Today's Date: _____/_____/_____

Name: _____
First MI Last

Address: _____
Street City State Zip Code

Phone: Day - _____ Evening - _____ Cell - _____

Email: _____ Do you wish to receive email newsletters? Yes / No
(Email may be used for communication between patient and practitioner)

Age: _____ DOB: ____/____/____ Gender: _____ Height: _____'_____" Weight: _____lbs.

Marital: M S D W Occupation: _____

Is English your primary language? __Y / N_ If No, what is your primary language?_____

In Case of an Emergency, Call: _____
Name Relationship to You Phone Number

FOR MINORS: List both parents' names and address:

_____
Name Address

_____
Name Address

How did you hear about us?_____

Chief Complaint: _____
Complaint as a Result of:_____
Date of Injury: _____/_____/_____Have you seen a Doctor for this Injury? __Y / N__
Exams: _____When? _____/____/_____

Present Health Concerns (in order of importance):
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you under the care of a Primary Care Physician? Yes / No Your Last Check-up _____/____/_____
Do You Have a PACEMAKER? __Y_/__N__

Please list with dates:
Surgeries: _____
Hospitalizations: _____
Illnesses: _____
Injuries: _____

Rx Prescription Drugs & Dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

(Please use back side, if you need more space)

Please mark any of the following that you are taking:

___Pain relievers (aspirin, Tylenol, ibuprofen)
___Cortisone (cream or pills)
___Sleeping pills
___Laxatives
___Blood pressure medication
___Blood Thinners (Coumadin, plavix, aspirin)
___Diet Pills/Appetite suppressants
___Thyroid Medication
___Antacids (Rolaids, Tums)
___Tranquilizers
___Heart medication
___Antidepressants

REVIEW OF SYSTEMS (Check if you now have or Circle if you had previously, any of the following):

SYSTEMIC REVIEW:
- o Hot flashes
- o Night sweats
- o Excessive Thirst
- o Fever
- o Chills
- o Sudden Loss or Gain of Weight
- o Uncontrolled Pain
- o Insomnia
- o Alcoholism
- o Autoimmune Disease
- o Cancer
- o Thyroid (low/high)

CARDIOVASCULAR
- o Chest pain
- o Stroke
- o Heart Disease
- o High or low blood pressure
- o Hardening of arteries
- o High Cholesterol
- o Pain over heart
- o Poor circulation
- o Previous heart attack
- o Irregular heart beat
- o Nosebleeds
- o Cold hands/feet
- o Swelling / Edema

HEMETALOGIC:
- o Anemia
- o Blood diseases
- o Fatigue
- o Dizziness
- o Excessive bleeding
- o Abnormal bruising
- o Blood clots

GENITO/URINARY
- o Blood/pus in urine
- o Frequent urination / UTI
- o Inability to control urine
- o Incontinence
- o Kidney infection, Stones
- o Lowered libido
- o Night time urination
- o Sexual dysfunction
- o STD _____

RESPIRATORY:
- o Tuberculosis
- o Asthma/wheezing
- o Difficulty breathing
- o Cough
- o Pneumonia

Other: _____

ENDOCRINE:
- o Hair loss/thinning
- o Hormone therapy

SKIN
- o Boils
- o Acne / Eczema
- o Dry skin
- o Itching, Rash, Hives
- o Sensitive skin
- o Sores that won't heal
- o Brittle Nails

GASTROINTESTINAL
- o Belching
- o Gas / Bloating
- o Cramping
- o Bad breath / Bitter taste
- o Ulcers
- o Heartburn
- o Colon trouble
- o Constipation
- o Diarrhea
- o Blood in Stools
- o Difficulty swallowing
- o Distention of abdomen
- o Excessive hunger
- o Gall bladder trouble
- o Hemorrhoids (piles)
- o Rectal Itching
- o Indigestion
- o Nausea
- o Pain over stomach
- o Poor appetite
- o Vomiting

Frequency of BM_____

Color of stool _____

FOR MEN:
- o Erection difficulties
- o Penis discharge
- o Prostate trouble
- o Testicular pain or mass

EYES, EARS, NOSE &THROAT:
- o Headaches / Migraines
- o Hearing loss
- o Ringing in ears
- o Earache
- o Blurred or failing vision
- o Eye pain or itchy eyes
- o Enlarged glands
- o Persistent cough
- o Sinus problems
- o Frequent colds
- o Sneezing/runny nose
- o Hay fever
- o Hoarseness
- o Gum trouble
- o Mouth/tongue sores
- o Jaw Pain (TMJ)

