●10175 Fortune Pkwy ● Unit 304● Jacksonville● FL 32256● Ph (904) 880-1889● www.FamilyAcupunctureClinic.com

Family Acupuncture & Herbal Clinic

Welcome to Family Acupuncture Clinic, please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Height: _____ Weight: _____ Sex: _____

City: _____ State: ____ Zip code: _____ Employer: _____

Phone: (H) _____ (C) _____ (W) _____ Occupation: _____

Email: _____ Marital Status: _____ Spouse's Name: _____

Physician: _____ Phone _____ Referred to this clinic by: _____

In Emergency, Notify: _____ Relationship: _____ Phone: _____

Your Main Concerns: _____

_____

When did the problem begin (be specific)? _____

Symptoms relieved by_____ Symptoms worsened by_____

Intensity: ☐ mild ☐ moderate ☐ severe ☐ other_____;

Duration: ☐ constant ☐ intermittent ☐ with certain motions_____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____ Other concurrent therapies: _____

Have you had acupuncture treatment in the past? ☐ Yes ☐ No When_____ with Who? _____

Did the problem relate to any accident/ injury? ☐ Yes ☐ No Date of accident/ injury: _____

Past Medical History ☐ Cancer ☐ Pacemaker ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Issue ☐ Seizures ☐ high cholesterol Other conditions: _____

Allergies (drugs, chemicals, foods, etc.) _____

Surgeries (types & dates): _____

Significant Traumas (Physical and Emotional): _____

Family Medical History: _____

Medications, Herbs, Supplements (List those you are currently taking): _____

_____

_____

Muscles, Joints & Bones: Do you have pain or tightness? ☐ No ☐ Yes Where? _____

Please describe the type of pain: ☐ Shooting☐ Throbbing ☐ Numbness ☐ Sharp ☐ Tingling☐ Burning☐ Dull ☐ Aching☐ Stiffness Other _____

List any activities or movements that are painful to perform: ☐ Sitting☐ Bending☐ Standing ☐ Lying Down ☐ Walking ☐ Lifting Other _____

Does your pain interfere with your: ☐ Sleeping ☐ Dressing ☐ Tying Shoes ☐ work performance ☐ Bathing ☐ Toileting ☐ Preparing Food ☐ Eating ☐ Taking Medicine ☐ Walking ☐ Exercising?

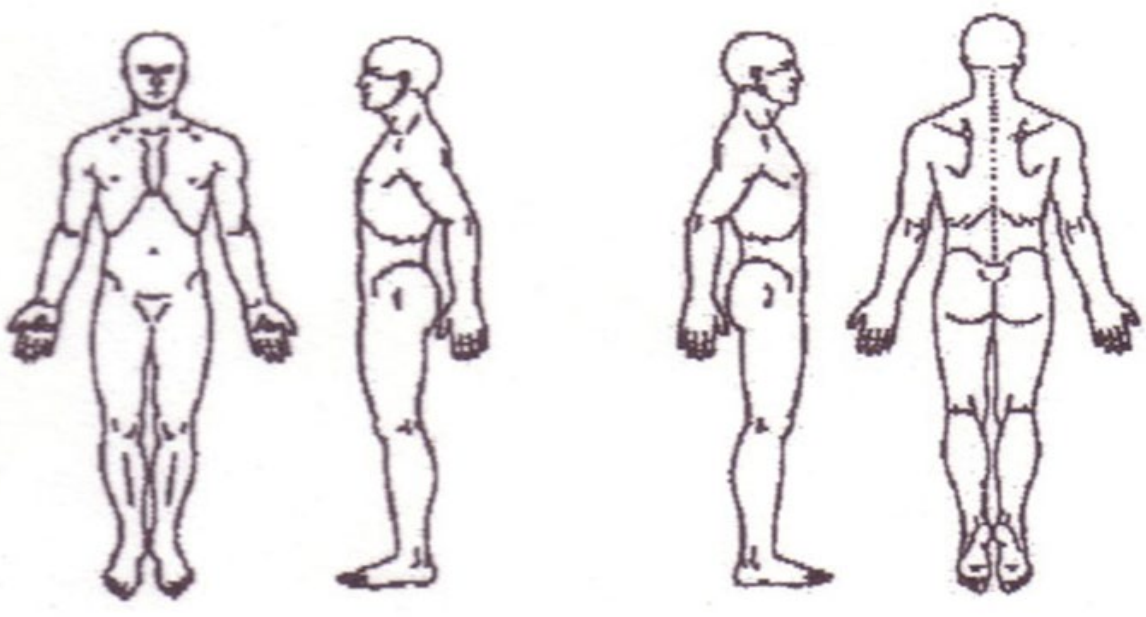
What number best describes your pain now? 0 1 2 3 4 5 6 7 8 9 10 Worst pain

I have (check all that applies): ☐ **Swollen** joints ☐ Arthritis/joint pain ☐ Tendonitis ☐ Bone pain ☐ Muscle cramping. ☐ Muscle pain ☐ Repetitive Strain Injury ☐ Fractured Bone(s) Where? _____ Other_____

