Melissa Pfannenstiel, L.Ac., P.C.
Healing with Chinese Medicine

CLIENT INFORMATION

Name: ____

Mailing Address: ____

City: __________________________ State: _____ Zip Code: __________________

Home Phone: ___________________ Cell Phone: ___________________________

Birth Date: ___________ Age: ________ Birthplace: __________________________

Gender: _________ Height: ______________ Weight: ________________________

Occupation: ________________ Marital Status: _________ # of Children: ___________

Emergency Contact: __________________________ Phone: ___________________

E-mail address: ____

Who shall I thank for referring you to this office? ________________________________

Have you received acupuncture before? ____________________________________

Support Practitioners:

Medical Doctor _______________________ Chiropractor ______________________

Massage Therapist _____________________Therapist ________________________

Other ____

CLIENT INFORMATION AND CONSENT FORM

Your treatment may include one or more of the following:

Acupuncture: Insertion of gentle sterilized needles through the skin into underlying tissues of specific points on the body. **Electric stimulation** may also be used.

Cupping: A technique to relieve pain symptoms in which suction cups made of glass are applied to the skin using a vacuum created by heat.

Gua Sha: Painless scraping on the body with a blunt, round instrument to release metabolic waste.

Moxibustion: Burning of an herb called Mugwort above the body over acupoints.

Tui Na: Traditional massage techniques.

Herbal Medicine: May be presented in the form of tablets or concentrates.

Dietary Therapy: Food suggestions based on traditional Chinese medical theory.

Oils/Liniments: Used for medicinal purposes and with massage.

Purpose of Treatment: The purpose of treatment is to provide a health care service that is based on a traditional Chinese system of medical theory. Diagnosis and treatment based on these theories are used to promote health and to treat organic and functional disorders.

Benefits of Treatment: The benefits of treatment include relief of presenting symptoms and improved balance of bodily energies which may lead to prevention or elimination of the presenting problem, and strengthening of the patient's constitution. Of course, the practitioner cannot guarantee the outcome of any course of treatment.

Possible Side Effects of Treatment: Possible side effects include drowsiness, minor bleeding or bruising. In a very small amount of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a positive sign. Please advise your practitioner if worsening of symptoms continues for more than 2 days.
Some traditional herbs are inappropriate during pregnancy. Please advise your practitioner if you could be pregnant or if you are indeed with child.

Risks of Treatment: Traditional Chinese medical practices have been shown to be relatively safe. However, there are some uncommon but potential risks. These potential risks may include:

1. Discomfort during the insertion of a needle.
2. Dizziness or fainting.

PLEASE TURN OVER and SIGN

3. Localized, minor bruising or swelling, temporary discoloration of the skin.
4. Minor burns with the usage of some types of moxa.

5. A broken needle (very rare with the use of disposable needles).
6. Infection (very rare with the use of disposable needles).
7. Gastro-intestinal upset with the use of Chinese herbs (if this should occur, please notify your practitioner).

Cancellation Policy: Melissa Pfannenstiel, L.Ac., P.C. appreciates and requires a **24 hour notice of cancellation.** In the event of multiple cancellations, a fee will be charged.

Is there anything your practitioner needs to know?
Apart from the usual medical details, it is important you let your practitioner know:
~ If you have ever experienced a fit, faint or other odd detached sensations;
~ If you have a pacemaker of any other medical implants;
~ If you are pregnant;
~ If you have a bleeding disorder;
~ If you are taking anti-coagulants (blood thinners) or any other medication.

Statement of Consent
I confirm that I have read and understood the above information, and I consent to having treatments from Melissa Pfannenstiel, L.Ac., P.C. I also understand that I can refuse treatment at any time. I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interest. I understand the practitioner may review my medical records, 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 this consent to treatment, have been told the risks and benefits of treatments, and have had an opportunity to ask questions. I release Melissa Pfannenstiel, L.Ac., P.C. from any and all liability that may occur in connection with the above-mentioned procedures. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

______________________________________ ___________________
Print name in full Date

____
Signature

____
Parent or Guardian Signature, if under 18 years of age

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CLIENT HEALTH HISTORY

Name____

Date_______________________

What are your **primary concerns** for seeking treatment?

1.____

2.____

3.____

Have you sought treatment for any of these concerns? If yes, please specify.

____

____

Please list current medications, vitamins and/or supplements

____

____

____

Please list any current allergies or sensitivities (food, drug, environmental)

____

____

Do you have any reason to believe you are pregnant? YES NO

Do you have a pacemaker? YES NO

Please list any major surgeries, hospitalizations or accidents (include dates)

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Please list any major childhood illnesses

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____

Please list any relevant life events or additional medical history

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HEALTH HISTORY

Please indicate **'P'** (**past**) **'C'** (**current**) **'F'** (**family**) if any of the conditions below apply:

( ) Arthritis
( ) Chronic Fatigue
( ) Fibromyalgia
( ) Asthma
( ) Cancer
( ) Stroke
( ) Heart Condition
( ) HIV/AIDS
( ) Lupus
( ) Pneumonia
( ) Rheumatic Fever
( ) Epilepsy
( ) Hypothyroidism
( ) Diabetes
( ) Venereal Diseases
( ) Hyperthyroidism
( ) Low Blood Pressure
( ) Bleeding disorders
( ) Hepatitis
( ) High Blood Pressure
( ) Osteoporosis
( ) Headaches/Migraines
( ) Neurological
( ) Kidney Disease/Stones
( ) Candida Infection
( ) IBS
( ) High cholesterol