NEURO-PSYCHIATRIC:
- o Tingling
- o Weakness
- o Numbness
- o Seizures
- o Epilepsy
- o Paralysis
- o Poor balance
- o Poor memory
- o Poor concentration
- o Depression
- o Anxiety
- o Eating disorder

MUSCULOSKELETAL:
- o Arthritis
- o Osteoporosis
- o Swollen joints
- o Difficulty walking
- o Obesity
- o Muscular pain
- o Joint Pain / stiffness
- o Neuropathy
- o Tremors, cramps

Pain, weakness, numbness in:

____Head ____Neck
____Arm ____Shoulder
____Hand ____ Finger
____Back ____Hip
____Leg ____Feet

List All: Vitamins, Minerals & Supplements & Dosage: Taking a Daily Multi-Vitamin? __Y / N__

_____ _____ _____

_____ _____ _____

Please mark if YOU or Family members have experienced the following:

___Cancer:_____

___Diabetes:_____

___Heart Disease: _____

___Blood Pressure: _____

___Mental Illness: _____

___Lung Condition: _____

(*Please indicate: self, mother, brother, etc.*)

Do you have any infectious diseases? (Circle any that apply) AIDS / HIV / Hepatitis /TB / Other_____

GYNECOLOGICAL:

- o Menopause
- o Breast lump
- o Breast discharge
- o Bleeding between periods
- o Clots in menses
- o Heavy menstrual bleeding
- o Pain with periods
- o Irregular cycle
- o Menopausal symptoms
- o PMS
- o Previous miscarriage
- o Scanty menstrual flow
- o Vaginal discharge
- o Vaginal itching
- o Could you be pregnant

Age period started: _____ Last Period ____/_____/___ Periods last _____days. Periods come every _____days.

_____# of pregnancies _____# of living children. _____# of miscarriages. _____# of abortions.

Are you pregnant? __Y / N__ If yes, How long?_____ Are you trying to get pregnant? __Y / N__

SOCIAL HISTORY 1=low 10=high

Energy level (1-10) _____ Stress level (1-10) _____ Normal_____

SLEEP:

Average hours of sleep: _____hrs /night Bedtime: _____am/pm Wake-time: _____am/pm

Wake rested? _____ Sleep well? _____ Do you have problems: falling asleep / staying asleep

Do you wake up at night? _____

CONSUMPTION:

Tobacco: _Y / N_, # Packs a day_____ for _____Yrs.

Caffeine: _Y / N_, _____ /day _____

Alcohol: _Y / N_, _____(/day /week /month)

Meals a day? _____Regularly? _____

Water Intake: _____ (OZ / Glasses) /day

List Types of Physical Exercise: _____

_____

_____

Rate how you feel about Your:

	Worst					Great
Self	○	○	○	○	○	○
Family	○	○	○	○	○	○
Sex	○	○	○	○	○	○
Health	○	○	○	○	○	○
Exercise	○	○	○	○	○	○
Work	○	○	○	○	○	○
Spirituality	○	○	○	○	○	○

Would you like additional information or would you like to discuss: (check)

Weight Loss _____

Nutrition_____ Lifestyle _____

Smoking _____ Other _____

FINANCIAL ARRANGEMENTS

How would you like to pay for your Services?

Cash Check Credit/Debit Card

[We are not allowed to bill Insurance or receive 3rd party payments.]

I have read the above information and certify it to be true and correct to the best of my knowledge and belief. I hereby authorize office to treat as necessary, in accordance with state statutes, for the care and management of this complaint and future complaints I choose to seek care for from this office.

X_____

Patient Signature

Date_____/_____/_____

ACUPUNCTURE INTEGRATIVE PROFESSIONALS
352 S. DENVER STREET SUITE 307, SLC, UT 84111

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy, massage, Chinese or western herbal medicine, and nutritional counseling.

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

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will notify the acupuncturist who is caring for me if I am or become pregnant. 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 which the acupuncturist thinks at the time, based upon the facts then known, and is in my best interest. I understand that results are not guaranteed.

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

Name:_____
(PLEASE PRINT)

X_____
(Signature)

Date: _____/_____/_____

Witness: _____

Date: _____/_____/_____

To be completed by the patient's representative, if necessary, e.g., if the patient is a minor or is physically or legally incapacitated:

Name of Patient: _____
(PLEASE PRINT)

Representative: _____
(PLEASE PRINT)

X_____
(Representative Signature)

Date Signed: _____/_____/_____

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