PACIFIC ACUPUNCTURE
HERBAL MEDICINE & FERTILITY

11750 Highland Road, Suite 405 • Hartland, MI 48353 • 734-800-4118

This Information is essential for the diagnosis procedure and helps us to provide you with a better treatment. Please fill out as accurately you can.

THIS INFORMATION IS CONFIDENTIAL

Name: _____Referred By: _____

Address: _____

Home Phone: _____ Work Phone: _____

Email: _____

Occupation: _____

Emergency Contact: _____ Emergency contact phone: _____

Birth date: _____ Height: _____ Weight: _____

Describe your principal complaint? _____

_____

What has been diagnosed (By M.D.)? _____

_____

Any problems during your birth? _____

_____

Vaccination history: Any reactions that you remember? Any unusual vaccinations?

_____

Childhood Illnesses: Any surgery or accidents?

Age: _____

_____

Age: _____

_____

Adolescence Illnesses: Any surgery or accidents?

Age: _____

_____

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Age: _____

_____

Adulthood: Any surgery or accidents?

Age: _____

_____

Age: _____

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Age: _____

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Age: _____

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Please note all major illnesses in your immediate family, like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders etc.

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Are you taking any medication? Please note all medication, herbs vitamins and minerals you take even if you take them only occasionally.

_____

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_____

Do you have any scars? Note location of all operation or injury scars (even minor ones)

_____

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Name: _____ Date: _____

Symptom list

Circle any problem, disease, or symptom you have now Underline items that affected you in the past

Skin: eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

Heart and vascular: Fast pulse (over 100 beats/min.), slow pulse (less than 60 beats/min.), palpitation, irregular pulse, feeling of pressure in the chest short of breath, chest pain, dizziness, migraine headache with nausea, cold hands/cold feet, Raynaud's disease, flushed face, anemia, high blood pressure, low blood pressure, cold sweats, red face feel dizzy or faint when standing up quickly or standing for a long time

Gastrointestinal: constipation, diarrhea, no appetite, stomach pain, indigestion, heartburn, intestinal gas, belching, ulcer, gastritis, lack of stomach acid, hemorrhoids, ileocecal valve, spasm, peritonitis, pancreatitis, irritable bowel, polyps, GI tumors

Respiratory: asthma, bronchitis, emphysema, cough, wheeze, pneumonia, lung abscess

Hormonal imbalance: low thyroid, overactive thyroid, diabetes, hypoglycemia, blood sugar,

Other hormone imbalance_____

Male: impotence, premature ejaculation, prostate gland problem, vasectomy, infertility

Female: menstrual problems, cramping heavy/light/irregular periods, PMS, emotional reactions, menopause symptoms, tubal ligation, infertility, low libido

Autoimmune and inflammatory conditions: Hashimoto's disease (thyroid), rheumatism, systemic lupus erythematosus, colitis, Crohn's disease, alopecia (baldness), allergy, food allergy, atopic, dermatitis, neurodermatitis, cellulitis, sinus allergy, vulvitis, low immunity

Effects of focal infections: rheumatic disease, rheumatic fever, arthritis, skin disease,

Connective tissue or ligament diseases: Myofascial pain syndrome, fibromyalgia, tendinitis, ligaments pericarditis constant slight fever, glomerulonephritis, plantar fasciitis, scarlet fever, ear infections, streptococci infections, staphylococci infections, easily catch cold or sore throat, swollen glands

Ear, nose & throat: deafness, tinnitus (ringing in the ear), itchy ear, ear pain, frequent ear infections, sinus headaches, yellow mucus, stuffy nose, post-nasal-drip, dry throat, itchy throat, constant sinus congestion, streptococci throat infections, sore throat

Oral disease: bleeding gums, periodontitis, dental abscess, mumps, stomatitis (inflammation of the mouth), TMJ, toothaches without cavities

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General: insomnia, psychosomatic weakness, exhaustion, emotional problems (angry, irritable, depressed, anxious), difficult concentrating on a task, easily get car sick, sea sick, or air sick no appetite for breakfast, moody in mornings, unusual sweating (palm, sole, or elsewhere), never sweat

Before noontime: no energy, feel spacey, scattered minded, energetic all evening through midnight, but hate to wake up early in the morning, long shower or bath makes you feel dizzy or faint

Medication and drugs: Birth control pill, cigarettes, alcohol, cocaine, marijuana

Other:

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Informed Consent to Treatment

I consent to acupuncture treatment and other procedures associated with Traditional Chinese Medicine by the member of clinic medical staff. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (acupressure massage), Chinese or Western herbal medicine and nutritional counseling.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising, tingling or numbness around the near needing sites that may last a few days. There have been very rare instances reported of fainting, infecting and scarring. There have been extremely rare instances report of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy.

I understand that the herbs need to be prepared and the tea 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 clinic medical staff of any unanticipated or unpleasant effects associated with the consumption of the herbal tea.

I will notify the clinic medical staff member who is caring for me if I am or become pregnant.

I do not expect the clinic medical staff to be able to anticipate and explain all possible risks and complications of treatment. I wish to rely on the clinic staff to exercise judgment during the course of treatment that the clinic medical staff thinks at the time, based upon the facts then know is in my best interest.

I understand that the clinical medical and administrative staff may review my medical 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 had read to me, this consent to treatment, have been told about the risk and benefits of acupuncture and other procedures, and have had an opportunity to ask question. No guarantee has been made. I intend this consent form to cover the entire course of treatment for my present condition and future condition(s) for which I seek treatment.

To be completed by patient (or by patient's guardian if the patient is a minor or is physically or legally incapacitated)

Name of Patient (please print) _____

Signature of Patient (or gaurdian) _____

To be completed by the member of the clinical medical staff providing information and obtaining consent.

Name of Medical Staff (please print) _____

Signature of Medical Staff _____