
☐	☐	HIV
☐	☐	Hepatitis
☐	☐	Gonorrhea
☐	☐	Syphilis
☐	☐	Genital warts
☐	☐	Herpes

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by JoAnn W. Bennett, L.Ac, Marnie McCurdy, L.Ac, 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 JoAnn W. Bennett, L.Ac, or Marnie McCurdy, L.Ac, including those working in the clinic or office listed below or any other office or clinic, whether signatories to this for 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 be an unpleasant taste or smell. 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. 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 clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk from 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 supplements (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 upon 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.

_____ _____

Patient's Signature Date

By voluntarily signing below, I am consenting to acupuncture and herbal medicine for the sole purpose of labor induction.

_____ _____

Patient's Signature Date

Privacy Policy

All patient information is confidential and private. JoAnn W. Bennett, L.Ac and Marnie McCurdy, L.Ac will not share or disclose any personal information for any reason without your consent.

Please sign and date to acknowledge that you have read and understand the above statement.

Patient's Signature _____ Date _____

Should you wish JoAnn W. Bennett, L.Ac or Marnie McCurdy, L.Ac, to release your information or consult with other physicians regarding your treatment, please initial below.

Initial _____ Date _____

I permit JoAnn W. Bennett, L.Ac or Marnie McCurdy, L.Ac, to leave phone messages for me.

Initial _____ Date _____