SYMPTOM SURVEY (PLEASE CIRCLE THE NUMBER WHICH APPLIES)

0=NEVER 1=RARELY 2=OCCASIONALLY 3=FREQUENTLY 4=ALWAYS

0 1 2 3 4 low appetite

0 1 2 3 4 ravenous appetite

0 1 2 3 4 loose stools
0 1 2 3 4 gas/abdominal bloating
0 1 2 3 4 fatigue after eating
0 1 2 3 4 hemorrhoids
0 1 2 3 4 bruise easily
0 1 2 3 4 anemia
0 1 2 3 4 heartburn/acid reflux
0 1 2 3 4 mouth sores
0 1 2 3 4 belching or vomiting
0 1 2 3 4 gums bleeding/swollen
0 1 2 3 4 thirst hot? cold?
0 1 2 3 4 bad breath

____

0 1 2 3 4 abnormal sweating
0 1 2 3 4 allergies
0 1 2 3 4 asthma
0 1 2 3 4 shortness of breath
0 1 2 3 4 cough
0 1 2 3 4 dry nose/mouth/skin/throat
0 1 2 3 4 fatigue
0 1 2 3 4 catch colds easily
0 1 2 3 4 tired after little exertion
0 1 2 3 4 general weakness
0 1 2 3 4 nasal discharge
0 1 2 3 4 sinus congestion

____

0 1 2 3 4 sore, cold or weak knees
0 1 2 3 4 low back pain
0 1 2 3 4 frequent urination
0 1 2 3 4 urinary incontinence
0 1 2 3 4 ear/ hearing problems
0 1 2 3 4 early morning diarrhea
0 1 2 3 4 feel cold often
0 1 2 3 4 swollen ankles
0 1 2 3 4 poor memory
0 1 2 3 4 hair loss
0 1 2 3 4 infertility
low normal high libido

____

0 1 2 3 4 irritable
0 1 2 3 4 ligament/tendon issues
0 1 2 3 4 tight feeling in chest
0 1 2 3 4 alternating diarrhea/constipation
0 1 2 3 4 frequent sighing
0 1 2 3 4 neck/shoulder tension
0 1 2 3 4 muscle spasms/twitches
0 1 2 3 4 numb extremities
0 1 2 3 4 dry, irritated eyes
0 1 2 3 4 ear ringing (tinnitus)
0 1 2 3 4 anger easily
0 1 2 3 4 red eyes

____

0 1 2 3 4 feel heart beating
0 1 2 3 4 insomnia
0 1 2 3 4 sores on tip of tongue
0 1 2 3 4 anxiety
0 1 2 3 4 chest pain
0 1 2 3 4 disturbing dreams
0 1 2 3 4 restlessness
0 1 2 3 4 palpitations

____

0 1 2 3 4 dizzy upon standing
0 1 2 3 4 see floaters in eyes
0 1 2 3 4 heat in palms or soles of feet
0 1 2 3 4 afternoon fever
0 1 2 3 4 night sweats
0 1 2 3 4 frequently flushed face
0 1 2 3 4 feeling of heaviness
0 1 2 3 4 nausea
0 1 2 3 4 foggy thinking
0 1 2 3 4 enlarged lymph nodes
0 1 2 3 4 cloudy urine
0 1 2 3 4 nighttime urination

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WOMEN ONLY:

Are you pregnant? ________ Are you on the birth control pill? _____ # of pregnancies ________

#of live births_______ # of abortions _______ # of miscarriages __________

Age of menarche ___________ Age of peri-menopause ______ Age of menopause _________

Vaginal discharge? _______ Clear/White/Yellow/Green Itch/Burn/Pain/Foul Odor

Date of last PAP Smear ____________________ Results _________________

Have you been diagnosed with (circle): Fibroids/ Fibrocystic Breasts/ Endometriosis/ Ovarian Cysts/ PID

Is your period regular? _______ # of days in cycle ____ # of days of blood flow ____________

Amount of blood flow? Excessive ____ Moderate ____ Slight _____

Color of flow? Fresh red ____ Dark red ____ Pale red ____ Purple ____ Brown ____

Clots? ______ Clot size _______ Pain with passing clots? ____

Pain with period? Before ____ During____ After____ Severity of pain (1(low)-10 (high) _______

Nature of pain? Sharp/ Stabbing/ Burning/ Dull/ Bloated/ Constant/ Intermittent/ Aching

Location of pain? _________________________________ (low abdomen, low back, thighs, etc.)

Do you experience any of the following before or during you menstrual period (please circle):

Water retention Breast tenderness/swelling Depression Irritability Headaches

Insomnia Diarrhea Constipation Nausea Hot flashes Night sweats

Yeast infections Libido changes Dizziness Appetite changes Vaginal dryness

MEN ONLY:

Date of last prostate check ________________________ Results _____________________

Circle all that apply:

Groin pain Decreased libido Testicular pain Impotence Back Pain

Painful urination Urine retention Dribbling urination Delayed stream

Incontinence

Premature ejaculation Nocturnal emissions Rectal dysfunction Increased libido

WOWZA!! YOU MADE IT THROUGH!!!! ☺