AcuSource Healing

Consent To Acupuncture Treatment Form

Acupuncture is a form of therapy used to balance the body's life energy, called Qi (chi). It involves the insertion of fine, sterile needles into points on the body that have been empirically proven effective in the treatment of specific disorders. By balancing the body's energy (Qi), acupuncture can normalize the body's physiological functions and can help prevent or modify the perception of pain. Other methods of treatment within the scope of acupuncture include: electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artimisia alone or Artimisia formulations), mechanical stimulation (stimulation of a point on the surface of the body by means of an apparatus or instrument), cupping (the application of glass cups with vacuum to the skin), gua sha (the rubbing of the skin with a smooth object such as a porcelain spoon), and Sotai (a Japanese movement therapy).

I understand that acupuncture is generally considered safe, but it may have some side effects including slight discomfort at the site of needle insertion, numbness or tingling near the needle site that may last several days, bruising, minor bleeding, dizziness, fainting, nausea, or temporary aggravation of pre-existing conditions. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, organ puncture, and infection. Burns and scarring are a potential risk of moxibustion and cupping. Bruising is an intended outcome of Gua Sha and cupping therapies and is not normally painful.

I understand that the results of treatment are not guaranteed and that I may refuse or stop treatment at any time. I understand that acupuncture cannot totally replace the resources available through a biomedical physician and that it is recommended that I consult a physician regarding any condition for which I am seeking acupuncture treatment. I understand that I must notify the acupuncturist if I become pregnant.

I hereby request and voluntarily consent to acupuncture treatments. I have read and understand, or have had read to me and understand, this consent to treatment, have been told about and understand the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I understand that while this document describes the major risks of treatment, other side effects may occur. 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.

_____ _____

Date Consent Completed | Print name of Licensed Acupuncturist

_____ _____

Patient's Name (print) | Signature of Licensed Acupuncturist

_____

Signature of Patient or Representative

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Health History Questionnaire

This information is important for the diagnosis process. Some questions may seem unrelated to your current condition, but may be important to diagnose and treat you. Please complete this questionnaire as accurately as possible. Thank you.

Date: _____ Emergency Contact: _____
Patient Name: _____ Name/relation: _____
Address: _____ Telephone:_____
_____ Marital Status: S M W D

Date of Birth: _____ Sex: M F
(H) Telephone:_____ Occupation: _____
(C) Telephone:_____ Physician Diagnosis: _____
(W) Telephone:_____ _____
Email Address: _____ Physician Name: _____
Physician Address: _____
Physician Telephone:_____ Allergies: _____
Date of last Exam: _____ Height: _____ Weight: _____

What is the principle complaint or condition that brought you here today? _____
_____
_____

When did this problem first occur? _____
Is it constant or does it come and go?_____
Does the condition cause pain? Yes No Location:_____
Describe the pain: Dull Sharp Burning Numbness Other: _____

Does the pain ever move (ie. from joint to joint) or travel (i.e. shooting down leg)? Yes No
Describe _____

What makes the pain better? Heat Cold Movement Rest Pressure Massage
Other: _____

What makes the pain worse? _____
Is your condition affected by seasonal changes?
Describe _____

Do you experience frequent headaches? Yes No How often? _____
Location of headache pain: _____
Type of pain: Dull Sharp Pounding Other_____
What helps relieve headache? _____
What makes headache worse? _____

Average number of hours per night that you sleep: _____
Difficulty falling asleep? Yes No Staying asleep? Yes No
Do you wake up early and then are unable to fall back asleep? Yes No
Do you take anything for sleep? _____

Describe your bowel habits: Regular Constipation Diarrhea
How many days pass between bowel movements?
Do you often experience diarrhea in the early morning when you first wake up? Yes No

Is your urine (circle): Clear or Cloudy Light or Dark Quantity: Little Average Large
Do you have difficulty urinating (describe)_____
Do you experience pain, frequency, or urgency?_____

Do you have any emotional difficulties?
(circle all that apply) Anxiety Panic Attacks Depression Mania Mood Swings Irritability
Other: _____

