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Today's date _____

Name_____ Nickname_____

Phone (primary)_____H/W/C? (secondary)_____H/W/C?

Address _____

City _____ State _____ Zip _____ Email Address _____

Would you like a reminder email before your appointment? Y/N

Age _____ Date of Birth _____ Place of Birth _____

Height _____ Weight _____ Marital/Partnership Status _____

Employer Name _____ Referred By _____

Family Physician _____ Physician Phone _____

Emergency Contact _____ Phone_____

Have You Been Treated By Acupuncture or Oriental Medicine Before?: Yes ☐ No ☐

Main Problem(s) you would like help with _____

_____

How long ago did this problem begin (be specific)? _____

_____

To what extent does this problem interfere with your daily activities (work, sleep, etc)? _____

_____

Have you been given a diagnosis for this problem: If so, what? _____

_____

What kinds of treatment have you tried? _____

Past Medical History (please include date): Cancer _____ Diabetes _____ Hepatitis _____

High Blood Pressure _____ Heart Disease _____ Rheumatic Fever _____ Thyroid Disease _____

Seizures _____ Venereal Disease _____ HIV/AIDS _____ Other _____

Surgeries (type of and date)_____

_____

Significant Trauma (auto accidents, falls, etc) _____

_____

Significant Dental Work (type and date)_____

Allergies (drugs, chemicals, foods/result) _____

Family Medical History (check): Diabetes ☐ Cancer ☐ High Blood Pressure ☐

Heart Disease ☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐

Other ☐_____

Medicines taken within the last two months (vitamins, drugs, herbs, etc)

Name of Medication/Supplement	Reason for Taking It
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Occupational Stress (physical, chemical, psychological, etc) _____

_____

Do you have a **regular exercise program**? Yes ☐ No ☐ Please Describe _____

_____

Have you ever been on a **restricted diet**?Yes ☐ No ☐ What Kind? _____

_____

Please describe your **average daily diet, including meals, snacks and beverages**:

Morning_____

Afternoon_____

Evening_____

Snacks (what and when?) _____

How many **packs of cigarettes** do you smoke per day? _____

How much **coffee**_____, **tea** _____ **or cola** _____do you drink per day?

How much **alcohol** do you drink per week? _____

Please describe any use of recreational drugs _____

Please check any you have had in the last three months:

General
- ☐ Poor appetite
- ☐ Fevers
- ☐ Sweat easily
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold or hot)
- ☐ Thirst, no desire to drink
- ☐ Sudden energy drop – what time of day? _____
- ☐ Poor sleep
- ☐ Chills
- ☐ Tremors
- ☐ Poor balance
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Change in appetite
- ☐ Weight gain
- ☐ Weight loss

Skin and Hair
- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Other hair or skin problems

Head, Eyes, Ears, Nose, and Throat
- ☐ Dizziness
- ☐ Glasses
- ☐ Poor vision
- ☐ Cataracts
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Poor hearing
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks
- ☐ Migraines
- ☐ Eye pain
- ☐ Earaches
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Headaches - where and when _____ _____
- ☐ Other head or neck problems _____ _____

Cardiovascular
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Swelling of hands
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Difficulty in breathing
- ☐ Other heart or blood vessel problems _____ _____

Respiratory
- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm what color _____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Other lung problems _____ _____

Approximately when was your last cold or flu?_____

Gastrointestinal
- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other stomach or intestinal problems _____ _____

Genito-urinary
- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Difficulty achieving erection
- ☐ Difficulty maintaining erection
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Other genital or urinary system problems _____
- ☐ Do you wake up to urinate?
- ☐ Yes ☐ No.

How often?_____
Any particular color to your urine? _____

Pregnancy and Gynecology
Number of pregnancies ____
Number of births _____
Premature births _____
Miscarriages _____
Abortions _____
Age at first menses _____
Days between menses _____
Duration _____
First day of last menses ____
- ☐ Unusual character (heavy or light)

- Painful periods
- Vaginal discharge
  What color?_____
- Changes in body/psyche prior to menstruation
- Clots
- Vaginal sores
- Irregular periods
- Last Pap _____
- Breast lumps

Are you sexually active?_____

Do you practice birth control?

Yes No N/A

What type and for how long?

