Informed Consent to Oriental Medical Healthcare

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and 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.

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 some 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. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on 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 treatment. I understand that the results are not guaranteed. I understand that 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 the 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. I also understand that Metapoint Acupuncture and Wellness, LLC requires a minimum of **24 hours notice** for an appointment change or cancellation. A $35.00 service fee will be charged for any missed appointments.

_____	_____	_____
Patient's Name (please print)	Patient's Signature	Date

If under 18 years old:

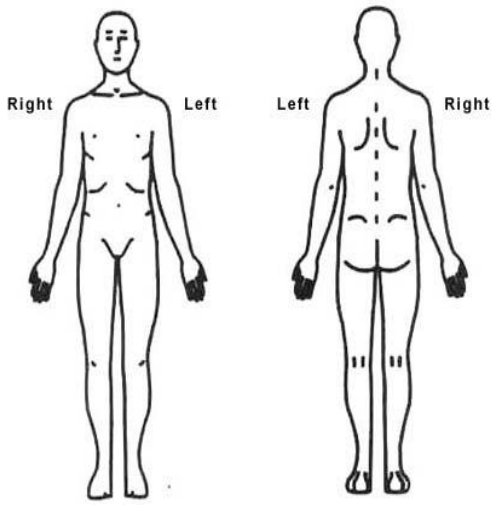
_____	_____
Print name of patient's representative	Relationship or authority of patient's Rep.
_____	_____
Signature of Patient's Representative	Date of signature

Name:

Sex : F M Date / / Date of birth / / Age
Main phone # Other phone #
E-mail address _____ Allow email contact by Metapoint Acupuncture: ❍ Yes ❍No Mailing address:
Relationship status
of children
Family physician
Chiropractor
Do you have health insurance? ❍Yes ❍No If yes, name of insurance company
Does your insurance cover acupuncture? ❍Yes ❍No
Who is your employer?
Emergency contact name phone
How did you find out about our clinic? Friends/Relatives(name)_____ Website/Google search Referred by_____ Periodicals Other (please specify)

Main Problem/Chief complaint:
What diagnosis, if any, have you received for this problem?
When did this problem begin?
What are the causes of this problem (if known)?
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?
What kind of treatment have you tried?
What makes this problem worse?
What makes this problem better?
Is there anybody in your family with the same/similar problems?

PLEASE INDICATE PAINFUL AREAS WITH CIRCLES OR SHADING



Medical History **(Please include the month/year when the event occurred or when the diagnosis was established)**
Surgeries:
Hospitalization(s):
Significant trauma: (auto accidents, sports injuries, etc.)

DIAGNOSIS	SELF?	FAMILY?	DIAGNOSIS	SELF?	FAMILY?
CANCER			**VENEREAL DISEASE**		
DIABETES			**ALCOHOLISM**		
HEPATITIS	(TYPE)	(TYPE)	**DEPRESSION**		
THYROID			**ANXIETY**		
SEIZURES			**TUBERCULOSIS**		
ARTHRITIS			**HIGH CHOLESTEROL**		
BREATHING PROBLEMS			**HIGH BLOOD PRESSURE**		
HEART DISEASE			**ANEMIA**		
DIGESTIVE ISSUES			**OTHER**		

Please list any current medications you are taking:

_____

_____

Habits
Do you smoke ? ❍Yes ❍No What? How many per day?
Since when?
Please describe any use of drugs for non-medical purposes:
Do you exercise regularly? ❍Yes ❍No
Please describe your exercise program:
How many hours do you sleep in general?
What time do you usually go to bed?
Caffeine consumption and Diet
How much coffee do you drink? _____cups/day
Colas _____number/day
Tea _____ cups/day
What kind of alcoholic beverages do you usually drink, if any?
Average number of alcoholic drinks/week?
How much water do you drink per day? _____
Are you a vegetarian? ❍Yes ❍No ❍Yes, but not so strict
Do you eat a lot of spicy food? ❍Yes ❍No

Please describe your average daily diet (Please be as specific as possible):

Morning

_____

Afternoon

_____

Evening

_____

Snacks

_____

How would you rate your current stress level? (circle: 1= least, 10 =highest) 1 2 3 4 5 6 7 8 9 10

In what areas of your life do you feel the most stressed? Check all that apply: ❍Job/Career
❍Partner/Spouse relationship ❍Parents/Family ❍Financial ❍Friends

❍Other(s): _____

Occupation :
Do you usually work indoors or outdoors?
Occupational stress (chemical, physical, psychological, etc):
Height_____ Weight now_____ Weight one year ago_____ Weight maximum _____@Year _____

Please check any of the following symptoms that you are currently experiencing:

Body Temperature (Chinese Kidney System)

❍Cold hands ❍Hot body temperature ❍Profuse perspiration ❍Perspire easily

❍Cold feet ❍Cold body temperature ❍Lack of perspiration ❍Night time urination

❍Sweaty palms ❍Afternoon flushing ❍Night sweating

❍Sweaty feet ❍Hot flashes ❍Strong thirst

Energy and Stamina (Chinese Lung and Kidney Systems)

❍ Easily fatigued ❍Lethargy ❍Easily prone to illness ❍Wheezing

❍Shortness of breath ❍Sweating without exertion ❍Frequent colds / flus / sinuses

❍Chronic allergies

Blood Function (Chinese Liver, Heart and Spleen Systems)

