St.Clair Family Acupuncture

This is a confidential questionnaire to help determine the best treatment plan for you. If you have any questions please ask.

Name_____ Date_____
Home Address_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Email_____
Sex_____ Height_____ Weight_____ Birthday_____ Age_____
Physician/s_____ Physicians phone number_____
Occupation_____ Have you received acupuncture before: ❑Yes ❑No
Marital Status: Married ❑ Single ❑ Divorced ❑ Widowed ❑ Number of Children_____
Who should we thank for referring you to this office?_____

Chief Complaint_____ Onset_____
Treatments (MD, DC, PT, Drugs, Surgery, etc.)_____
Secondary Complaints_____
Accidents, Surgeries, Hospitalizations (Please include date)_____
_____
Please provide any Lab tests, X-Rays, MRI's or doctor reports that are relevant.

Medicine	Dose	Reason	How long	Prescribed by	Last checkup

Please continue medicines on back of page if necessary.

Habits: ❑Coffee ❑Tea ❑Tobacco ❑Alcohol ❑Water ❑Soda ❑Non-Medical Drugs
Allergies_____ Food Sensitivities_____ Cravings_____

How do you feel about the following areas of your life?

	Great	Good	Fair	Poor	Bad	Comments
Significant Other	❑	❑	❑	❑	❑	_____
Family	❑	❑	❑	❑	❑	_____
Diet	❑	❑	❑	❑	❑	_____
Sex	❑	❑	❑	❑	❑	_____
Self	❑	❑	❑	❑	❑	_____
Work	❑	❑	❑	❑	❑	_____
Exercise	❑	❑	❑	❑	❑	_____
Spirituality	❑	❑	❑	❑	❑	_____

Family History

❑Asthma ❑Cancer ❑High blood pressure ❑Diabetes ❑Heart Disease ❑Seizures ❑Hepatitis
❑Arthritis ❑Infectious disease ❑STD ❑Emotional disorder ❑High Cholesterol

Symptom Survey

❑Asthma ❑Cancer ❑High blood pressure ❑Diabetes ❑Heart Disease ❑Seizures ❑Hepatitis
❑Arthritis ❑Infectious disease ❑STD ❑Emotional disorder ❑High Cholesterol

❑Back Pain ❑Abdominal Pain ❑Chest Pain ❑Headache ❑Sciatic Pain ❑Neck Pain ❑Leg Pain

❑Dizziness ❑Eye Problems ❑Gallstones ❑Soft brittle nails ❑Easily angered ❑Hyperthyroid
❑Spasm or muscle twitching ❑Difficulty making decisions

❑Insomnia ❑Sleeping Problems ❑Heart Palpitations ❑Cold Hands & Feet ❑Vivid Dreams
❑Nightmares ❑Mentally restless ❑Sweat easily ❑Poor Memory ❑Anxiety

❑Low energy ❑Lack of appetite ❑Excessive appetite ❑Loose stool ❑Diarrhea ❑Indigestion
❑Belching ❑Heartburn/reflux ❑Bloating ❑Edema ❑Bruise easily ❑Worry ❑Stress

❑Frequent colds ❑Cough ❑Shortness of Breath ❑Nasal problems ❑Skin Problems ❑Bronchitis
❑Sore throat ❑Mucus/Phlegm ❑Constipation ❑Hemorrhoids ❑Colitis/Diverticulitis ❑IBS

❑Low back ache ❑Knee weakness ❑Hearing impairment ❑Ear ringing❑Kidney stones
❑Urinary problems ❑Decreased sex drive ❑Hair loss ❑Depression❑Hypothyroid

For Women

Are you pregnant? ❑Yes ❑No Are you trying to get pregnant? ❑Yes ❑No
#of Pregnancies_____ # of live births_____
Age of 1st period _____ Age of last period (Menopause)_____
Number days between periods_____ Number of days of flow_____
Color_____ Clots_____ Date of last gynecologic exam_____

Menstrual symptoms: ❑Pain ❑Bloating ❑Discharge ❑Nausea ❑Swollen breasts ❑Constipation
❑Mood Swings ❑Hot Flashes ❑Libido Change ❑Headache ❑Insomnia ❑Fibroids
❑Endometriosis ❑Fibrocystic Breasts ❑Ovarian Cysts ❑PID ❑Hysterectomy❑Osteoporosis
❑Breast Cancer

For Men

Date of last prostate check up_____ Results_____
❑Prostate problems ❑Frequent Urination ❑Delayed urination ❑Dribbling ❑Incontinence
❑Retention of urine ❑Increased libido ❑Decreased libido ❑Impotence ❑Premature ejaculation
❑Groin Pain ❑Testicular pain ❑Back pain

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of Acupuncture and other Oriental Medicine procedures by the acupuncturist named below. **I understand that I am not receiving a western medical diagnosis and that any health concerns that I may have should be consulted with by my regular medical doctor.**

I understand that methods of treatment may include; acupuncture, moxibustion, cupping, electrical stimulation, breathing techniques, exercise therapy, Tui-na (Chinese massage), herbs and nutritional counseling. I am under no obligation to perform any one therapy.

Acupuncture is a safe method of treatment but may have side effects including; bruising, numbness or tingling near the needling sites. I understand that I should not make significant movements while the needles are being inserted, retained or removed. The herbs and supplements that might be recommended are traditionally considered safe in the practice of Oriental Medicine. I will notify the acupuncturist if I experience any side effects.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment. 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 in my best interest. I understand that results are not guaranteed.

Privacy Notice

This office follows all the rules of HIPPA as related to privacy. I understand that my health information will be used only to carry out treatment and for health operations such as appointments and collecting payment. I agree that notes may be mailed to my address or phone messages may be left at my home. I understand that I have the right to request how my personal information is used. I understand that I have the right to revoke consent at any time for all future transactions. I understand that I am being treated in a small office and that all reasonable measures are taken to protect my privacy. The office reserves the right to change its privacy policies in accordance with applicable law.

Billing

Payment is due at the time of service. There is a $50 charge for missed appointments or cancellations with less than 24 hours notice(not including emergencies). St. Clair Family Acupuncture will handle all submissions for applicable insurance. I understand that any copay, coinsurance and any charges not covered by my insurance company is my responsibility.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment. I do affirm that I have been advised to consult a physician regarding the condition or conditions for which I am seeking acupuncture treatment. 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(or legal guardian) _____

Print Name of Representative_____

Date Consent Completed_____

Acupuncturist _____Gregg St.Clair_____