_____

Musculoskeletal

- Neck pain
- Back pain
- Hand/wrist pain
- Muscle pain
- Muscle weakness
- Shoulder pain
- Knee pain
- Foot/ankle pain
- Hip pain

Neuropsychological

- Seizures
- Areas of numbness
- Concussion
- Bad temper
- Dizziness
- Lack of coordination
- Depression
- Easily susceptible to stress
- Loss of balance
- Poor memory
- Anxiety
- Other neurological or psychological problems

_____

Please note the severity of your problem now:

No Problem (0/10) Worst Imaginable (10/10)

Please note the severity of your problem within the last week:

No Problem (0/10)

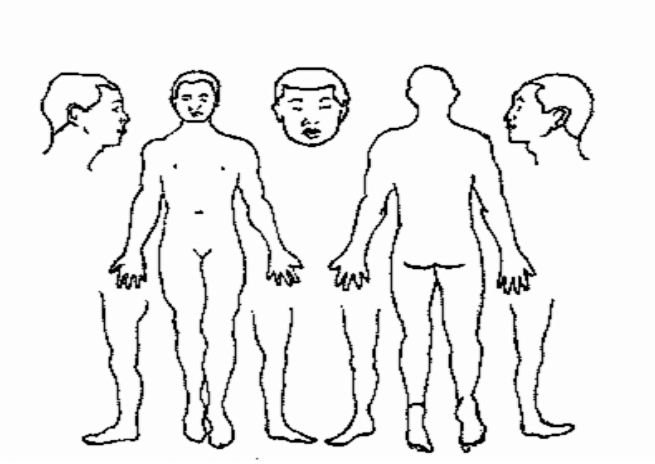
Comments (please mention any other problems you would like to discuss):

_____

_____

_____

Indicate painful or distressed areas:



Traditional Chinese Medicine Consent to Treat and Financial Policy

Nicole Sharkey, EAMP, L.Ac.
Seattle Institute of Oriental Medicine, Seattle, 2008-2011, MAcOM
Licensed in Washington State, #AC60247061 (09/15/11)

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of Chinese/Oriental/East Asian medicine on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above 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 within the scope of Chinese/Oriental/East Asian medicine may include, but are not limited to, acupuncture, acupressure, moxibustion (direct or indirect application of heat to acupuncture points or needles), cupping (cups made of glass or other materials placed on the skin with a vacuum created by heat or other device), electrical stimulation (use of electrical device to produce electrical stimulation on the acupuncture needles), Tui-Na (Chinese massage), gua sha (Chinese dermal friction technique), Chinese herbal medicine, bleeding, bleeding cupping, and nutritional counseling based on traditional Chinese medical theory**.** I understand that the herbs may need to be prepared and the teas consumed (or applied on the skin) according to the instructions provided orally and in writing. Herbal formulas may include plant, mineral and animal materials. ***If I do not want animal-based products in my formula, I understand that I must notify my practitioner at every visit when herbs are prescribed.**

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, dizziness or fainting, and needle sickness. Occasionally, needles can break. Bruising is a common side effect of cupping. Burning and/or scarring are potential risks of moxibustion and 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 effect and risks may occur. The herbs and nutritional supplements that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. ***I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of the herbs.** I understand that some herbs may interact with prescription, over-the-counter medication, or supplements, and as such, **I will notify the acupuncturist if I am taking any medication or supplements concurrently with Chinese herbs**. I understand that some herbs may be inappropriate during pregnancy. ***I will notify the acupuncturist who is caring for me if I am or become pregnant. *Patients with severe bleeding disorders, pace makers, diabetes, contagious diseases or lymphedema should inform practitioners prior to any treatment.**

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 that s/he thinks best at the time based upon the facts then known. I understand that results are not guaranteed. I understand that the acupuncturist is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (*i.e.* MD) for those services and for routine check-ups.

I understand that the acupuncturist may review my patient records and lab reports.

I understand acupuncture treatments are my financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I will provide my acupuncturist with at least 24 hours notice if I need to cancel or reschedule an appointment and I understand that I will be charged a $50.00 fee for any appointment broken with less than 24 hours notice.

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

Signature of patient or legal representative Date

Printed Name Relationship to patient