❍Dizziness ❍Tingling in extremities ❍ Itchy or dry ❍ Blurry vision

❍Poor night vision ❍Poor memory ❍Scanty menses ❍Tinnitus

❍Floaters ❍Difficulty concentrating ❍Fainting ❍Weak or brittle nails

Heart Function

❍Heart palpitations ❍Manic moods ❍Forgetfulness ❍Tongue ulcers

❍Anxiety ❍Restless dreams ❍Hallucinations ❍Speech impediment

❍Mental restlessness ❍Insomnia ❍Depression ❍Severe shyness

❍Chest Pain ❍Arrhythmia ❍High Blood Pressure ❍Low Blood Pressure

❍Hemophilia ❍Rapid Heart Beating ❍Heart Murmur ❍Mitral valve prolapse

Lung Function

❍Persistent cough ❍Chronic allergies ❍Dry or flaky skin ❍Headaches

❍Nosebleeds ❍Nasal dryness ❍Sneezing ❍Difficulty breathing

❍Sinus congestion ❍Sore throats ❍Wheezing ❍Cigarette smoking

Allergies to : ❍Mold ❍Cedar ❍Pet fur ❍Dust ❍Pollen ❍Oak ❍Hay Fever

❍Environmentally Sensitive

Spleen Function (Chinese Theory)

❍Low or weak appetite ❍Abdominal bloating ❍Gurgling in intestines ❍Hemorrhoids

❍Abrupt weight gain ❍Gas ❍Fatigue following a meal ❍Hypoglycemia

❍Abrupt weight loss ❍Strong food cravings ❍Bruise easily ❍Indigestion

Stomach Function

❍Stomach ache ❍Bad breath ❍Stomach ulcer ❍Nausea

❍Acid reflux ❍Bleeding gums ❍Belching ❍Vomiting

❍Ravenous appetite ❍Heartburn ❍Hiccups ❍Mouth ulcers

Bowel Function and Elimination (Intestinal Function)

❍Loose stools ❍Constipation ❍Difficulty moving bowels ❍I.B.S. or Colitis

❍Diarrhea ❍Blood in stools ❍Small, hard, dry stools ❍Crohn's Disease

❍Incomplete stools ❍Mucous in stools ❍Less than 1 BM/ Day ❍Eating Disorder

Accumulated Dampness (Chinese Theory)

❍Mental fogginess ❍Swollen hands ❍Edema in the legs

❍Mental sluggishness ❍Swollen feet ❍Edema in the abdomen

Accumulated Dampness, cont. (Chinese Theory)

❍Poor mental focus ❍Joint stiffness / ache ❍Chest congestion

❍Heaviness of the head, the limbs, or of the whole body ❍Symptoms worsen in rainy weather

Liver and Gall Bladder Function (Chinese Theory)

❍Chest pain ❍Irritability ❍Depression ❍Skin rashes

❍Chest tightness ❍Easy to anger ❍Pain in the ribcage ❍Acne

❍All over body tension ❍Easily frustrated ❍Heaviness in ribcage ❍Headaches

❍Muscle spasms ❍Convulsions ❍Chronic neck tension ❍Migraines

❍Muscle cramps ❍Numbness / tingling ❍Shoulder tension ❍Gall stones

❍Seizures ❍Lump in throat ❍Ringing in ears ❍Eye pain / dryness

❍Alternating diarrhea and constipation ❍Easily overwhelmed by stressful circumstances

Eyes (Chinese Liver Function)

❍Itchy eyes ❍Grittiness ❍Bloodshot ❍Far sighted

❍Dry eyes ❍Poor night vision ❍Seeing spots ❍Astigmatism

❍Watery eyes ❍Red and irritated ❍Near sighted ❍Glaucoma

Kidney and Urinary Bladder Function (Chinese Theory)

❍Frequent cavities ❍Weak knees ❍Cold lower back ❍Hair loss

❍Broken / loose teeth ❍Knee soreness ❍Cold hips / buttocks ❍Early graying of hair

❍Weak bones ❍Low back pain ❍Cold knees ❍Hearing loss

❍Ringing in the ears ❍Prostate problems ❍Incontinence ❍Quick to fear / fright

Urinary Function

❍Normal color ❍Reddish color ❍Small amount ❍Night-time urination

❍Dark Yellow ❍Cloudy ❍Large amount ❍UTI / Pain or burning

❍Clear color ❍Strong odor ❍Very frequent ❍Hesitancy

❍Difficulty initiating the stream of urination ❍Dribbling ❍Weak stream

Libido Function

❍Normal ❍High sex drive ❍Diminished sex drive ❍Vaginal dryness

❍Pain with intercourse ❍Fatigue following sexual activity ❍Infertility

Medical Evaluation

I was evaluated by a physician, OB/GYN, reproductive endocrinologist, or chiropractor for the condition(s) being treated within the last 12 months. ❍**Yes** ❍**No**

I recognize that I should be evaluated by a physician for the condition(s) being treated by the acupuncturist. ❍ **Yes** ❍**No**

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome, and we would like to ask your permission to share information in each of the following areas.

Many of our patients are under the care of a Western Medical Doctor, a Chiropractor, or another type of Medical professional . In an effort to maximize your clinical results, we may want to contact your Doctor(s), and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your Doctor? ❍**Yes** ❍**No**

_____ _____

Patient Signature Date