

**Weatherford Chiropractic Health Center, PA: ACUPUNCTURE (Existing patient)**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PATIENT CONDITION (ALL QUESTIONS SHOULD BE ANSWERED)**

**Main Reason for this visit** \_\_\_\_\_

**When did the symptoms first appear** \_\_\_\_\_ \*Was onset: \_\_ Gradual \_\_ Sudden Is it getting worse? \_\_ Y \_\_ N

**Cause of symptoms:** \_\_\_\_\_

**How often do you experience Symptoms?**

- \_\_ Constant (100%)\_Frequent (75%)\_Intermittent (50%)  
 \_\_ Occasional (25%)\_Rare (10% or less)

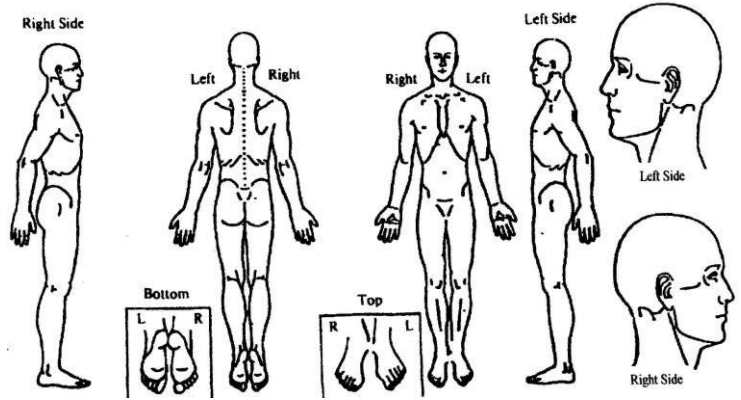
**Type of Pain:** \_Sharp\_Dull\_Throb\_Numb\_Ache  
 \_\_Shooting\_Burning\_Tingle\_Cramp\_Stiff\_Other

Do the symptoms radiate (travel)? \_\_ Yes \_\_ No

Where does it radiate to? \_\_\_\_\_

What gives relief? \_\_\_\_\_

What makes it worse? \_\_\_\_\_



**PLEASE MARK ALL AREAS OF PAIN (INCLUDING ANY RADIATIONS) ON THE FIGURE ABOVE**

**Does it interfere with:** \_Work\_Daily Activities\_Sleep

**Rate the pain from 0 (no pain) to 10 (worst pain felt)** \_\_\_\_\_

**Please indicate here if you are:** Pregnant Taking Blood thinners Have a Bleeding Disorder  
 (Circle all that apply) Neuropathy Autoimmune Disorder Diabetic

**Please circle the symptoms or conditions you experience frequently:**

<u>Sp/ St</u>	<u>Ht/ P</u>	<u>Lu/ LI</u>	<u>Ki/ UB</u>	<u>Liv/ GB</u>
Excessive appetite	Insomnia	Cough	Low back pain	Eye problems
Loose stool/ diarrhea	Palpitations	Shortness of breath	Knee problems	Jaundice
Digestive problems	Cold hands & feet	Decrease sense of smell	Hearing impairment	Difficulty digesting oily foods
Vomiting	Nightmares	Nasal problems	Ear ringing	Gall stones
Belching/ burping	Mentally restless	Skin problems	Kidney stones	Light-colored stool
Heartburn/ reflux	Laughing for no reason	Claustrophobia	Decreased sex drive	Soft or brittle nails
Stomach bloating	Chest pain	Colitis/ diverticulitis	Hair loss	Easily angered
Obsession in work	Poor memory	Constipation	Urinary problems	Difficult relationships
Blood in stool	Sadness	Allergies	Dental problems	Difficulty making decisions
Lack of appetite	Depression	Asthma	Fatigue	Dizziness
Hemorrhoids	Anxiety	Get sick easily	Edema	Headache
Easily bruise	I usually feel chilled	I usually feel warm		

**Please check/indicate if the following pertain to you:**

**NOTE: This Symbol ♀: before a question, indicates that it is for Women only**

**KD Yin Deficiency**

- Do you have lower back weakness, soreness or pain?
- Is your hair prematurely gray?
- Do you have night sweats?
- Would you describe yourself as “afraid” frequently?
- Do you have knee problems?
- ♀: Is your mid-cycle cervical mucus scanty or missing?
- Do you have ringing in your ears?
- Do you have dark circles under your eyes?
- Are you prone to hot flashes?
- Do you have dizziness?
- ♀: Do you have vaginal dryness?

