Crescent City Acupuncture and Herbal Medicine, LLC
Jimi Smith, LAc · Kate Iberg, LAc
4322 Canal Street, Upstairs
New Orleans, LA 70119
Voice: 504.858.1295 Fax: 504.264.5489
www.crescentcityacu.com

Confidential Patient Information

Name: ____
FIRST MIDDLE LAST

Address: ____
Street

City: ___________________________________ State: _____________ Zip: ______________

Home Phone: ____________________ Work: ___________________ Cell: ________________

Fax: ___________________ E-Mail Address: ____

Would you like to receive appointment reminders via e-mail? **Y** **N**

Date of Birth: ________________ Age: ______ Sex: ______ Height: ________ Weight: ________

Marital Status: Married Domestic Partner Single Divorced Widowed Other:____________

Occupation: _________________________ Employer: ______________________________

Employment Status: Full-Time Part-Time Self-Employed Retired Student Unemployed

Emergency Contact: ____
NAME PHONE RELATIONSHIP

Primary Physician: ____
NAME PHONE HOSPITAL/OFFICE/CLINIC

Who should we thank for your referral?: ____

If not referred, how did you find us?____

FOR ALL PATIENTS:	**Do you have a pacemaker or other electrical implant?**	**Y**	**N**	**IF YES, SINCE WHEN? ____________**
FOR FEMALES:	**Are you PREGNANT or is there a CHANCE you MAY be PREGNANT?**	**Y**	**N**	**IF YES, HOW LONG?____________**

Financial Arrangements

How do you plan to handle your account? CASH CHECK CREDIT CARD WORKERS COMP

Cancellation Policy

The time that is scheduled for you is reserved especially for you and not available to any other individual. A late cancellation fee equal to the cost of your treatment is charged per occurrence if there is less than 24 hours notice of a cancellation or request to reschedule (unless in case of emergency – of course!).

I agree to the aforementioned terms. All information given herein is correct and complete to the best of my knowledge.

PATIENT SIGNATURE: __________________________________ DATE: __________________
(Parent/Guardian Signature if patient is under 18 years of age)

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Confidential Comprehensive Health History

Please carefully and thoroughly complete this questionnaire so that I may provide you with the best, most thorough evaluation possible. All information is confidential, as always. If there is anything that you feel that I should know that is not asked, please don't hesitate to write it in the margins, bottom, or back of the page. If you have any questions, or if anything is not clear, please don't hesitate to ask!

Have you ever had acupuncture before? If so, how recently? For what?

What is the health concern / chief complaint that you want addresses today?

When was the onset of this condition?

What makes it worse? **What makes it better?**

To what extent does this condition affect your daily routines? (e.g. work, home, sleep, exercise, digestion, sex)

What treatment/therapies have you tried for this condition? (e.g. MD, chiro, massage, RICE, stretching, etc)
Does/did any of these help?

Please list any other health concerns that you may have:

Please list any medications, supplements, vitamins, herbs etc. that you are presently taking or have taken in the last 2 months:

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Confidential Comprehensive Health History

Please list any known Food or Drug allergies:

FOOD:

DRUG:

Habits (Please check any and all that apply to you, PAST or PRESENT):

Alcohol:	Yes	No	How many per	Day	Week?______	Age started?_________	Quit?________
Tobacco:	Yes	No	Cigarettes?	Chew/Dip?	How many?		
Marijuana:	Yes	No	How many per	Day	Week?______	Age started?_________	Quit?________
Coffee:	Yes	No	Cups per day?______________________			Age started?_________	Quit?________
____________	Yes	No	How many per	Day	Week?______	Age started?_________	Quit?________
____________	Yes	No	How many per	Day	Week?______	Age started?_________	Quit?________
____________	Yes	No	How many per	Day	Week?______	Age started?_________	Quit?________
____________	Yes	No	How many per	Day	Week?______	Age started?_________	Quit?________

Are you on a restricted or special diet (e.g. vegetarian, low carb, Atkins, gluten-free, etc.)?

Please describe your typical daily diet:

Breakfast:

Morning Snack:

Lunch:

Afternoon Snack:

Dinner:

Evening Snack:

Do you exercise regularly? How? How often?
(COMPETITIVE ATHLETES please briefly list your training routine and upcoming key events)

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Surgeries – *please include approx. date*

Hospitalizations – *please include approx. date and reason*

Significant Traumas (sports, auto, fractures, falls, etc) - *please include approx. date*

Pregnancy History:
Number of: Living?_______ Ectopic?______ Miscarriage?_______ Induced Abortion?_______

Do you use birth control / contraception? Which form?

