Patient Information Form

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Today's date:				
First name:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.			Marital status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Partner ☐ Widowed
Last name:	Birth date: (mm/dd/yy)	Age:		
Email:	Social Security No.:			Phone number(s) Home: Work: Cell:
Street address:		Apt:		
City:	State:	Zip:		
How did you learn about us? ☐ Physician referral ☐ Friend ☐ Internet ☐ Other (Please include the name of whom referred you.) Name:				
Employment status: ☐ F/T ☐ P/T ☐ Unemployed ☐ School ☐ At home ☐ Retired ☐ Disabled				Occupation:
Reason for visit:				

Height: ft. in.	Weight: lbs.	Primary physician: Phone:
Have you had acupuncture before: ☐ Yes ☐ No	Chinese herbal medicine? ☐ Yes ☐ No	
Western medical diagnosis (if applicable):		
Other medical treatment received: ☐ Fertility clinic ☐ Physical therapy ☐ Chiropractic ☐ Massage ☐ 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...)? ☐ Yes ☐ No		
How much water do you drink per day?		
Are you vegetarian? ☐ Yes ☐ No		

How often do you use the following?	Daily	Once/week	Rarely	Never	How often do you participate in the following physical activities?
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:

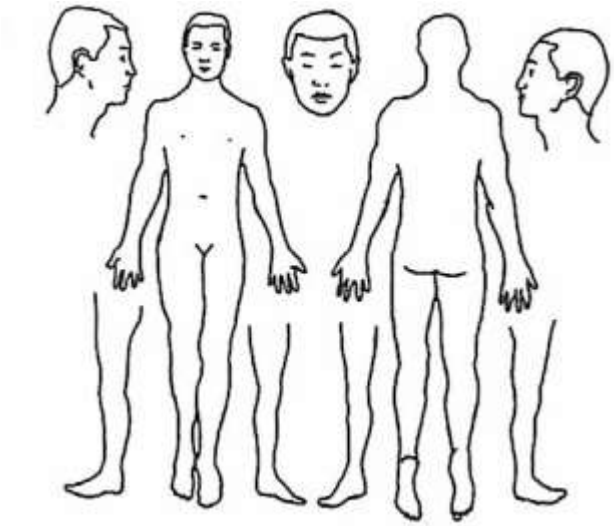
Print the names of relatives (living or deceased) in the rows to the left. Place a (√) in the appropriate column for any illnesses that you or the relatives listed have had.

Were you adopted? ☐ Yes ☐ 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	Venereal 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:

N=Numbness **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.

Patient Name (Print)_____ **Date**_____

Patient Signature_____

If I need to reschedule or cancel my appointment, in order to avoid a $45 cancellation fee, I must CALL the office with
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.

Patient Signature _____ **Date** _____