elements acupuncture

57 Michigan Ave
Suite 102
Valparaiso, IN, 46383

New Patient History Form

All information is treated as confidential and will not be released without consent.

Name: ______________________ ______________ ________________________ Today's Date: ______________
(first) (middle) (last)

Name Preference: ____ Date of Birth: __________________________

Age: ________________ Height: _________________ Weight: _____________ Gender: ____________________

Address: ____

City: ____ State: __________________ Zip: _____________

Home Phone: ___________________________________ Work Phone: ______________________________________

Cell Phone: ______________________________ Employer/Company ____

We might call patients at times, and wish to ensure your privacy regarding treatment at this clinic. In the event that we are unable to reach you by phone please **indicate where it is appropriate to leave messages for you**:

☐Home ☐Cell ☐ With family member ☐At work ☐ Never leave message

Occupation: ____ Marital Status: ________________________

E-Mail Address: ____

Would you like to hear from us by email instead of phone? ☐Yes / ☐No

Would you like to join our Email Newsletter List? ☐Yes / ☐No

Would you like to receive updates and information from our clinic? ☐Yes / ☐No

Emergency Contact:

Name: ____ Phone: ________________________

Relationship: ____

Primary physician: ____

Address and/or Phone: ____

Who can I thank for referring you? ____

Have you tried natural medicine, homeopathy, acupuncture, Oriental medicine and/or herbal medicine before?

____

Financial Policy:

The office maintains a 24 hour cancellation policy: all appointments must be cancelled and/or rescheduled more than 24 hours before the appointment time, or the full visit charge will be applied to the patient's account.

Payment is due in full at the time of service. The patient or the patient's responsible party is responsible for all charges incurred for acupuncture treatments, accessory techniques and/or herbal recommendations. If the cost of treatment cannot be met at the time of service, the practitioner must be informed and a payment plan must be agreed upon prior to the treatment. Failure of payment within three weeks, or failure to follow the agreed-upon payment plan, will result in a $10 late fee, and a bill will be mailed to the address listed by the patient above. After three more weeks, another $10 late fee will be assessed and another bill mailed. If, three weeks after the second late fee is assessed, non-payment continues, the account will be sent to a collections agency for further action.

I understand and agree to follow the Financial Policy as stated above:

Printed Name ____ Today's Date _________________

Signature ____

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Informed Consent:

Information for Patients

Nature of Treatment: Your treatment may include acupuncture, moxibustion, cupping, electric or magnetic stimulation, acupressure, dermal friction (Gua Sha), infra-red (heat lamps), Asian Bodywork (Thai, Shiatsu, Tui Na), Chinese herbs, therapeutic exercises and dietary counseling based on the fundamentals of Chinese medicine.

Purpose of Treatment: The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. We cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Acupuncture and Oriental medicine have been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:

- Discomfort during and after the insertion of a needle
- "Needle sickness" (dizziness, fainting, nausea)
- Localized, minor bruising or swelling
- Minor burns with the use of Moxa
- Gastro-intestinal upset with the use of Chinese herbs (if this occurs, please consult with your practitioner so that your formula can be modified)
- Possible, temporary aggravation of symptoms that existed prior to treatment
- A broken needle (rare with the use of disposable needles)

Special Situations: Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify us if you might be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your acupuncturist has had training in Clean Needle Technique and Universal Precautions.

Please notify your practitioner if you have any adverse effect from treatment

I request and consent to the performance of acupuncture and Oriental Medicine procedures at this clinic. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature on this form indicates that I have read and understand the information provided regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I hereby release the practitioner from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Printed Name ____ Today's Date ________________

Signature ____

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Chief Complaint(s)

Main problem(s) with which you'd like our help:

____

____

Date of accident/injury/onset ____________________ Have you had this problem before? _____________

Have you had any diagnostic tests for this problem? _______________________________________

____

Have you been given a diagnosis for this problem? ____

____

Have you tried other treatments? ☐Yes / ☐No What type? ____________________________________

____

General Information:

Please list any medications (prescribed and over-the-counter), vitamins and supplements you are currently taking or have taken in the past 2 months:

____

____

I have an infectious disease (includes STIs) - (please identify): __________________________________

____

I have metal/artificial joints in my body (please specify where): ________________________________

I have a pacemaker ☐Yes / ☐No

Family History: Do you have a family history of any of the following diseases or conditions? Please include your parents, brothers/sisters, and grandparents, if known. Check all that apply.

