RVA ACUPUNCTURE

Relief Starts Here

Confidential Patient Record

DATE

Please print legibly and fill out the form in its entirety.

Is your visit today a work-related injury or automobile accident? YES NO

Name:

Address: Date of Birth: Age:

City: Email:

State: Phone #: (home)

Zip: (work)

Sex: MALE or FEMALE (mobile)

Preferred Contact: PHONE or EMAIL

Emergency Contact (include phone #):

Relation to you:

What is your occupation?

What is your primary reason for today's visit?

Have you had acupuncture before?

How did you hear about us?

Would you like to be added to our monthly online newsletter? YES NO

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FINANCIAL AGREEMENT & LATE CANCELLATION POLICY

Welcome to our office. We are here to provide customized care that assists you in healing and wellness. We ask that you contribute to this by arriving on time for your appointments. If you are more than 15 minutes late, you may not be able to be seen and will be charged for your reserved treatment time. Please give at least 24 hours' notice to avoid the late cancellation penalty.

Internal and topical herbs are an additional charge unless specifically included in a care plan and are not covered by insurance or FSA plans.

Payment is due at the time of service in the form of credit card, check, or cash. $25 will be charged for a returned check and future payments must be made by alternate means.

FINANCIAL AGREEMENT

☐ *I understand that I am financially responsible for all charges and services, and charges for any missed appointments WITHOUT 24-HOURS NOTICE. I authorize payment of medical benefits to myself or the names provided for professional services rendered. I authorize release of any medical information necessary to process this claim.*

Patient/Parent/Guardian Signature Date

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form 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 have an unpleasant smell or taste. 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

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Name _____ Age _____ Date _____

Height_____ Weight _____ Blood Pressure _____/_____

Please number the boxes with the following grading scale **(leave blank** if you don't experience it)
1 = Experience the symptom once or more per week.
2 = Experience the symptom once every couple of weeks.
3 = Experience the symptom once per month.

Earth

__ Indigestion, gas, bloating, heartburn, reflux
__ Stomach distension or pain
__ Nausea
__ Appetite is __ good ___ poor
__ Stools are ___ loose ___ soft ___ well formed
__ Bowel movements ___ times daily
__ Blood in stools
__ Frequent over-thinking, frequent worrying
__ Weakness of arms and legs
__ Chronic hemorrhoids
__ Feel sleepy, tired after eating
__ Difficulty losing or gaining weight
__ Phlegm or mucous in nose, ears (wax)
__ Lots of thin, clear mucous
__ Yellow or green phlegm
__ Frequent gurgling sounds in stomach
__ Undigested food in stools
__ Sweet taste in mouth
__ Craving for sweets
__ Mouth sores or bleeding gums
__ Toothaches
__ Headaches at forehead
__ Dry heaves or hiccups

Wood

__ Irritability, frequent moodiness, anger
__ Impetuosity, depression, mental restlessness
__ Tight feeling in chest or side of trunk, breasts
__ Frequent sighing or need to take a deep breath
__ Burping, belching, frequent hiccups
__ Stools hard like little pebbles or long and thin
__ Eye redness or pain
__ Headaches on temples, top or back of head
__ Sudden dizziness or vertigo
__ High pitched ringing in ears
__ Blurred vision, eye floaters, poor night vision
__ Dizziness when getting up or after exertion
__ Brittle nails or dry skin
__ Twitching muscles or eyelids
__ Numbness of limbs
__ Tremors, convulsions
__ Sudden hearing loss, ear pain
__ Genital itching, swelling or pain
__ Easily startled
__ Bitter taste in mouth
__ Feeling of lump in throat, difficult swallowing
__ "Liver" spots, varicosities

Metal

__ Respiratory Problems
__ Sinus Problems
__ Allergies, sinus congestion
__ Hands and feet go to sleep easily
__ Fevers, colds & flu, sore throat
__ Cough
__ Phlegm is __ clear __ yellow
__ Phlegm is __ thick ___ watery
__ Spontaneous sweating
__ Chronic asthma
__ Fatigue and dislike of talking
__ Facial edema or swelling
__ Frequent colds
__ Asthma, harder to exhale than inhale
__ Prefer open windows in a closed room

Fire

__ Palpitations (can feel heart beating in chest)
__ Insomnia, difficulty falling asleep
__ Insomnia, difficulty staying asleep
__ Perspiration or palpitations with excitement
__ Discomfort at high altitude
__ Get drowsy often
__ Unsettled or anxious
__ Dry mouth and throat
__ Tongue sores
__ Chest pain or stifling sensation in chest
__ Circulation problems
__ Skin rash that is red, burning or itching
__ Burning urination

Water
__ Hearing loss
__ Ear ringing
__ Low back pain
__ Knee pain
__ Cold feet
__ Crave salt
__ Feel cold easily
__ Darkness under eyes
__ Failing memory
__ Low blood pressure
__ High blood pressure
__ Hair thinning or loss, early gray hair
__ Frequent urination, incontinence or dribbling
__ Frequent night urination
__ Color of urine is __ pale __ yellow __ dark yellow
__ Urine is __ clear __ cloudy or turbid
__ Asthma, harder to inhale than exhale
__ Difficulty breathing when lying down
__ Flushed face easily
__ Bone or joint problems
__ Early morning diarrhea or chronic diarrhea
__ Prolonged physical or emotional stress
__ History of blood loss
__ Night sweats or hot flashes, flushed face
__ Increased or reduced sex drive
__ Low grade fever
__ Frequent terror, fear or fright
__ Poor memory

Women
__ Started menstruation at age ____
__ Cycle starts every ___ days (or varies ___days to ___days)
__ Menstrual flow lasts ___ days
__ Yeast or other genital infections
__ Clear watery vaginal discharge
__ Thick or yellow vaginal discharge
__ Irregular menses
__ Taking birth control pills
__ Heavy menstrual bleeding
__ Dark menstrual blood with clots
__ Bright red menstrual blood
__ Pale color menstrual blood
__ Spotting or dribbling for many days
__ Menstrual pain before, during, or after period
__ Menstrual low back pain
__ Short/early cycle
__ Long/delayed cycle
__ Post or pre-menstrual symptoms
__ Frequent painful or swollen breasts
__ Cysts, lumps, tumors
__ Menopause started at age ___

Men
__ Prostrate trouble
__ Dribbling urination
__ Weak or slow urine stream
__ Testicular swelling or pain
__ Difficulty with erections
__ Urethral trouble or discharge

History of back pain in family? If yes,
__ mother
__ father
__ grandparents

Have you been diagnosed with:

__ Thyroid disease
__ Liver trouble
__ Diabetes
__ Gallbladder Problems
__ Cardiovascular disease
__ Irritable Bowel Syndrome
__ Any kind of Arthritis
__ Kidney trouble
__ Ulcers
__ Fibromyalgia

Please list any medications you are taking:

_____

_____

_____

_____

Please list any nutritional supplements you are taking:

_____

_____

Please list any recreational drugs you are using:

_____

_____