**KD Yang Deficiency**

- Is your back sore or weak?
- Are you typically colder than those around you?
- Are you often fearful?
- Do you wake up at night or early in the morning because you have to urinate?
- Do you urinate frequently, and is the urine diluted and/or profuse?
- ♀: Do you feel cold cramps during your period that respond to a heating pad?
- ♀: Do you have low back pain pre-menstrually?
- Are your feet cold, especially at night?
- Is your libidolow?
- Do you have early morning loose/urgent stools?
- ♀: Do you have profuse vaginal discharge?

**SP (Qi, Blood, and/or Yang Deficiency)**

- Are you often fatigued?
- Is your energy low after a meal?
- Do you crave sweets?
- Are your hands and feet cold?
- Are you prone to heaviness or grogginess in the head?
- Do you have varicose veins?
- Do you sweat a lot without exerting yourself?
- Have you ever been diagnosed with hypothyroid or anemia?
- Have you been diagnosed with low blood pressure?
- ♀: Is your menstruation thin, watery, profuse, or pinkish in color?
- ♀: Do you ever spot a few days or more before your period comes?
- ♀: Are your menstrual cramps accompanied by a bearing down sensation in your uterus?
- Do you have poor appetite?
- Do you feel bloated after eating?
- Do you have loose stools, abdominal pain, or digestive problems?
- Are you prone to feeling sluggish?
- Do you feel dizzy or light-headed, or have visual changes when you stand up fast?
- Are you prone to worry?
- Are you often sick, or do you have allergies?
- Do you have hemorrhoids or polyps?
- ♀: Are you more tired around ovulation or menstruation?
- ♀: Have you ever been diagnosed with uterine prolapse?

**Blood Deficiency**

- Do you have dry, flaky skin?
- Are your fingernails or toenails brittle?
- Do you have diminished nighttime vision?
- ♀: Do you get dizzy or light-headed around your period?
- ♀: Are your menses scant or late?
- Are you prone to getting chapped lips?
- Is your hair brittle or dry?
- Are your lips, the inner side of your lower eyelids, or tongue pale in color?
- ♀: Are you losing hair on your head?

**Blood Stasis**

- Do you experience periodic numbness of your hands and feet, especially at night?
- Do you have red cherry spots (hemangioma) on your skin?
- Do you have dark spots in your eyes?
- Have you been diagnosed with any vascular abnormality or blood clotting disorder?
- ♀: Your menstrual flow ever brown or black in color?
- ♀: Do you have painful, unmovable breast lumps?
- Do you have varicose/spider veins?
- Do you have chronic hemorrhoids?
- ♀: Does your menstrual blood contain clots?
- ♀: Have you been diagnosed with endometriosis or uterine fibroids?
- ♀: Do you feel mid-cycle pain around your ovaries?
- ♀: Do you have piercing or stabbing menstrual cramps?

**LR Qi Stagnation**

- Are you prone to emotional depression?
- Are your pupils usually dilated and large?
- Do you experience heartburn or wake up with a bitter taste in your mouth?
- ♀: Does it feel as if your ovulation lasts longer than it should?
- ♀: Do you become bloated pre-menstrually?
- ♀: Do you feel bloated or irritable around ovulation?
- ♀: Do you have a lot of pre-menstrual breast distention or pain?
- ♀: Is your menstrual blood thick and dark, or purplish in color?
- Are you prone to anger and/or rage?
- Do you have difficulty falling asleep at night?
- ♀: Do you become irritable pre-menstrually?
- ♀: Are your breasts sensitive/sore at ovulation?
- ♀: Are your menses painful?
- ♀: Do you experience nipple pain or discharge from your nipples?
- ♀: Do you feel your menstrual cramps in the external genital area?

**HT (Any Disorder)**

- Do you have nightmares?
- Do you seem low in spirit or lacking vitality?
- Are you prone to agitation or extreme restlessness?
- Do you fidget?
- Do you sweat excessively, especially on your chest?
- Do you wake up early in the morning and have trouble getting back to sleep?
- Do you have heart palpitations, especially when anxious?