Family Health History – *please check all that apply*

	SELF	MOTHER	FATHER	SISTER	BROTHER	CHILD	SPOUSE
Allergies (please specify)							
Autoimmune Disorder							
Anemia / Blood Disorder							
Diabetes							
Cancer or Tumors							
Seizures							
High Blood Pressure							
High Cholesterol							
Heart Disease / Attack							
Stroke							
Kidney or Bladder Disorder							
Stomach or Intestinal Disorder							
Tuberculosis							
Hepatitis (type if known)							
HIV / AIDS							
Drug or Alcohol Abuse							
Depression / Mental Illness							
Other:							
Other:							
Other:							
Age at Death (if applicable)							

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Confidential Comprehensive Health History

Please check any symptoms that you have had in the LAST 3 MONTHS (CIRCLE IF SEVERE)

General:	chills	fevers	poor sleep
sweating easily	night sweats	change in appetite	fatigue
bleed/bruise easily	peculiar taste/smell	weight gain	weight loss
cravings (foods, other): ________________________________		energy drop (time of day?)________________	
undiagnosed pain	strong thirst	other:	other:
Skin and Hair:	eczema	psoriasis	rashes
ulcerations, carbuncles	loss of hair	hives	itching
acne/pimples	moles	fungus	other:
Head, Eyes, Ears, Nose, Throat:	headaches/migraine	dizziness/vertigo	earaches
blurry vision	poor night vision	sinus pressure	nose bleeds
floaters (spots in eyes)	ringing ears / tinnitus	itchy eyes	itchy ears
sores of lips, mouth, tongue	teeth/jaw grinding	sinus infection	hearing loss
Cardiovascular, Circulatory:	high blood pressure	low blood pressure	chest pain
cold hands/feet	numb hands/feet	swelling/edema	fainting
lightheadedness	palpitations	other:	other:
Respiratory:	cough	asthma (exercise?)	sneezing
pain with deep breath	chest tightness	seasonal allergies	mucus
shortness of breath	other:	other:	other:
Genito-Urinary:	painful urination	frequent urination	genital pain
urgent urination	difficult urination	decrease flow of urine	impotence
night urination	incontinence	blood in urine	kidney stone
genital sores	other	other	other
Digestive:	chronic bad breath	heartburn	nausea
rectal pain/itching	abdominal pain/cramping	gas	bloating
vomiting	diarrhea	constipation	belching
hemorrhoids	blood in stool	mucus in stool	other:
Neurological/Psychological:	seizures	loss of balance/coordination	temper
memory loss	areas of numbness/pain	easy stress susceptibility	anxiety
depression	addiction	other:	other:

Have you ever taken medication for any condition in this section? When? For what?

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Confidential Comprehensive Health History (Female Only)

Please check any symptoms that you have had in the LAST 3 MONTHS (CIRCLE IF SEVERE)

Gynecological: irregular periods painful periods PMS
breast lumps/swelling vaginal discharge vaginal sores cramping
pain with intercourse clots in discharge other: other:

Age of first menses:________ Date of last menses:____________________ Menopause? Y N Age?_______

Typical Cycle Length (days): ________________________ Typical Period Length (days):_____________________

Do you regularly have PAPs? Y N Date of last PAP: __________________

Have you ever taken oral contraceptives? When and for how long?

Please list any other issues that I may not have addressed and that you would like to discuss:

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Consent to Treatment

I agree to receive acupuncture treatments and related therapies by Crescent City Acupuncture and Herbal Medicine, LLC. Treatment methods may include, but are not limited to, acupuncture, Tui-Na massage and bodywork, cupping therapy, gua-sha, herbal medicine, nutritional supplements, heat and moxibustion therapy, electro-stimulation, physiotherapy exercises, as well as lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. However, I understand that only sterile disposable single-use needles are used, and a clean and safe environment is maintained. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify Jimi Smith, LAc or Kate Iberg, LAc immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Jimi Smith, LAc or Kate Iberg, LAc to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on him to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known.

I will notify Jimi Smith, LAc or Kate Iberg, LAc if I am or become pregnant.

I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

I understand that Crescent City Acupuncture and Herbal Medicine, LLC has the right to refuse treatment to any patient at anytime.

By voluntarily signing below, I show that I have read (or have had read to me) and understood this consent to treatment. I have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This consent form shall cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

____
Print Name of Patient (and Representative)

X_______________________________________
Patient Signature

____
Today's Date

X____________________________________
Jimi Smith, LAc
Crescent City Acupuncture & Herbal Medicine, LLC

X____________________________________
Kate Iberg, LAc
Crescent City Acupuncture & Herbal Medicine, LLC