

Roseanna Woods, L.Ac.

Patient Information

Patient's Name _____ Today's Date _____

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Office _____

Other Phone _____ Email _____

Birth Date _____ Age _____ Gender _____ Soc. Sec. # _____

single married divorced widowed domestic partnership other

Referred by _____

Emergency Contact _____ Relationship _____

Emergency Contact Phone # home _____ Office or Cell _____

Physician's Name _____ Phone _____

Physician's Address _____ Date of last visit _____

Employment full-time part-time self-employed student unemployed retired

Occupation _____ Number of hours of work/study per week _____

Employer's Name _____ Phone _____

Employer's Address _____

Spouse / Domestic Partner Name _____

Spouse / Partner Employer _____ Phone _____

Spouse / Partner Employer Address _____

Billing and Insurance

Account paid by self Insurance Workman's comp other

Note on Insurance

Payment in full is due at the time services are rendered. Upon request a Superbill will be provided. A Superbill is a receipt that you may submit to your insurance company to seek reimbursement for payments made. You may call your insurance company to inquire if acupuncture services are covered under your policy.

Primary Insurance _____ Phone _____

Primary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy # / ID # _____ Group # _____

Secondary Insurance _____ Phone _____

Secondary Insurance Address _____

Policy Holder's Name _____ Relationship _____

Policy # / ID # _____ Group # _____

Patient's Name _____ Today's Date _____

What health issue do you want treated? Please describe as fully as possible

What treatment have you been using for relief of this issue?

Have you ever had an acupuncture treatment? When and for what reason?

Are you presently being treated for a medical condition? Please describe

Do you have other health concerns?

Are you taking any medication, herbal remedy, vitamin or nutritional supplement? Please list:

Medication Allergies _____

Food Allergies _____

Habits – Please check any habits which apply to you now or in the past

Coffee yes no # per day _____ age started _____ age quit _____
Tobacco yes no # per day _____ age started _____ age quit _____
Marijuana yes no # per day _____ age started _____ age quit _____
Alcohol yes no # per day _____ age started _____ age quit _____
Crack/Cocaine yes no # per day _____ age started _____ age quit _____
Heroin yes no # per day _____ age started _____ age quit _____
Other yes no # per day _____ age started _____ age quit _____

Major Hospitalizations – Please list any hospitalization or surgeries you have undergone

Year	Operation or Illness	Name of Hospital	City and State

Are you carrying a pacemaker? yes no If yes, date placed _____

(For woman) Are you pregnant? yes no If yes, for how many months _____

Patient's Name _____ Today's Date _____

General

- past current
- Poor appetite
 - Excessive appetite
 - Change in appetite
 - Insomnia
 - Fatigue
 - Fevers
 - Chills
 - Sweat easily
 - Night sweats
 - Strong thirst
 - Other _____

Cardiovascular

- past current
- High blood pressure
 - Low blood pressure
 - Blood clots
 - Palpitations
 - Phlebitis
 - Chest pain
 - Irregular heart beat
 - Cold hands/feet
 - Swelling of hands/feet
 - Other _____

Genito-urinary

- past current
- Kidney stones
 - Pain on urination
 - Burning urination
 - Frequent urination
 - Urgency to urinate
 - Blood in urine
 - Unable to hold urine
 - Other _____

Skin and Hair

- past current
- Rashes
 - Hives
 - Eczema
 - Pimples
 - Itching
 - Dryness
 - Tumors, lumps
 - Other _____

Respiratory

- past current
- Asthma
 - Bronchitis
 - Frequent colds
 - COPD
 - Pneumonia
 - Cough
 - Coughing blood
 - Production of phlegm
 - Other _____

Male

- past current
- Pain/itching of genitalia
 - Genital lesions/discharge
 - Lumps in testicles
 - Weak urinary stream
 - Impotence
 - Other _____

Head and Neck

- past current
- Dizziness
 - Fainting
 - Headaches
 - Concussions
 - Neck stiffness
 - Enlarged lymph glands
 - Other _____

Gastro-intestinal

- past current
- Nausea
 - Vomiting
 - Belching
 - Bad breath
 - Gas
 - Indigestion
 - Pain or cramp
 - Constipation
 - Diarrhea
 - Blood in stools/black stools
 - Hemorrhoids
 - Rectal pain
 - Gall bladder disorder
 - Other _____

Female

- past current
- Freq. urinary tract infection
 - Freq. vaginal infection
 - Pain/itching of genitalia
 - Genital lesion/discharge
 - Pelvic inflammatory disease
 - Abnormal pap smear
 - Irregular periods
 - Painful menstruation
 - Abnormal bleeding
 - Premenstrual syndrome
 - Menopausal syndrome
 - Breast lumps
 - Other _____

Ears

- past current
- Infection
 - Ringing
 - Decreased hearing
 - Other _____

Eyes

- past current
- Blurred vision
 - Poor night vision
 - Spots
 - Cataracts
 - Glasses/contacts
 - Visual changes
 - Eye inflammation
 - Other _____

Neurological

- past current
- Seizures
 - Tremors
 - Numbness/tingling of limbs
 - Concussion
 - Poor coordination
 - Paralysis
 - Other _____

Musculoskeletal pain

- past current
- Neck
 - Arms L R
 - Hands L R
 - Legs L R
 - Feet L R
 - Upper back
 - Lower back
 - Other _____

Nose, throat and mouth

- past current
- Nose bleeds
 - Sinus infection
 - Hay fever or allergies
 - Recurring sore throat
 - Grinding teeth
 - Difficulty swallowing
 - Other _____

Psychological

- past current
- Depression
 - Anxiety
 - Stress
 - Irritability
 - Treated for psychological problems
 - Other _____

Infection screening

- past current
- HIV
 - TB
 - Hepatitis
 - Gonorrhea
 - Chlamydia
 - Syphilis
 - Genital warts
 - Herpes: oral / genital
 - Other _____

INFORMED CONSENT TO TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the licensed acupuncturist named below and/or other licensed acupuncturist(s) who now or in the future treat me while employed by, working or associated with or serving as a back-up for the acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Chinese massage, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but occasionally there may be some side effects, including bruising or tingling near the needling sites that may last a few days, and dizziness and 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 the clinic uses sterile disposable needles and maintain a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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 will notify the acupuncturist if I am or become pregnant. I understand that the herbs need to be taken according to the instructions provided orally and in writing. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of the treatment which the acupuncturist thinks at the time, based upon the facts then known is in my best interests. I understand that results are not guaranteed.

I understand that clinical 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, the above 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.

To be completed by patient (or by patient's representative if the patient is a minor or is physically or legally incapacitated):

Print Name of Patient

X _____
Signature of Patient (or Representative) Date

Print name of Patient Representative Relationship

To be completed by the treating acupuncturist::

Roseanna Woods, Lac.

Print Name of Treating Acupuncturist

X _____
Signature of Treating Acupuncturist Date