**Excess Heat**

- Are your mouth and throat usually dry?
- Are you often thirsty for cold drinks?
- Do you often feel warmer than those around you?
- Do you wake up sweating or have hot flashes?
- ♀: Do you have a short menstrual cycle?
- ♀: Do you have vaginal irritation?
- ♀: Do you breakout with red acne, especially pre-menstrually?

**Dampness**

- Do you feel tired and sluggish after a meal?
- Do you have cystic or pustular acne?
- Do you have urgent, bright, or foul-smelling stools?
- Are you overweight?
- Do you have a wet, slimy tongue?
- Does your body feel like a barometer? Can you sense when it will rain?
- ♀: Does your menstrual blood contain stringy tissue or mucus?
- ♀: Are you prone to yeast infections & vaginal itching?
- ♀: Do you have fibrocystic breasts?

**♀ For Women Only:**

Have you gone through menopause or have you had a hysterectomy? Yes No

Age of first period: \_\_\_\_\_ Date of last period: \_\_\_\_\_ Number of children (live births): \_\_\_\_\_

Number of days between periods (your cycle): \_\_\_\_\_ Number of days of flow: \_\_\_\_\_

Are you or is there possibility you are pregnant? Yes No

**♀ Check All that Apply:**

**Color of flow:**  pale/light red  red  bright red  dark red  dark red/brown  dark red/purple

**# of pads /tampons you use per day:** \_\_\_\_\_ 1<sup>st</sup> day \_\_\_\_\_ 2<sup>nd</sup> day \_\_\_\_\_ 3<sup>rd</sup> day \_\_\_\_\_ 4<sup>th</sup> day

**Pain and Cramping:** Yes No

Are they? -mild (mil) -moderate (mod) -severe (sev) - (please indicate the severity in the spaces below)

\_\_\_\_\_ 1<sup>st</sup> day \_\_\_\_\_ 2<sup>nd</sup> day \_\_\_\_\_ 3<sup>rd</sup> day \_\_\_\_\_ 4<sup>th</sup> day \_\_\_\_\_ Before flow \_\_\_\_\_ After flow

**Amount of flow:**

even throughout

clots  Yes /  No When? \_\_\_\_\_ 1<sup>st</sup> day \_\_\_\_\_ 2<sup>nd</sup> day \_\_\_\_\_ 3<sup>rd</sup> day \_\_\_\_\_ 4<sup>th</sup> day \_\_\_\_\_ Before flow \_\_\_\_\_ After flow

spotting  Yes /  No When? \_\_\_\_\_ 1<sup>st</sup> day \_\_\_\_\_ 2<sup>nd</sup> day \_\_\_\_\_ 3<sup>rd</sup> day \_\_\_\_\_ 4<sup>th</sup> day \_\_\_\_\_ Before flow \_\_\_\_\_ After flow

light  Yes /  No When? \_\_\_\_\_ 1<sup>st</sup> day \_\_\_\_\_ 2<sup>nd</sup> day \_\_\_\_\_ 3<sup>rd</sup> day \_\_\_\_\_ 4<sup>th</sup> day \_\_\_\_\_ Before flow \_\_\_\_\_ After flow

heavy  Yes /  No When? \_\_\_\_\_ 1<sup>st</sup> day \_\_\_\_\_ 2<sup>nd</sup> day \_\_\_\_\_ 3<sup>rd</sup> day \_\_\_\_\_ 4<sup>th</sup> day \_\_\_\_\_ Before flow \_\_\_\_\_ After flow

**Other symptoms related to menses: (please circle all that apply)**

Discharge PMS Headache Nausea Constipation Diarrhea

Swollen Breasts Mood Swings Increased Appetite Decreased Appetite Insomnia

**Have you ever been diagnosed with? (please circle all that apply)**

Fibroids Fibrocystic breasts Endometriosis Ovarian Cyst PID

Polycystic Ovary Syndrome STD \_\_\_\_\_

**Fertility Information:** # of IVF procedures \_\_\_\_\_ # of IUI procedures \_\_\_\_\_

**Has a physician diagnosed a difficulty with fertility due to?**

Female Factor  Male Factor  Unexplained

## **INFORMED CONSENT TO RECEIVE TREATMENT AND CARE: ACUPUNCTURE/CUPPING**

Weatherford Chiropractic Health Center, PA, practices chiropractic, Acupuncture, Herbal Medicine, and other Physical Medicine procedures, which is a Complementary and Alternative Medicine (CAM.) Each patient is treated as an individual and there is no “one size fits all” course of diagnosis or treatment.

