GO HEALTH CHIROPRACTIC - ACUPUNCTURE

PATIENT INFORMATION

Date: _____

Name_____ Age_____ Date of Birth _____

Address_____ City_____ State_____ Zip_____

Primary Phone (h, c, w) _____ Secondary Phone (h, c, w) _____

Email_____ (we do not share your email with anyone)

Male _____ Female _____ Height: _____ Weight: _____

Married_____ Single_____ Committed Relationship_____ Separated_____ Divorced_____ Widowed _____

Occupation: _____ Employer: _____

Referred by_____

Emergency contact_____ Relationship_____ Phone _____

MEDICAL HISTORY

Main Health Concern: _____

_____

_____

Describe your symptoms: _____

_____

_____

When /How did this condition occur? _____

_____

How does this affect your daily life? _____

_____

Better or worse since onset? _____

What makes it feel better? _____ What makes it feel worse? _____

Have you ever received any treatment for this condition? __yes __no

If yes, what and by whom?_____

What was the diagnosis? _____

What were the results of the treatment? _____

_____

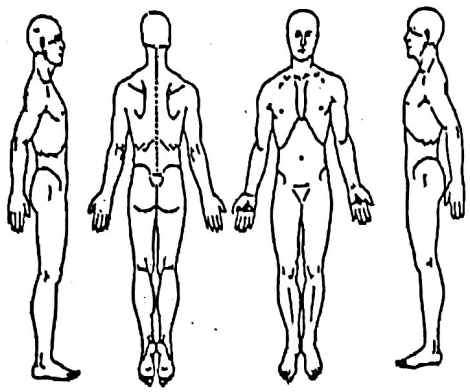
_____

Do you have other health concerns? _____

_____

_____

DO YOU HAVE PAIN? ___ YES ___ NO



If Yes, please describe pain and mark area on diagram

1. My worst pain area is my _____
The pain is: constant / intermittent / dull aching / sharp / burning
Rate Pain on a scale of 1-10 (10 = worst):_____
Aggravated By: pressure / cold / heat / exercise / other _____
Alleviated By: pressure / cold / heat / exercise / other _____
Do you take pain medication? Dose_____, _____days/wk

2. My next to worst pain area is my_____
The pain is: constant / intermittent / dull aching / sharp / burning
Rate Pain on a scale of 1-10 (10 = worst):_____
Aggravated By: pressure / cold / heat / exercise /other _____
Alleviated By: pressure / cold / heat / exercise / other _____
Do you take pain medication? Dose_____, _____days/wk

Past Medical History

How was your childhood health? (Please note any illnesses, injuries, traumatic events, etc...) _____

Have you been diagnosed with any of the following?:
_____ Asthma _____Cancer _____Diabetes _____Heart Disease _____ High Cholesterol _____ Allergies
_____ High Blood Pressure_____ Thyroid Disorders _____Emphysema _____Seizures _____Clotting Disorders
_____ Hepatitis _____HIV / Aids _____ Tuberculosis
___Other (describe)_____

Family Medical History (parents, siblings, grandparents) _____

Surgeries (list type and date): _____

Accidents/Injuries: _____

Allergies (drugs, chemicals, food, seasonal /pollens): _____

Abuse: _____Sexual _____Psychological _____Physical Are you currently in therapy? _____

Please indicate if you have the following:
_____Pace Maker _____Bleeding Disorder _____Are Pregnant (if so your due date)

Please list current medications (include vitamins, supplements, herbs)

Indicate any symptoms you have now or have had in the last month:

General:

_____ Hot Body Temp
_____ Cold Body Temp
_____ Sweat Easy
_____ Night Sweats
_____ Low Energy
_____ Strong Thirst (hot or cold)
_____ Thirst, no desire to drink

Liver / Gallbladder

_____ Irritable / Anger
_____ Depression/ Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red/Dry/Itchy Eyes
_____ Dizziness
_____ Blurred Vision / spots
_____ Sensation of Lump in Throat
_____ Clench Teeth at Night
_____ Muscle Cramps/twitching
_____ Tension
_____ Poor Circulation
_____ Soft/Brittle Nails or Hair
_____ Emotional Eater
_____ Breast Tenderness
_____ Gallstones
_____ Crave Sour/ Crunchy food
_____ Difficulty Making Decision
_____ Frequent Sighing / Yawning
_____ Ribside Pain

