IOINTERNATIONALORANGE NEW ACUPUNCTURE CLIENT

Please fill out the form in its entirety.
All of the information requested is essential for providing you with the best possible care. Thank you!

PLEASE PRINT CLEARLY		
First and Last Name:		Date:
Preferred Name:		Gender:
Street Address:		Date of Birth: / Age:
City:		State: / Zip:
Home Phone: ( )	Cell Phone: ( )	May we call & leave you a message? o YES o NO
EMERGENCY CONTACT		
Emergency Contact:		Relationship:
Emergency Contact's Phone: ( )	Emergency Contact's Cell Phone: ( )	
PRIMARY CARE PROVIDER		
Provider's Name:		Phone: ( )
Provider's Address:		Date of Last Visit:
Have your complaints been diagnosed? o Yes o No Diagnosis:______________________________		

GENERAL HEALTH
Chief Complaint: What is the primary concern associated with your visit today?
How long have you had this/these issues?
Does anything make the condition better? o Yes o No If Yes, please describe:
Does anything make the condition worse? o Yes o No If Yes, please describe:
Have you been treated for this condition before? o Yes o No If Yes, please describe:
Are you currently being treated for any other medical conditions? o Yes o No If Yes, please describe:

Are there any other issues or health concerns you are hoping to work on?
Have you tried acupuncture before? o Yes o No

Do you have any known allergies? o YES: o Medications o Foods o Other o No If Yes, please describe:					
List pharmaceuticals, both prescription and over-the-counter, that you are currently taking:					
List all herbal remedies and supplements that you are currently taking (herbs/vitamins/minerals/supplements/etc.):					
FEMALE REPRODUCTIVE					
Age of first menses:	Date of first day of last menses:	Duration of flow (# of days):			
Color: o Brown o Purple/Maroon o Dark/Scarlet o Bright Red o Rust/Salmon o Light Pink/Pale					
Clots: o YES o NO	Consistency: o Thick o Thin	Number of days in Cycle (21, 28, 33, etc.):			
PMS: o Pain o Cramps o Breast Tenderness/Swelling o Other: ____________________________________					
I understand that I must notify my Acupuncturist if I become pregnant. __________________ (Initial)	Date of menopause: _____________				
PAST MEDICAL HISTORY (please include dates)					
Childhood illnesses:					
Major illnesses:					
Surgeries/operations:					
Circle symptoms you have had in the **last year**:					
Depression Difficulty focusing Dizziness Easily startled	Often worried Often angry Often fearful Often sad	Fatigue Headaches Poor sleep Loss/gain of weight	Nervousness/irritability Anxiety Overwhelmed by life		
Circle symptoms you have **or have had** in the past:					
Allergies Anemia Arthritis	Bleeding disorders Cancer Diabetes	High blood pressure Low blood pressure Chest pains	Other:		

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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 acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at International Orange (IO) or any other clinic or office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), and nutritional counseling.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risk of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although IO uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I will notify an IO staff member who is caring for me if I am or become pregnant.

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

I understand the IO clinical and administrative staff may review my patient 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 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.

ACUPUNCTURIST NAME: ______________________________

PATIENT SIGNATURE: X______________________________ ____________________

(or Patient Representative. Please indicate relationship to patient) Date

ADDITIONAL INFORMATION
Please provide any additional information about yourself or your condition that was not covered in the questions above:

I hereby verify that all of the above information is true and correct to the best of my knowledge and belief.

______________________________ ____________________

Signature Date