The CAM practices utilized may include, but are not limited to, one or more of the following: acupuncture, dietary supplements, herbal remedies, exercise, lifestyle counseling ,chiropractic, massage, cupping, trigger point release/scrapping, moxibustion, stretching, physical manipulation, electrical muscle stimulation, needle retention, micropuncture (bleeding therapy), and diagnostic palpation on various areas of the body.

I understand that the diagnosis given to me conforms to the principals of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment. I understand that the doctors at Weatherford Chiropractic Health Center,PA are not Oriental Medicine doctors, but are trained in TCM basic diagnosis in relation to acupuncture.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand that the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

I understand that no guarantee has been made concerning the use and effects of CAM. I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

I understand that I may stop treatment at anytime.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

**Acupuncture:** I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. The attending acupuncturist can easily handle any immediately reported problems that arise from the acupuncture treatment, and the possibility of minor problems need not be a cause of concern. Some very rare risks of acupuncture include pneumothorax and infection. Burns and or scarring are a potential risk of indirect moxibustion. Rarely, bodywork may cause a temporary increase of symptoms or new symptoms may present. Needle Sickness is a potential temporary side effect where a vertigo or even loss of consciousness can occur.

**Moxibustion:** I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or a group of points. this generally produces a pleasurable sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion. The attending doctor can easily address this.

**Cupping:** I understand it uses round vacuum cups over a large muscular area, such as the back to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injuries.

**Deep Tissue/Scrapping:** I understand that I may also be given, Soft tissue/Trigger Point therapy as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, mild bleeding, sore muscles or aches, and the possible aggravation of the symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Herbs and Nutritional Supplements:** I understand that supplements may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiological functions. Herbs are used to facilitate the body's own restorative process. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them.

I understand that recommended herbs are traditionally considered safe in the practice of CAM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limited to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my physician if any unanticipated or unpleasant effects associated with the consumption of herbal teas, tinctures, topical creams, or patent (pill form) medicine.

I understand that Weatherford Chiropractic Health Center doctors cannot be expected to anticipate and explain all risks and complications. I understand and agree that my doctor will exercise judgment during the course of treatment which they feel at the time, based on the facts known then, is in the best interest of me as the patient.

**Contraindications** for acupuncture treatment and certain herbs include a history of a bleeding disorder or current anticoagulant therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications. Though acupuncture is safe during pregnancy, I agree to tell my doctor as soon as possible if I become pregnant, as certain cautions and contraindications are vital.

Potential benefits of treatment include but are not limited to: restoration of health and the body's maximum functional capacity without the use of drugs or surgery; relief of pain and symptoms of disease; assistance in injury and disease recovery; and prevention of disease or its progression.



## Patient Authorization and Consent for Treatment

I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. and I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such a time that I make known that I choose to terminate it. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

**Print Name of Patient:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### CONSENT TO TREAT A MINOR CHILD

I authorize, Weatherford Chiropractic Health Center, PA, to treat \_\_\_\_\_ (name)

who is my \_\_\_\_\_ (relationship)

**Adult's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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### Office Use ONLY

- I have discussed the above information with the patient and given the patient an opportunity to ask questions.
- Patient appeared cognitive and appeared to understand risks and SE

**Provider's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## Acupuncture Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments.

Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hours notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized your appointment time.

There will be a \$40.00 charge for a cancelled and rescheduled acupuncture appointment without a 24 hour notice due to the fact that an acupuncture appointment takes up such a large portion of our schedule. We recognize that there are situations that cannot be foreseen i.e. illness, other doctor's appointments, life, etc. but we will still need to charge the \$40.00 missed appointment fee. Please realize how important it is to keep your reserved time. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Print Name of Patient \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_