

Patient Information Form

Today's date:					
First name:		<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Marital status:	
Last name:		Birth date: (mm/dd/yy)		<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Partner <input type="checkbox"/> Widowed	
Email:		Social Security No.:		Phone number(s)	
Street address:			Apt:		Home:
City:		State:	Zip:	Work:	
				Cell:	
How did you learn about us? <input type="checkbox"/> Physician referral <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Other					
(Please include the name of whom referred you.) Name:					
Employment status:					Occupation:
<input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> Unemployed <input type="checkbox"/> School <input type="checkbox"/> At home <input type="checkbox"/> Retired <input type="checkbox"/> Disabled					
Reason for visit:					
Height: ft. in.		Weight: lbs.		Primary physician:	
Have you had acupuncture before:		Chinese herbal medicine?		Phone:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Western medical diagnosis (if applicable):					
Other medical treatment received: <input type="checkbox"/> Fertility clinic <input type="checkbox"/> Physical therapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Massage <input type="checkbox"/> Other:					
Please list the family members you live with:		Please list any prescription or over-the-counter medication you are currently taking:		Please list any herbal medicine and other supplements you are currently taking:	
Have you ever been exposed or have suspicions of exposure to heavy metal toxicity? (Dental work, excessive fish consumption, lead paint...) Or, toxins (mold, chemicals...)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How much water do you drink per day?					
Are you vegetarian? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How often do you use the following?				How often do you participate in the following physical activities?	
	Daily	Once/week	Rarely	Never	
Cigarettes / Cigars					Running / Walking:
Alcohol					Swimming:
Drugs					Yoga:
Coffee					Biking:
Soft Drinks					Weight Training:
Artificial Sweeteners					Gym / Fitness Class:
Fast food					Other:

PATIENT INFORMATION FORM CONTINUED

Patient name: _____

Please indicate which of the following symptoms you have had **recently** and their severity on a scale of 1-5, where 5 is the worst you can bear.

Blurred vision / poor night vision	Abdominal pain	Absentminded / loss of memory
Brittle nails	Alternate constipation / loose	Angered easily
Depression / Stress	Aversion to cold	Annoyed by little things
Dizziness	Bad breath	Changes in sexual energy
Emotional eating	Bloating / gas	Considered suicide
Feeling of lump in throat	Bruise easily	Difficulty making decisions
Genital itching / pain / lesions	Cold nose	Difficulty relaxing
Headaches / Migraines	Constipation	Dislike criticism
Irritability / frustration / impatience	Crave sweets	Experienced sexual abuse
Muscle twitching / spasm	Difficulty getting up in the morning	Family problems
Neck / shoulder tension	Fatigue / after eating	Feeling of depression
PMS	Foggy mind	Frequent crying
Red / Dry / Itchy Eyes	Heartburn	Frightening dreams or thoughts
Sensation or pain under rib cage	Heaviness in the head / body	Hopeless outlook
Sighing	Hemorrhoids	Lack of concentration
Unfulfilled desires	Increased appetite	Lonely or depressed
Visual problems / floaters	Increased thirst	Nail biting
	Intestinal pain / cramping	Nervous with strangers
Ankle swelling	Loose stool	Nervousness or anxiety
Bladder infection	Muscular tired / weak	Problems at work
Cold hands / feet	Nausea / vomiting	Sexual difficulties
Crave salty food	Overweight	Shy or sensitive
Fear	Pensive / over-thinking	Sought psychiatric help
Feel cold easily	Poor appetite	Worry a lot
Frequent urination	Poor digestion	
Hearing problems	Prefer Warm / Cold drinks	Allergies / Asthma
High sex drive	Sweat easily	Alternate fever / chills
Lack of bladder control	Unusual bleeding (nose, anus, etc.)	Cough with phlegm
Loss of head hair	Water retention	Dry cough
Low sex drive	Yeast infection	Dry mouth / nose / throat
Night sweats / hot flashing		Grief / Sadness
Poor long-term memory	Aversion to heat	Itchy / painful throat
Tinnitus	Bitter taste in mouth	Nasal discharge / drip
Wake to urinate	Chest pain / tightness	Shortness of breath
	Forgetful	Sinus infection / congestion
Insomnia / Sleep problems	Palpitations	Skin rashes / hives
Lack of joy in life	Tongue / mouth ulcers / cankers	Snoring
Restless / easily agitated		Weak immune system
Vivid dreams		

Occupation: please explain your duties and the stress levels involved

Personal impact: please explain any personal stresses in your life

Passions and hobbies: describe things

PATIENT INFORMATION FORM CONTINUED

Patient name: _____

Print the names of relatives (living or deceased) in the rows to the left. Place a (√) in the appropriate column for any illnesses that you or the relatives listed have had.

Were you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	Anemia	Anorexia	Arthritis / Gout	Asthma	Bleeding / Bruising Problems	Bulimia	Cancer or Tumors	Convulsions / Epilepsy	Diabetes	Drinking or Drug Problems	Eczema	Emphysema	Gallstones	Heart Trouble	Hepatitis	High Blood Pressure	Infertility	Frequent Infections	Kidney or Bladder Problems	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Pneumonia	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal Disease	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Veneral Disease	Weight Problems		
You																																					
Father																																					
Mother																																					
Siblings (list)																																					
Children (list)																																					
Grandparents																																					

Have you had any other significant illnesses? _____

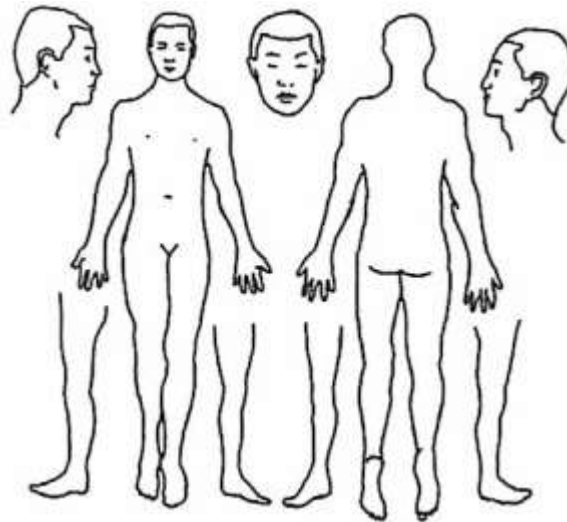
Have you had any surgeries or been hospitalized? _____

Have you had any significant trauma (accidents, injuries, etc.)? _____

Do you have any allergies (drugs, chemicals, food, etc.)? _____

Please indicate painful or distressed areas with:

B = Bumpness **P** = Pins and Needles **S** = Stabbing Pain **A** = Achy **T** = Tightness



Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Jenny Karns, L.Ac. and/or other acupuncturists who now, or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturists named, including those working at the clinic/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. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, 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 of 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.

DU}YbhB Ua Yfbc}bE: _____

8UY _____

DU}YbhG} bU} fY _____

7UbW`U}cb Dc`JW}i

If I need to reschedule or cancel my appointment, in order to avoid a \$45 cancellation fee, I must CALL the office with at least 24 hours advance notice. Patients who do not arrive for their appointments and have not called ("no call/no show") will be charged the full price of the missed session, payable before the next appointment can be scheduled.

DU}YbhG} bU} fY _____

8UY _____