

NEW PATIENT QUESTIONNAIRE

Heavenly Stems Acupuncture

Melissa Margolis, L.Ac.

2229 Santa Clara Ave. Suite B

Alameda, CA 94501

Name _____

Address _____

Phone # _____

Emergency Contact (name & #) _____

Birthdate _____

Occupation/Employer _____

Email _____

Health Insurance (Carrier and ID#:) _____

Western medications currently taking: _____

Nutritional supplements, vitamins, herbs, etc. _____

Allergies: _____

Do you exercise regularly? _____ What kind? _____

Health habits: Cigarettes? _____ How many? _____

Alcohol? _____ How much? _____

Caffeine? _____ How much? _____

Sweets? _____ How much? _____

Vegetarian, vegan, or carnivorous? _____

Late night or morning person? _____

Stress level of lifestyle high or low? _____

Height: _____ Weight: _____

What brings you to seek acupuncture today? _____

Have you had acupuncture before? _____

Have you taken Chinese herbs before? _____ If yes, what form? _____

Urinary Frequent urine Painful urine Urgent urine
 Difficult urine/incomplete urination Kidney stones
 Waking up at night to urinate---how many times?_____

Skin and Hair Rashes Acne Hives Eczema
 Psoriasis Dandruff Itching
 Hair loss Brittle hair
 Other_____

Neurological Seizures Numbness Tingling Muscle twitches
 Low back pain Shoulder pain Hip pain
 Leg pain Knee pain Ankle pain Foot pain
 Arm pain Elbow pain Hand pain Wrist pain

Emotional Irritability Excess anger Mood swings Depression
 Anxiety Suffered recent shock Stress
 Difficulty concentrating Poor memory

Gynecological PMS Painful periods Irregular cycle
 Heavy menstrual flow Scanty menstrual flow
 Amenorrhea---how long since last menses?_____

Peri-menopause Post-menopause
 Breast tenderness Breast lumps
 Vaginal discharge Chronic yeast infection

Endocrine/Constitutional Diabetes Type I / II
 Hypothyroid Hyperthyroid
 Immune disorder _____
 Hepatitis _____
 Cancer_____

Other: _____

INFORMED CONSENT FORM FOR ACUPUNCTURE PATIENTS

Please read this information carefully, and ask the practitioner to clarify any parts you do not understand.

Acupuncture and traditional Chinese medical treatments are shown to be very effective for maintaining physical well-being and ameliorating many complaints. Though many patients undergo treatments without undesirable side effects, practitioners are required to advise patients of the possible risks of acupuncture.

Any of the following side effects can occur, though it is not possible to anticipate all of the complications which may arise in each individual case. If there are specific risks which apply in your case, the practitioner will discuss these with you.

Possible side effects of acupuncture include:

- Drowsiness may occur. If affected, one might wish to refrain from operating a motor vehicle. One might also ask for help getting down the stairs if dizziness occurs.
- Fainting may occur during or after the treatment, especially in patients prone to fainting, and especially during the first treatment.
- Minor bleeding or bruising may occur at the sites of the acupuncture needles.
- In less than 3% of patients, symptoms may become initially worse before they improve for 1-2 days following the treatment. This is often a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.

Possible side effects of cupping:

- Bruising at the sites of the cups, in a circular shape, is very common, and it self-resolves in several days. The marks may be light or dark purple.

Regarding Chinese herbal supplements:

- The herbs, formulas, and nutritional supplements from plant, animal and mineral sources that have been recommended have been regarded as safe traditionally in the practice of Chinese medicine, although some may be toxic in large doses or inappropriate during pregnancy. If you are a vegetarian, only formulas from plant or mineral sources will be given.

Regarding electro-acupuncture:

---People with pacemakers or other electrical implants should not have electro-acupuncture. Please inform the practitioner if you have one.

Please let the practitioner know if:

- If you have ever experienced a fit, a faint, or other odd sensations
- If you have a pacemaker or other electrical implants
- If you are pregnant
- If you have hemophilia or a bleeding disorder
- If you are taking anti-coagulants (blood thinners) or other medications
- If you have damaged heart valves or any other particular risk of infection

STATEMENT OF CONSENT

I confirm that I have read and understood the above information, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. 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 the treatment which, based upon the facts known at that time, is in my best interests. I understand that the practitioner may request to review my medical records and lab reports, but that 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 about the risks and benefits of treatments provided by this clinic, and have had the opportunity to ask questions of the practitioner. 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

_____ Signature

_____ Date

Missed Appointment / Late Cancellation Policy

Please give at least **24 hours notice** for appointment changes and cancellations.

Missed Appointments / “No-Shows”

Patients who miss appointments without giving prior notification will be charged a late cancellation fee. This applies to insured and uninsured clients.

Patients will be charged \$45 for the first “no-show” and \$90 for all subsequent “no-shows”.

Late cancellations

Patients cancelling and rescheduling appointments with less than 24 hours notice will be charged a **\$25** late cancellation fee. (Serious emergencies excepted, at the discretion of Heavenly Stems Acupuncture)

Statement of Consent

I agree to Heavenly Stems Acupuncture’s missed appointment and late cancellation policy.

Name _____ Date _____