How would you rate your ability to concentrate? Poor Fair Good Excellent

How would you rate your stress level? Low Moderate High

How would you rate your appetite? Poor Fair Good Excessive
Do you crave certain foods? Sweets Salty Spicy Other: _____
Are you often or excessively thirsty? Yes No Do you prefer (circle) Warm or Cold beverages

Do you often feel cold? Yes No Do you often feel warm? Yes No
Describe the amount you sweat (circle): Very little Average Excessive
Do you experience night sweats? Yes No Hot flashes? Yes No

Do you exercise? Yes No Type and frequency:
How would you rate your energy level? Poor Fair Good Excellent

Do you currently take any medications? Yes No
(list prescriptions, herbs, birth control, vitamins, etc) _____
_____

Do you have a history of smoking? Yes No
Number of cigarettes/day_____ Packs/day_____ Years smoked____

Do you drink alcoholic beverages? Yes No Type of Beverages:
Quantity/day? _____ per week _____ per month _____

Do you have a history of drug use? Yes No
Substance type and date last used _____
Are you in any treatment program? Yes No

Past Medical History:

Any complications during your birth? Yes No
Describe _____
Any reactions to Vaccines? Yes No
Describe_____

Childhood Illnesses (Include Accidents and Surgeries)
Illness and Age: _____
_____

Adolescence Illnesses (Include Accidents and Surgeries)
Illness and Age: _____
_____

Adulthood Illnesses (Include Accidents and Surgeries)
Illness and Age: _____
_____

Do you have any scars? Yes No Location _____

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Family History:

Please note all major illnesses in your immediate family (ie. Diabetes, Heart Disease, High Blood Pressure, Neurological Disorders, Psychological Disorders, Blood Disorders, Orthopedic Problems etc.)

Mother: _____

Father: _____

Siblings: _____

Grandparents: _____

Female:

Is there any chance you could be pregnant? Yes No Date of last menstrual period

Age at first menses_____ Age at Menopause_____

Average number of days in your cycle _____ Average number of days of menstrual flow _____

Is your menstrual flow (circle) Light Moderate Heavy

Color of menses (circle) Deep Red Bright Red Pink Purplish/dark Brown

Does your menstrual blood contain clots? Yes No

Do you experience bleeding between periods? Yes No

Do you experience pre-menstrual symptoms (ie. breast tenderness, irritability etc.)? Yes No

Do you have any vaginal discharge? Yes No Describe: _____

Number of children_____ Number of miscarriages _____ Number of abortions _____

Any complications during childbirth? Yes No Describe: _____

Postpartum depression? Yes No

Male:

Circle if applicable: Testicular pain Testicular swelling Impotence Enlarged Prostate

Other: _____

_____

Patient Signature: _____

Date: _____

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Infrared Sauna Profile Chart

Client Name: _____

Date: _____

Please take a moment to carefully read the following intake information and sign where indicated.
If you have a specific medical condition or specific symptoms, far infrared saunas may be contraindicated.
A referral from your primary care provider may be required prior to service being provided.
These confidential questions are designed to give you the best treatment possible.

f you are under a doctor's care, please consult with your health care practitioner prior to sauna use. Sauna use is contraindicated for pregnant women, nursing mothers, and hemophiliacs.

Drink plenty of water before, during, and after your sauna session to replenish lost fluids.

Are you pregnant or nursing? Yes_____ No_____
If yes, it is required that we have a note from your doctor prior to beginning your treatment.

Are you a hemophiliac? Yes_____ No_____
If yes, it is required that we have a note from your doctor prior to beginning your treatment.

Are you under the care of a:
Physician_____ Acupuncturist_____Chiropractor_____ Other_____
If yes, please specify: _____

Were you referred by a physician, chiropractor, or acupuncturist? Yes_____ No_____

It is your responsibility to inform AcuSource Healing, LLC of any changes to the above information. AcuSource Healing cannot guarantee the results or outcome of treatments. By signing below you acknowledge that you understand all of the above and have provided all information fully and accurately.

Client Signature: _____