

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date ____ / ____ / ____		First Name		Last Name		Middle Initial	
Gender M F	Date of Birth ____ / ____ / ____	Age	Eye Color:		Height:	Weight:	
Street Address				City		State	Zip
Phone (Daytime) - Home Work Mobile Circle One ()				Phone (Nighttime) # - Home Work Mobile Circle One ()			
Alternate Phone # - Home Work Mobile Circle One				Place of Employment		Occupation	
Name & Phone Numbers of Partner: Primary () Alternate ()				Name & Phone Numbers of Emergency Contact: Primary () Alternate ()			
E-Mail:							
How did you hear about us? <i>Please circle one and write the name</i> Current Patient: _____ Doctor: _____ Advertisement: _____ Friend: _____ Insurance: _____ Other: _____							
Have you received a Diagnosis for your condition(s)? Y / N If so what: By Whom:				Have you had Acupuncture before? Y / N Did you have a positive __ Experience __ Out come			

	Severe	Moderate	Slight	Major Complaint(s), in order of importance to you:
1.	—	—	—	_____
2.	—	—	—	_____
3.	—	—	—	_____
4.	—	—	—	_____
5.	—	—	—	_____

When/how did this condition occur? Give dates if possible.

1) _____

2) _____

3) _____

How do these conditions impair your daily activities?

1) _____

2) _____

3) _____

Treatment(s) you have received for this condition:

1) _____

2) _____

3) _____

What treatments helped the most?

1) _____

2) _____

3) _____

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		ALLERGIES Medications, Seasonal, Environmental, Food.	OCCUPATIONAL CONCERNS Check (<input type="checkbox"/>) if your work exposes you to the following:	DIET & EXERCISE Check (<input type="checkbox"/>) all that apply.
Year	Surgery/ Hospitalization/ Accidents/ Trauma (Physical & Emotional)		<input type="checkbox"/> Stress <input type="checkbox"/> Environmental <input type="checkbox"/> Heavy Typing <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Others:	<input type="checkbox"/> Regular Exercise <input type="checkbox"/> Low-Fat <input type="checkbox"/> Low-Carb <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other:
				<input type="checkbox"/> Drink Coffee: Cups/Day
			Occupation: _____	<input type="checkbox"/> Drink Soda oz/Day

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose sprays, and topical creams. NOTE: If need more space, use page 5.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SUPPLEMENTS

Name	Purpose	How Long	Dose	How Often	Last Dose

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a "C" under the appropriate person's column. "P" should be used to indicate a past problem. Leave blank those that do not apply. If any of the above family members are deceased, please list their age at death and cause. If you require more space, use the space below.

<i>Age</i>	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
AIDS / HIV							
Alcohol							
Anxiety							
Anorexia / Bulimia							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
Headaches							
Heart Trouble							
Hepatitis							
High Blood Pressure							
Immune Disorder							
Insomnia							
Kidney Trouble							
Liver Trouble							
Migraine							
Neck Pain							
Thyroid Disorder							
Tobacco							
Weight Problem							
Other Emotional Problems: _____							
Other: _____							

Notes:

SYMPTOMS – NOTE: For each symptom you currently have, rate its severity from 1-5 (5 being the worst).

Leave blank if Not Applicable.

LIVER / GALLBLADDER

- _____ Irritability / Anger
- _____ Depression / Stress
- _____ Headaches / Migraines
- _____ Visual Problems
- _____ Red / Dry / Itchy Eyes
- _____ Gall Stones
- _____ Dizziness
- _____ Blurred Vision
- _____ Feeling of Lump in Throat
- _____ Clenching of Teeth at Night
- _____ Muscle Cramping / Twitching
- _____ Tension
- _____ Joints/Neck/Shoulder Pain/Tight
- _____ Poor Circulation

- _____ Soft / Brittle Nails

- _____ Emotional Eater

- _____ Bad Taste

- _____ Bad Breath
- _____ Do you Crave: Sour

KIDNEY/ URINARY BLADDER

- _____ Urinary Problems

- _____ Bladder Infection
- _____ Dropped Bladder
- _____ Incontinence
- _____ Lack of Bladder Control
- _____ Weakness/ Pain in Lower Back
- _____ Decrease Bone Density
- _____ Feel Cold Easily
- _____ Cold Hands
- _____ Cold Feet
- _____ Low Sex Drive / Libido
- _____ Excess Sexual Desire

Poor Memory

- _____ Loss of Hair
- _____ Hearing Problems
- _____ Cavities
- _____ Fear
- _____ Hot Flash/ Night Sweating
- _____ Do you crave: Salty

Heart / Small Intestine

- _____ Heart Palpitations
- _____ Chest Pain
- _____ Insomnia / Sleep Problems

_____ Easily Startled

- _____ Restlessness / Agitation
- _____ Vivid Dreams

_____ Do you crave: Bitter

LUNG / LARGE INTESTINE

- _____ Bloody Cough
- _____ Dry Cough
- _____ Cough with Sputum
- _____ Nasal Discharge / Circle Color
- _____ -
- _____ White Yellow Green
- _____ Post Nasal Drip / Circle Color:
- _____ White Yellow Green
- _____ Sinus Infection/ Congestion

- _____ Itchy, Red, or Painful Throat
- _____ Dry Mouth/ Throat/ Nose
- _____ Skin Rashes / Hives
- _____ Snoring
- _____ Grief / Sadness
- _____ Shortness of Breath
- _____ Allergies / Asthma

Low Resistance to Colds or Flu

- _____ Sneezing
- _____ Mild Fever Comes & goes
- _____ Smokes Cigarettes
- _____ Emphysema
- _____ Bronchitis
- _____ Black / Blood in Stools
- _____ Constipation
- _____ IBS
- _____ Colitis/ Spastic Colon
- _____ Diarrhea
- _____ Do you Crave : Pungent

SPLEEN / STOMACH

- _____ Heaviness Anywhere in the Body
- _____ Fatigue on a Scale of 1(**low**) –10 (**high**)
- _____ Hard to get up in the Morning
- _____ Muscles Feel Tired Often
- _____ Edema (swelling) _ hands
_____ _ feet
- _____ Easily Bruising & Bleeding
- _____ Bad Breath
- _____ Nausea/ Vomiting
- _____ Difficulty Digesting Fatty Foods
- _____ Nausea/ Vomiting
- _____ Gas / Belching
- _____ Hemorrhoids
- _____ Constipation

- _____ Diarrhea
- _____ Abdominal Pain
- _____ Indigestion / Heartburn
- _____ Over - Thinking
- _____ Tendency to Gain Weight
- _____ Brain Foggy
- _____ Do you Crave: Sweet

INFORMED CONSENT TO TREATMENT

I consent to acupuncture, chiropractic and other procedures associated with Traditional Chinese Medicine performed by Stephen J Feldman, DC FIAMA. I have discussed the nature and purpose of my treatment with the above named practitioner.

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 have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. 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 this clinic uses sterile disposable single-use needles, and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

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 Dr. Stephen Feldman, of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Dr. Stephen Feldman, if I am or become pregnant.

I do not expect Dr. Stephen Feldman to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named practitioner to exercise judgment during the course of treatment which he thinks at the time, based upon facts then known, is in my best interests.

I understand 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 have had read to me, this 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 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.

PRINT NAME OF PATIENT (OR REPRESENTATIVE)

PRINT NAME OF PRACTITIONER

X _____
SIGNATURE OF PATIENT (OR REPRESENTATIVE)

X _____