Head: ☐ Headaches/Migraines: how do you describe the pain: _____Frequency: _____

Location: _____How long it last: _____ Other Symptoms accompanied with it _____

Please indicate areas of pain or distress:



Please indicate usage per day or per week:

Cigarettes _____ per _____ Duration _____
Alcohol _____ per _____ Duration _____
Drugs _____ per _____ Duration _____
Coffee _____ per _____ Duration _____

Tea _____ per _____
Soft Drinks _____ per _____
Sugar _____ per _____
Other _____ per _____

Exercise & Energy:

How is your energy? _____ Do you fatigue easily? ____ Do you exercise? _____ How often _____

Emotions & Sleep:

How do you feel emotionally? _____Do you have (check all that apply): ☐ Panic attacks ☐ Depression ☐ Anxiety ☐ Bad temper ☐ Nervousness ☐ Fear attacks ☐ Poor memory ☐ Difficult concentration

How long do you normally sleep? ____hours per night I have difficulties with (check all that apply): ☐ Falling asleep ☐ Staying asleep ☐ Dream-disturbed sleep Waking up at about _____am/pm and not being able to fall asleep again

Cardiovascular:

I have (check all that apply): ☐ Chest pain ☐ Palpitation ☐ Varicose veins ☐ Phlebitis ☐ Cold hands and feet ☐ Irregular heartbeat ☐ Poor circulation ☐ Other: _____

Respiratory:
I have (check all that apply): ☐ Frequent colds ☐ Chronic runny nose ☐ Frequent sore throat ☐ Chronic cough. ☐ Coughing blood ☐ Cough up mucous ☐ Pain inhaling ☐ Shortness of breath on exertion/at rest ☐ Asthma

Gastrointestinal:
How is your appetite? _____ I have craving for _____
I have (check all that apply): ☐ Belching ☐ Nausea ☐ Vomiting ☐ Vomiting of blood ☐ Ulcers ☐ Bloating ☐ Acid regurgitation ☐ Heartburn ☐ Hernia ☐ Indigestion ☐ Severe stomach pain
Bowel movements: How often? _____time(s)/day _____days/week
I have (check all that apply): ☐ Irregular ☐ Constipation ☐ Diarrhea ☐ Gas ☐ Burning sensation ☐ Hemorrhoids ☐ Undigested food in stool ☐ Loose stool ☐ Hard stool ☐ Blood in stool ☐ Itchiness ☐ Painful bowel movements

Urinary:
Urination: How often? _____ Times per day Color: ☐ Pale ☐ Yellow ☐ Dark yellow/orange ☐ Other _____
I have or had (check all that apply): ☐ Trouble starting stream ☐ frequent urination ☐ Incontinence ☐ Pain ☐ Burning ☐ Dribbling when sneezing ☐ Blood in urine ☐ Kidney stones ☐ Urinary tract infections ☐ other

Eyes, Ears, Nose, &Throat:
I have (check all that apply): ☐ Nose bleeds ☐ Stuffy nose ☐ Postnasal drip ☐ Painful/red eyes ☐ Poor vision ☐ See spots/floaters ☐ Dizziness ☐ Cold sores ☐ Bleeding gums ☐ Dry mouth ☐ Ear pain ☐ Ringing in ears ☐ Clogged/popping in ears

Skin & Hair:
I have or often have (check all that apply): ☐ Dry skin ☐ Skin rashes ☐ Itching ☐ Acne ☐ Eczema ☐ Hives ☐ Hair loss ☐ Premature graying ☐ Other:

Women:
Are you pregnant? ☐ Yes ☐ No ☐ Possible At what age did you start menstruating? _____ Day of Last Menses: _____ Number of days between cycles: _____ Number of days of flow: _____ Color: _____
I have or had (check all that apply): ☐ Irregular menstruation ☐ Heavy flow ☐ Light flow ☐ No flow ☐ Clots ☐ vaginal itching/burning ☐ Spotting between periods ☐ Discomfort/pain before period ☐ Discomfort/pain during period ☐ other _____Any vaginal discharge? ☐ No ☐ Yes Color _____

Men:
I have (check all that apply): ☐ Prostatitis ☐ Impotence ☐ Penis blood/mucous discharge ☐ Other _____

Comments: _____
_____
_____
_____

The above information is true to the best of my knowledge!

_____ _____ _____
Your Name (Please Print Name) Signature Date

Parent / Guardian (if applicable) _____ Date _____

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ACUPUNTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 licensed 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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 large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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 the clinical staff to exercise judgment during treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over the counter). I understand 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 an opportunity to ask questions. I agree with the current or future recommendations for care. 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.

Your Name (Please Print Name)_____Signature_____Date_____

Parent / Guardian (if applicable) _____ Date _____

Acupuncturist name: Dr. Xiaolu Luo, AP., DOM Signature_____ Date_____