Comprehensive Patient Profile for Chinese Medicine Visit

Please note that Chinese Medicine views the body as an intricate relationship between organs and systems. In order to fully understand your condition, it is important that you take the time to fill out this form.

Full Name: _____ Date of Birth (mm/dd/yy): _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: _____ (H) _____ (W) _____ (M)

Occupation: _____ Marital Status: _____ Sex: ____ (M/F)

Emergency Contact: _____ Phone Number: _____

E-mail:_____

How did you hear about the clinic? _____

Have you received acupuncture before?

_No _ I am a bit Nervous _ I had a great experience _ I had a poor experience

Primary Health Concerns

Please list your primary health concerns/chief complaints: How long has this been of concern:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Of which of these concerns is the most important to you? _____

Describe your pain/discomfort: _____

Are you wearing an electronic device? ___(Y/N) *Are you pregnant?* ___(Y/N or N/A)

Hospitalizations

Please list to the best of your ability the times you have been hospitalized:

Illness/Procedure	Date	Hospital

Allergies

Please list any allergies you may have: _____

_____

Do you have any skin or mesh grafts, implants, plates, pins, or pacemakers?

_____

Medications

Please list all medications you are currently taking including vitamins, herbal and illicit:

_____

Please list how often you smoke and/or use alcohol:

_____

Women

Date of last Cycle? _____ *Cycle length:* _____ *Average days of flow:* _____
Are you using Birth Control? _ *Yes* _ *No* *Menopausal:* _____
Type of Birth control: _____ *how long have you been using birth control?* _____

Men

Genital Pain or discomfort: _____ *Testicular pain lumps or removal:* _____
Erectile Dysfunction: _____ *Low Sex drive:* _____ *High Sex drive:* _____
Prostate concerns: _____ *Change in Urination:* _____

Gastro – Intestinal

Belching ___ *Hemorrhoids* ___ *Fissures/Ulcers* ___
Bloating ___ *Constipation* ___ *Diarrhea* ___ *Abdominal Pain/Cramping* ___
Excessive Gas ___ *Acid Reflux* ___ *Nausea* ___ *Vomiting* ___

Goals/Beliefs – If necessary, please use the back of this sheet to answer
What are some of your health goals? _____
_____

If your quality of health was improved, what would that allow you to do that you are currently unable to do? _____

Blood Borne, Insect Borne and Sexually Transmitted Diseases

Due to the use of needles below the skin, please check if you are experiencing any of the following.
Any misinformation can result in termination of treatment, among legal complications.

☐ HIV/Aids	☐ Genital Warts	☐ Syphilis
☐ Hepatitis B	☐ Gonorrhea	☐ Trichomonas
☐ Hepatitis C	☐ Herpes	☐ Tuberculosis
☐ Chlamydia	☐ Malaria	☐ Other: _____
☐ Encephalitis	☐ Pelvic Inflammatory Disease	

Please read the following Informed Consent form and sign below.

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including but not limited to needling, acupressure massage, manual stimulation of needles and or using tuning forks, moxibustion, cupping, biofield tuning, dietary recommendations, lifestyle counseling and other techniques within the scope of practice of a Practitioner of Traditional Chinese Medicine.

I understand the nature and purpose of acupuncture and other procedures and alternative care. I further understand and am informed that, as in all health care, in the practice of acupuncture, even though the needles are pre-sterilized and once-use-only disposable, there are some slight risks to treatment including, but not limited to temporary soreness, bruising, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to be able to anticipate all risks and complications. I wish to rely on the acupuncturist to be able to exercise judgment during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

I have read the above consent and have had the opportunity to ask questions if necessary. I intend this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____	_____	____/____/____
Client Name	Client Signature	MM DD YY

Time Guarantee

We value your time. We will call you if we are running more than 15 minutes late. We request that you call the clinic if you are running 15 minutes late, as well. We also require a 24 hour cancellation notice. Missed appointments or late cancellations will be billed for an amount of $40.00.

PLEASE INITIAL _____