as designed wellness

CONFIDENTIAL
NEW PATIENT INFORMATION

Patients Last Name: First Name: Today's Date:

Street Address: City: State: Zip:

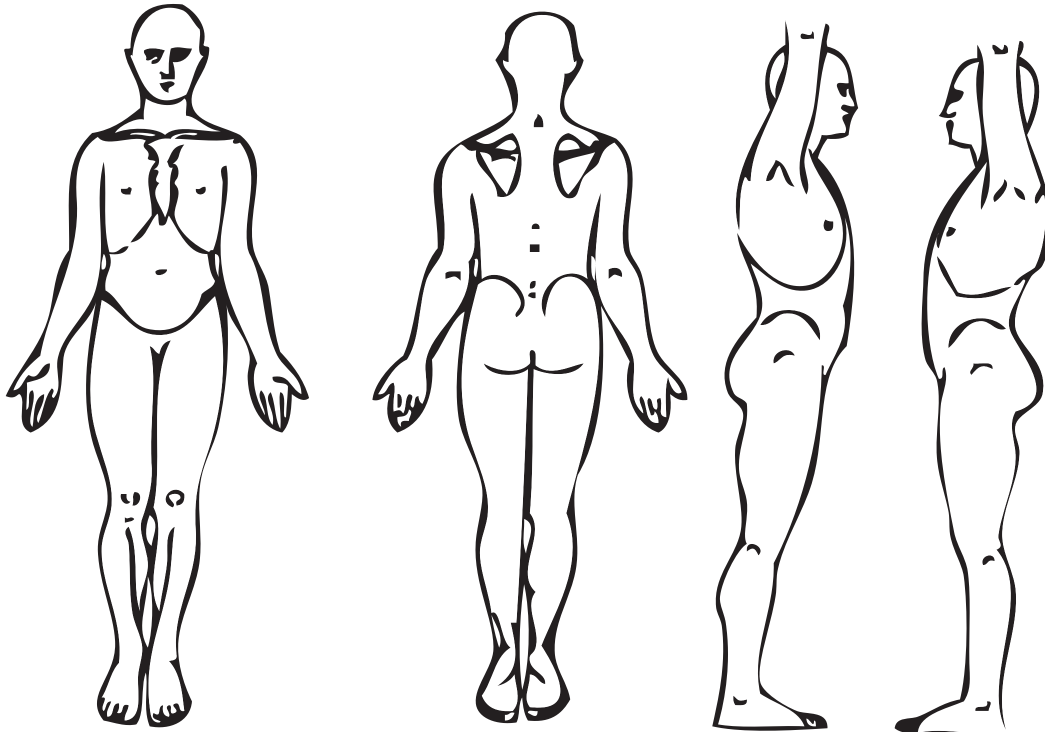
Home Phone: Work Phone: Cell Phone:

Email: Who can we thank or referring you?

Emergency Contact Name & Phone:

Sex: M◯ F◯ Date of Birth: Age: Occupation:

Please mark the areas of symptoms below.



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PERSONAL HEALTH INFORMATION

Chief Complaints (what would you like to treat today?):

Complaint #1:

How long have you had this condition? Medical Diagnosis (if any):

Complaint #2:

How long have you had this condition? Medical Diagnosis (if any):

Prescription Medications:

Vitamins, Herbs, Supplements:

Hospitalizations/Surgeries (specify date & reason):

Childhood Illness: CT Scan:

MRI: Special Studies:

X-Ray:

Allergies:

Are you taking blood thinners?: (Coumadin/Warfarin, Heparin, Plavix) Y ◯ N ◯

Do you have a pacemaker? Y ◯ N ◯

Are you pregnant? Y ◯ N ◯

FAMILY MEDICAL HISTORY (circle X for YOU and R for RELATIVE)

Cancer:	X	R	Stroke:	X	R
Hepatitis:	X	R	Asthma:	X	R
Diabetes:	X	R	Thyroid Disease:	X	R
Heart Disease:	X	R	High Blood Pressure:	X	R
Kidney Disease:	X	R	Lung Disease:	X	R
Mental Illness:	X	R	Rheumatoid Arthritis:	X	R
Alcoholism:	X	R	Other:	X	R
Autoimmune Disease:	X	R			

INFORMED CONSENT FOR TREATMENT & OFFICE POLICY

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Oriental medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other 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.

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

I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, numbness or tingling near the needling sites (that may last a few days), dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Unusual and extremely rare risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although, the acupuncturist uses sterile, disposable needles and maintains a clean and safe environment. Bruising is a common side effect of cupping and gua sha. 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, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment which the acupuncturist feels at the time is in my best interest, based upon the facts then known, during the course of the procedure.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that treatment from the acupuncturist named below does not substitute for appropriate medical evaluation and treatment by a licensed physician. I have been advised to consult with a licensed physician if there is worsening of my ailment/condition, if it does not improve within an estimated time frame or if a new ailment/condition arises. If I am presently under the care of a physician, I have been advised to continue all treatments and medications as prescribed.

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

Printed Name of Patient: ______________________________

Signature of Patient or Legal Guardian: ______________________________

Printed Name of Legal Guardian (if applicable): ______________________________

Date: ______________________________