MANY PATHS
ACUPUNCTURE
& SHIATSU-ANMA

Consent and Health History Forms

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Patient Information and Consent Form

Please read this information carefully, and sign below. Ask your practitioner if there is anything that you do not understand.

What is acupuncture? Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body. Traditional Chinese medicine explains acupuncture as a technique for balancing the flow of energy (chi or qi) through pathways (meridians) in your body.
Is acupuncture safe? Acupuncture is generally very safe. Serious side effects are very rare – less than one per 10,000 treatments.

A complete list of qualifications and scope of practice for each acupuncturist is available at the front desk.

Does acupuncture have side effects?
You need to be aware that:

- *drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive*
- *'Needle Shock' or 'Needle Sickness' – feeling of faintness, chilliness, and/or slight nausea.*
- *minor bleeding or bruising*
- *pain during or following treatment. Symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this if it accurs..*
- *Infection*
- *Broken needle*

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important that you let your practitioner know:

- *if you have ever experienced a fit, faint or funny turn*
- *if you have a pacemaker or any other electrical implants*
- *if you have a bleeding disorder*
- *if you are taking anti-coagulants or any other medication*
- *if you have damaged heart valves or have any other particular risk of infection.*

Single-use, sterile, disposable needles are used in the clinic.

Statement of Consent

I confirm that I have read and understood the above information, and I consent to having acupuncture treatment, or I am authorizing acupuncture treatment for my legal dependent or child. I understand that I can refuse treatment at any time.

Signature: _____ **Date:**_____

Print name in full:_____

Adult Medical History Form

PLEASE COMPLETE ALL **3** PAGES

Your answers on this form will help your provider understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details. **Thank you!**

Name:_____ Phone: _____

Street/Mailing Address:_____

City, State & Zip:_____

Email: _____ Date of birth: _____

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had acupuncture before? ❑ Yes ❑ No

Have you had massage/body work before? ❑ Yes ❑ No

PRESENT HEALTH CONCERNS (What brings you in today):

_____

_____

MEDICATIONS: *Prescription and non-prescription medicines, vitamins, supplements, home remedies, birth control pills, herbs:*

_____

_____

ALLERGIES or REACTIONS TO MEDICINES:

List:_____

PERSONAL MEDICAL HISTORY:

Please mark all that apply:

___ Heart Disease
___ Heart Attack or Stroke date:_____
___ High Blood Pressure
___ High Cholesterol
___ Bleeding or Clotting Disorder (Blood Thinners)
___ Bruise Easily
___ Pacemaker
___ Liver Disease
___ Arthritis
___ HIV positive
___ Hepatitis C
___ Diabetes
___ Thyroid Problems
___ Unexplained Weight Changes
___ Head Trauma
___ Osteoporosis
___ Kidney Disease
___ Cancer (Malignant) type:_____

Other History (*not listed above, such as surgeries*):

_____

REVIEW OF SYMPTOMS: Check all that apply

Constitutional:
___ Fevers/chills/sweats
___ Change in energy/weakness
___ Problems with sleep

Genitourinary:
___ Excessive thirst or urination
___ Nighttime urination
___ Leaking Urine
___ Unusual bleeding or discharge

Ears/Eyes/Nose/Throat:
___ Change in vision
___ Difficult hearing/ringing in the ears
___ Problems with teeth/gums
___ Hay fever/allergies

Gastrointestinal/Digestion:
___ Abdominal pain
___ Diarrhea / Constipation
___ Nausea/vomiting
___ Blood in stool
___ Acid reflux
___ Gas/bloating

Cardiovascular:
___ Coughing or wheezing
___ Chest pain
___ Difficulty breathing
___ Asthma

Psychiatric/Emotions:
___ Depression
___ Anxiety
___ Stress
___ PTSD
___ Grief
___ Nightmares

Menstruation:
___ Cramping/pain
___ Clotting
___ Breast pain or discharge
___ Hot flashes
___ Heavy bleeding
___ Menopause Concerns

Neurological:
___ Memory loss
___ Loss of coordination
___ Numbness
___ Dizziness
___ Headaches/migraines
___ Excessive Thirst

Skin:
___ Mole changes
___ Itching
___ Rash
___ Unexplained lumps

PAIN SCALE: (0 = no pain, 10 = unbearable)

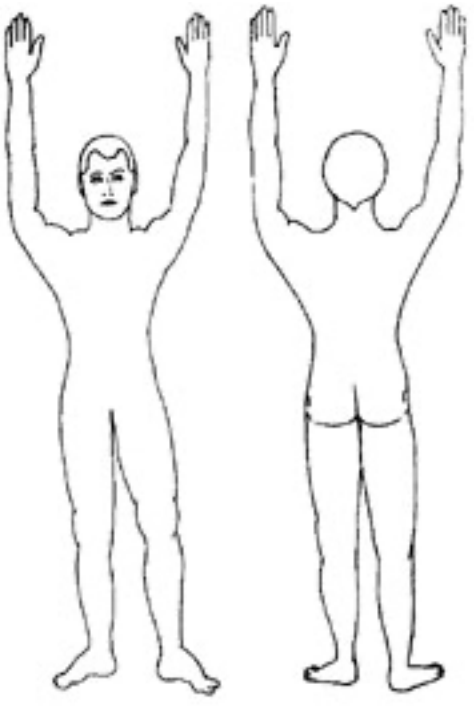
Average pain level: 0 1 2 3 4 5 6 7 8 9 10

Pain today: 0 1 2 3 4 5 6 7 8 9 10

Pain Frequency:
___ Constant (76% to 100%)
___ Frequent (51 % to 75%)
___ Intermittent (26% to 50%)
___ Occasional (0 to 25%)

Describe pain:
___ Sharp
___ Burning
___ Dull
___ Aching
___ Throbbing
___ Stabbing
___ Cramping
___ Shooting

Please mark an X on the picture where you have pain or other symptoms.



SOCIAL HISTORY (fill in only what applies)**:**

Tobacco Use
Cigarettes ❑ Never ❑ Quit: Date _____
❑ Current: Smoker: packs/day _____ Number of years _____
Other Tobacco: ❑ Pipe ❑ Cigar ❑ Snuff ❑ Chew ❑ Vape

Alcohol Use
Do you drink alcohol? ❑ No ❑ Yes: Number of drinks per week _____

Drug Use
Do you use any recreational drugs? ❑ Yes ❑ No
Have you ever used needles? ❑ Yes ❑ No
Are you under the influence of intoxicating substances right now? ❑ Yes ❑ No

Sexual Activity
Sexually Active: ❑ Yes ❑ No
STDs? ❑ Yes ❑ No

WEIGHT: Are you satisfied with your weight? ❑ Yes ❑ No

DIET: How do you rate your diet? ❑ Good ❑ Fair ❑ Poor

Exercise:
Do you exercise regularly? ❑ Yes ❑ No
What kind of exercise? _____
How long (minutes) _____ How often? _____ /week

Socioeconomics:
Occupation: _____
Employer: _____
Years of Education/Highest Degree: _____
Marital Status: ❑ S ❑ M ❑ D ❑ W ❑ Other: _____
Spouse/Partner's name: _____
Number of children/ages: _____
Who lives at home with you?
_____

Reproduction Health:
For women: # pregnancies: ____ # deliveries: ____ # abortions: ____ # miscarriages: ____
1st day, most recent period: _____ Age at 1st period: _____
Frequency of periods: _____ Length of each: _____ /days
Are you currently pregnant? ❑ Yes ❑ No
Do you have any concerns about your periods? ❑ Yes ❑ No