☐ Heart Disease ☐ High Blood Pressure ☐ Epilepsy / Seizures

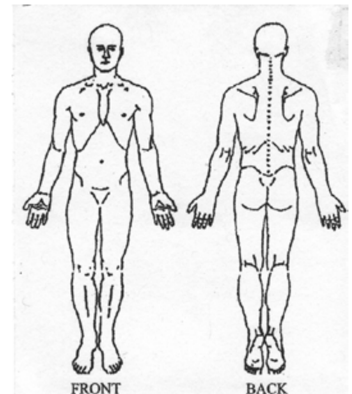
☐ Diabetes ☐ Stoke ☐ I'm Adopted

☐ Other ____

Do you have any allergies (seasonal, food, medications, etc)? ____________________________________

____

If you suffer aches, pains or other uncomfortable sensations not mentioned above, please draw them on the diagrams to the right, using heavier shading for more intense pain:



Do you have any additional comments or information I should know to further your treatment?

____

____

____

____

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Review of Systems (mark symptoms you frequently experience in 1st box, sometimes experience in 2nd box)

Immune/Respiratory/Sinus:
☐ ☐ Swollen Glands
☐ ☐ Frequent colds/flus
☐ ☐ Cough
☐ ☐ Asthma
☐ ☐ Shortness of Breath
☐ ☐ Congestion
☐ ☐ Wheezing
☐ ☐ Sinus Stuffiness/Pain

Head/Eyes/Ears:
☐ ☐ Headaches
☐ ☐ Migraines
☐ ☐ Jaw pain/TMJ
☐ ☐ Impaired hearing
☐ ☐ Earaches/infections
☐ ☐ Ringing
☐ ☐ Floaters/spots
☐ ☐ Blurriness
☐ ☐ Eye Pain/Strain
☐ ☐ Dryness

Musculoskeletal:
☐ ☐ Spasms/Cramps
☐ ☐ Weakness
☐ ☐ Nerve Pain

Mental/Emotional:
☐ ☐ Depression
☐ ☐ Mood Swings
☐ ☐ Poor concentration
☐ ☐ Anxiety
☐ ☐ Tension/Stress
☐ ☐ Memory problems
☐ ☐ Seasonal Depression

Neuroendocrine:
☐ ☐ Hair Loss
☐ ☐ Brittle Nails
☐ ☐ Excessive Fatigue
☐ ☐ Night Sweats
☐ ☐ Vertigo/dizziness
☐ ☐ Numbness/Tingling
☐ ☐ Trouble Sleeping

Skin:
☐ ☐ Rashes
☐ ☐ Acne/Boils
☐ ☐ Lumps
☐ ☐ Eczema
☐ ☐ Hives
☐ ☐ Itching

Urinary:
☐ ☐ Pain
☐ ☐ Frequency
☐ ☐ Frequent Infections
☐ ☐ Incontinence
☐ ☐ Kidney Stones

Cardiovascular:
☐ ☐ High Blood Pressure
☐ ☐ Low Blood Pressure

Intestinal:
☐ ☐ Change in Appetite
☐ ☐ Nausea
☐ ☐ Vomiting
☐ ☐ Gallstones
☐ ☐ Heartburn
☐ ☐ Excess Gas
☐ ☐ Constipation
☐ ☐ Diarrhea
☐ ☐ Hemorrhoids

Blood/Peripheral Vascular:
☐ ☐ Easily Bruise/Bleed
☐ ☐ Varicose Veins
☐ ☐ Cold hands/feet
☐ ☐ Palpitations/Fluttering

Female Reproductive (applies to lifetime):
Age of first menses (period) __________ Age of last menses __________ How many days between menses? ____________

Are you currently pregnant? ☐Yes / ☐No If "yes," what is you due date? ____
Pease describe any PMS symptoms you experience: ____

Date of last annual exam/Pap Results: ____

Pregnancies ________ | # Abortions __________ | # Miscarriages __________ | # Live Births ___________

Male Reproductive (applies to lifetime):
Have you experienced any pain or other symptoms related to sexual function/dysfunction? ☐Yes / ☐No
If yes, please describe: ____
Have you experienced changes in urination unrelated to fluid intake? ☐Yes / ☐No
If yes, please describe: ____
If you have been unable to conceive, have you had medical testing for this issue? ☐Yes / ☐No
If so, what were the results? ____

I verify that, to my knowledge, all information I have filled out on this Patient History Form is currently accurate, and I will inform this office should any relevant information, including addresses or phone numbers, change.

Printed Name ____ Today's Date ___________________

Signature ____