

Significant Trauma (physical or emotional)

Birth History (prolonged labor, forceps delivery, complications, etc.)

Allergies (chemical, environmental, food, drugs, etc.)

Medications (names & dosages) Please attach an additional page if necessary.

Vitamins/Supplements/Herbs

Exercise

Days per week

Length of workout

Type of Activity

Diet

Meals per day

Snacks

Caffeinated Drinks

Alcohol per week

What makes your condition better? (Rest, movement, heat/cold, fresh air, eating, crying, etc)

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc)

Personal History Please check any conditions or symptoms you have now.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Diverticulitis/IBS | <input type="checkbox"/> Elev.Blood Chol. | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Impotence | <input type="checkbox"/> Infertility | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Raynaud's Disease | <input type="checkbox"/> Respiratory Allergy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Ulcer |

Family Medical History Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM(grandmother), GF (grandfather) next to choice.

- | | | | |
|---|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Allergies __ | <input type="checkbox"/> Asthma __ | <input type="checkbox"/> Cancer __ | <input type="checkbox"/> Diabetes __ |
| <input type="checkbox"/> Heart Disease __ | <input type="checkbox"/> High Blood Pressure __ | <input type="checkbox"/> Seizures __ | <input type="checkbox"/> Stroke __ |
| <input type="checkbox"/> Other _____ | | | |
-

Please check if you have had any of these items listed below in the last year.
Put a star on the box if you had this in the past but do not any longer.

General

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Bleed/Bruise easily | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Dental/gum problems | <input type="checkbox"/> Peculiar taste/smell |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) | |

Skin and Hair

- | | | | |
|--|--------------------------------------|--|---|
| <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Itching | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Change in hair/skin texture | <input type="checkbox"/> Acne | <input type="checkbox"/> Face flushing | <input type="checkbox"/> Skin discoloration |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nails |
| | | <input type="checkbox"/> Scars Location: _____ | |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Headaches |

Cardiovascular

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Dizziness | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Pain with deep breath | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |

Gastrointestinal

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Loose stools (>2per day) | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Acid reflex/GERD | <input type="checkbox"/> Hernia | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

Genito-Urinary

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sores on genitals | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination |
| <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Nocturnal emission |
| <input type="checkbox"/> Dribbling after urination | <input type="checkbox"/> Pain in testicles | <input type="checkbox"/> Herpes | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Excessive libido | <input type="checkbox"/> Night urination ... | What time? _____ | How often _____ |

Gynecological/Reproductive

- | | | |
|---|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses? _____ |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses? _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Infertility | <input type="checkbox"/> Number of pregnancies _____ |
| <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> PMS | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> Number of live births _____ |
| <input type="checkbox"/> Painful menstruation | | <input type="checkbox"/> Number of miscarriages _____ |
| <input type="checkbox"/> Number of abortions _____ | | |
| <input type="checkbox"/> Do you practice birth control? _____ | | |
| <input type="checkbox"/> What type? _____ | | How long? _____ |

Musculoskeletal

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain Low__Middle__Upper__ | | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Soreness/weakness in lower body (back, knee, hip, ankle, foot) | | | |

Neuropsychological

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Seasonal Affective Disorder | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Anxiety/Panic attacks |
| <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | |

- Have you ever been treated for emotional problems? Yes No
- Have you ever considered or attempted suicide? Yes No
- Have you ever been treated for substance abuse? Yes No

Comments Please inform me of any other problems you would like to discuss.

Deana S. Rehmel, D.C., L. Ac.
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Acupuncture Financial Policy

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment. If at any time you have questions regarding any treatment, fee, or service, please discuss them with us promptly.

INSURANCE

All payments for acupuncture services will be required at time of service **in full**. We do not obtain insurance coverage for acupuncture and do not routinely bill for this service, as most policies do not provide payment. If you do have coverage, please provide the benefit details and the claim will be submitted for you. A receipt will be provided for you to submit to your insurance if you wish to pay the self-pay discount.

MINOR PATIENTS

An adult must accompany the minor at the time of the first visit. The adult accompanying the minor is responsible for payment at time of service.

FAILED APPOINTMENTS

By scheduling, you have agreed to attend all scheduled appointments in a timely manner. We require a **24-Hour** notice for cancellation of acupuncture appointments. Failure to cancel your appointment will result in being assessed a **\$65.00 fee**. This fee is due when billed or at your next appointment which ever comes first.

PATIENT'S STATEMENT

I have read and understand the Financial Policy of Dickinson Chiropractic, P.C. I understand that I am responsible for payment in full of acupuncture services at time of service.

Print Name of Patient

Date

Signature of Patient (or Representative)

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

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 retained, or removed. Bruising is a common side effect of cupping and gua sha. 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 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.

The herbs and nutritional supplements (which are from plant, mineral and animal 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

Print Name of Patient

Deana S. Rehmel, D.C., L. Ac.

Print Name of Acupuncturist

Signature of Patient (or Representative)

Signature of Acupuncturist

(Print Name of Patient Representative)

(Print Name of Witness/Translator)

Date Consent Completed

(Signature of Witness/Translator)