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

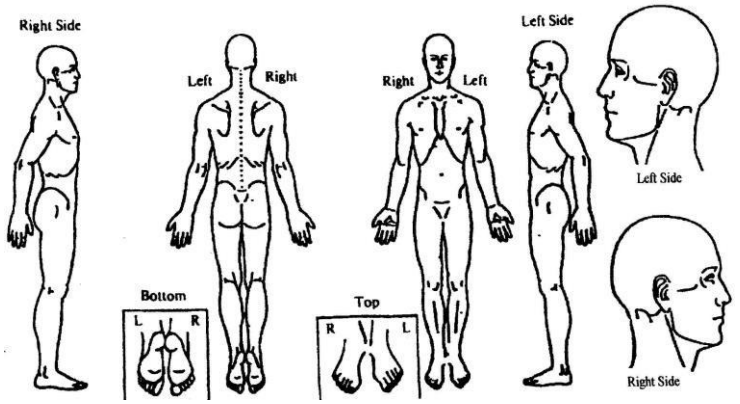
__Shooting Burning Tingle Cramp Stiff Other

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

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Please circle the symptoms or conditions you experience frequently:

Sp/ St	Ht/ P	Lu/ LI	Ki/ UB	Liv/ GB
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?
□ Do you have ringing in your ears?
□ Is your hair prematurely gray?
□ Do you have dark circles under your eyes?
□ Do you have night sweats?
□ Are you prone to hot flashes?
□ Would you describe yourself as "afraid" frequently?
□ Do you have dizziness?
□ Do you have knee problems?
□ ♀: Do you have vaginal dryness?
□ ♀: Is your mid-cycle cervical mucus scanty or missing?

KD Yang Deficiency

□ Is your back sore or weak?
□ Are your feet cold, especially at night?
□ Are you typically colder than those around you?
□ Is your libidolow?
□ Are you often fearful?
□ Do you have early morning loose/urgent stools?
□ 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?
□ ♀: Do you have profuse vaginal discharge?

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

□ Are you often fatigued?

□ Do you have poor appetite?

□ Is your energy low after a meal?

□ Do you feel bloated after eating?

□ Do you crave sweets?

□ Do you have loose stools, abdominal pain, or digestive problems?

□ Are your hands and feet cold?

□ Are you prone to feeling sluggish?

□ Are you prone to heaviness or grogginess in the head?

□ Do you feel dizzy or light-headed, or have visual changes when you stand up fast?

□ Do you have varicose veins?

□ Are you prone to worry?

□ Do you sweat a lot without exerting yourself?

□ Are you often sick, or do you have allergies?

□ Have you ever been diagnosed with hypothyroid or anemia?

□ Do you have hemorrhoids or polyps?

□ Have you been diagnosed with low blood pressure?

□ ♀: Is your menstruation thin, watery, profuse, or pinkish in color?

□ ♀: Are you more tired around ovulation or menstruation?

□ ♀: Do you ever spot a few days or more before your period comes?

□ ♀: Have you ever been diagnosed with uterine prolapse?

□ ♀: Are your menstrual cramps accompanied by a bearing down sensation in your uterus?

Blood Deficiency

□ Do you have dry, flaky skin?

□ Are you prone to getting chapped lips?

□ Are your fingernails or toenails brittle?

□ Is your hair brittle or dry?

□ Do you have diminished nighttime vision?

□ Are your lips, the inner side of your lower eyelids, or tongue pale in color?

□ ♀: Do you get dizzy or light-headed around your period?

□ ♀: Are you losing hair on your head?

□ ♀: Are your menses scant or late?

Blood Stasis

□ Do you experience periodic numbness of your hands and feet, especially at night?

□ Do you have varicose/spider veins?

□ Do you have red cherry spots (hemangioma) on your skin?

□ Do you have chronic hemorrhoids?

□ Do you have dark spots in your eyes?

□ ♀: Does your menstrual blood contain clots?

□ Have you been diagnosed with any vascular abnormality or blood clotting disorder?

□ ♀: Have you been diagnosed with endometriosis or uterine fibroids?

□ ♀: Your menstrual flow ever brown or black in color?

□ ♀: Do you feel mid-cycle pain around your ovaries?

□ ♀: Do you have painful, unmovable breast lumps?

□ ♀: Do you have piercing or stabbing menstrual cramps?

LR Qi Stagnation

□ Are you prone to emotional depression?

□ Are you prone to anger and/or rage?

□ Are your pupils usually dilated and large?

□ Do you have difficulty falling asleep at night?

□ Do you experience heartburn or wake up with a bitter taste in your mouth?

□ ♀: Do you become irritable pre-menstrually?

□ ♀: Does it feel as if your ovulation lasts longer than it should?

□ ♀: Are your breasts sensitive/sore at ovulation?

□ ♀: Do you become bloated pre-menstrually?

□ ♀: Are your menses painful?

□ ♀: Do you feel bloated or irritable around ovulation?

□ ♀: Do you experience nipple pain or discharge from your nipples?

□ ♀: Do you have a lot of pre-menstrual breast distention or pain?

□ ♀: Do you feel your menstrual cramps in the external genital area?

□ ♀: Is your menstrual blood thick and dark, or purplish in color?

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:_____1st day_____2nd day_____3rd day_____4th day

Pain and Cramping: Yes No

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

_____1st day_____2nd day_____3rd day_____4th day_____Before flow_____After flow

Amount of flow:

□ even throughout
□ clots □ Yes / □ No When?___1st day___2nd day___3rd day___4th day___Before flow___After flow
□ spotting □ Yes / □ No When?___1st day___2nd day___3rd day___4th day___Before flow___After flow
□ light □ Yes / □ No When?___1st day___2nd day___3rd day___4th day___Before flow___After flow
□ heavy □ Yes / □ No When?___1st day___2nd day___3rd day___4th 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.

PT INITIALS_____

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.

PT INITIALS_____

Patient Authorization and Consent for Treatment

I herby 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:** _____

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 _____