Heart / Small Intestine

_____ Heart Palpitations
_____ Chest Pains
_____ Insomnia/Sleep problems
_____ Vivid Dreams
_____ Difficulty Falling asleep
_____ Restless Sleep
_____ Anxiety / Agitation
_____ Mouth / Tongue sores
_____ Lack of Joy / Humor
_____ Crave Bitter Food

Stomach / Spleen

_____ Abdominal Pain
_____ Heaviness anywhere in body
_____ Fatigue worse after eating
_____ Increased / Decreased appetite
_____ Insulin Sensitivity / Hypoglycemia
_____ Loose Stool / Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Prolapse or Hernia
_____ Crave Sweets
_____ Hard to Digest Oily Foods
_____ Nausea / Vomiting
_____ Gas / Bloating
_____ Belching / Hiccups
_____ Gastritis / Heartburn
_____ Indigestion / Colic
_____ Overthinking / Worry
_____ Brain Fog
_____ Hard to get up in morning
_____ Edema (swelling)
_____ Muscle Fatigue

Kidney / Urinary Bladder

_____ Urinary Problems
_____ Frequent Urination
_____ Urgent Urination
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Wake up to Urinate > 2x
_____ Edema / Water retention
_____ Low Back Pain / Weakness
_____ Weak / Sore Knees
_____ Decreased Bone Density
_____ Feel Cold Easy
_____ Low / Excess Libido
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Tinnitus (low pitch)
_____ Fear / Depression
_____ Hot Flashes / Night Sweats
_____ Crave Salty Foods
_____ Lack of Willpower
_____ Kidney Stones (history)
_____ Impotence
_____ Lack of Stamina
_____ Infertility / Sterility

Lung / Large Intestine

_____ Allergies
_____ Asthma
_____ Dry Cough
_____ Cough / Sneeze / Phlegm
_____ Nasal Discharge
_____ Post Nasal Drip / Mucus
_____ Sinus Infection / Congestion
_____ Arm / Shoulder pain
_____ Shortness of Breath
_____ Frequent Colds / Flu > 2 per year
_____ Smelling Problems
_____ Skin Rashes / Hives
_____ Grief / Sadness
_____ Crave Spicy Food
_____ Skin Rash / Hives
_____ Itchy Skin
_____ Smoke Cigarettes

Lifestyle

How many caffeinated beverages (coffee, tea, soda) per day?_____ None _____
Do you smoke cigarettes? _____ How many years? _____ How many per day?_____ Quit/when? _____
Do you drink alcohol? _____ How many drinks per week? _____
Do you exercise regularly? _____ How often? _____ Forms of exercise _____
Stress: On a scale of 1-10 (10 = worst) estimate the level of stress you feel due to your **work** _____
your **health** _____ Other causes of stress _____
Sleep: How many hours of Sleep per night? _____ Difficulty falling asleep _____ How long? _____
Difficulty staying asleep _____ How many times wake during the night? _____ Restless Sleep _____
Light Sleeper _____ Vivid Dreams_____ Feel well rested in the morning _____
Other Sleep Issues _____

Other Comments or Concerns: _____
_____
_____
_____

Women Only (Menstruation and Pregnancy History)

I have / have had (check all that apply):
Age of menopause _____ Age of first menstruation _____ Are you pregnant_____
First day of last period _____ Average days of flow_____ Spotting/Bleeding between menses _____
# of days between menses_____ Flow Amount: Normal _____ Heavy _____ Light _____
Color of Flow: Light Red _____ Bright Red _____ Dark Red _____ Brown _____ Other _____
Cramps / Pain (rate scale 1-10) _____ Clotting (Large, Small, Dark Red) _____
Practice birth control Y /N Type and How Long: _____
Number of pregnancies _____ Number of live births _____

Do you experience any of the following PMS symptoms?
_____Nausea _____Vomiting _____ Breast Tenderness _____Food Cravings _____Anxiety _____ Irritability
____Depression _____Mood Swings _____Poor Sleep _____Headaches _____ Migraines _____Constipation
_____ Diarrhea / Loose Stools ____ Cramping _____ Low back Pain _____ Acne
_____Other _____
_____

Men Only

I have (check all that apply):
____ Swollen Testicles _____ Testicular Pain _____ Impotence _____ Premature Ejaculation _____ Infertility
_____ Cold or Numb Sensation in External Genitalia _____Nocturnal emission ____Penis blood/mucous discharge
_____Other_____
_____

Patient Signature: _____ Date: _____

GO HEALTH CHIROPRACTIC

the future of wellness

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I understand that I should be evaluated by a physician for the condition I am requesting consultation. The diagnosis and treatment plan I will be given by Go Health Chiropractic's Acupuncture Clinic is based upon Traditional Chinese medical principles and natural treatment only, and does not constitute a western medical diagnosis. I understand that I am not to rely on Traditional Chinese diagnosis and treatment as my sole remedy for the treatment I am seeking. I understand if no substantial improvement is made in the condition for which I am seeking consultation, I am to seek advice from a western medical doctor. Further, if I am concurrently undergoing western medical treatments, it is my responsibility to advise my physician of any herbal supplements I am concurrently taking.

Signature_____Date_____

Go Health Chiropractic Acupuncture Clinic
Informed Consent Form for Acupuncture Treatment

I understand that the treatment I receive at Go Health Chiropractic Acupuncture Clinic is performed by a licensed acupuncturist who is trained in strict standards set by the National Commission for the Certification of Acupuncturist for clean needle technique. The acupuncturist must abide by the standards set by the Occupational Safety and Health Administration regarding proper hygiene and sterilization of equipment, disposal of hazardous materials, as well as precautions regarding blood borne pathogens and clean needle technique. With disposable needles, there is no risk of AIDS or hepatitis being contracted from the needles.

I understand that the acupuncturist does not do Western medical (biomedical) diagnosis and that it is my responsibility to seek such diagnosis elsewhere if I have not already done so.

I understand that my treatment may include a variety of Oriental medical modalities such as acupuncture, moxibustion, herbal therapies, cupping, electrical stimulation, magnet therapy, dermal friction, acupressure, dietary counseling, breathing techniques and exercises based on Oriental medical principles. Possible side effects of Oriental medical treatment are rare but may include, and are not limited to:
Bruising, bleeding, skin irritation, mild pain in the treatment area, muscle weakness and soreness, brief fatigue or nausea, sensations of heat, cold, tingling or numbness, brief lightheadedness or fainting, broken needles, temporary worsening of some symptoms, and risks of infection or pneumothorax. The use of moxibustion could cause burns. I have been informed that the possible side effects of Oriental medical herbal treatment may include, but are not limited to, gastrointestinal disturbances, allergic reactions to certain substances and possible drug and herb interactions.

I understand that an herbal formula may consist of one or more medicinal substances of plant, animal or mineral origin. I agree to let my practitioner know of any restrictions or sensitivities I may have to the formulas.

I understand that no promises or guarantees can be made regarding the outcome of the treatment and that reasonable efforts will be made to give me information so that I might make educated decisions regarding the duration and appropriateness of continued care. I hereby authorize the acupuncturist to perform diagnosis and treatment according to the professional standards of Oriental Medicine and their own professional judgment.

I understand and I agree that I am responsible for the balance on my account and all fees are payable at the time service is received.

Please circle:
I have / do not have bleeding disorder. I have/do not have a pacemaker.

Patient Signature_____ Date _____

Practitioner Signature _____Date_____

ACUPUNCTURE LOCATED @ GO HEALTH CHIROPRACTIC

ACUPUNCTURE OFFICE POLICY

The following is a summary of our center's policies.

We believe that a clear definition will allow us both to concentrate on the most important issue; regaining and maintaining your health.

We are happy to answer any questions that you have.

Acupuncture Policies:

- Cancellation Policy:
  - If you cannot make your appointment we ask that you please contact our office by phone or email us with 24 hours in advance to cancel.
  - If your appointment is not cancelled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show Policy.'

- No Show Policy:
  - If you fail to cancel your appointment according to the 'Cancellation Policy' you are considered a 'No Show.' And when you fail to redeem this appointment time you will be responsible for payment of that acupuncture appointment, either you will take care of the payment at your next appointment or a statement of the missed appointment will be sent to the address on file.

Refusal of Service Policy

We reserve the right to refuse to provide services to any person at anytime. Should you be denied service you will be reimbursed for any unused services that have been paid in advance.

By signing below I acknowledge having received and read the above 'Acupuncture Office Policy,' I herby agree to the terms and conditions outlined above.

Patient Printed Name: _____

Patient/Guardian Signature: _____

Date: _____