HEALING SPACE ACUPUNCTURE

Consent Form for Traditional Methods

Information for Patients:

Your treatment may include one or more of the following practices:

Acupuncture:	Insertion of gentle sterilized needles through the skin into underlying tissues of specific points on the body. **Electrical stimulation** may also be used.
Cupping:	A technique to relieve pain symptoms in which suction cups made of glass are put on 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 acu-points.
Tui Na:	Traditional massage techniques.
Dietary therapy:	Based on traditional Chinese medical theory.
Oils/ Liniments:	Used for massage, aromatherapy or medicinal purposes.

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: 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.

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.
3. Localized, minor bruising or swelling, temporary discoloration of the skin.
4. Minor burns and scars with the usage of some types of moxa or heat lamp therapy.
5. Possible temporary aggravation of symptoms that existed prior to treatment.
6. A broken needle (very rare with the use of sterile, disposable needles).
7. Infection (very rare with the use of sterile, disposable needles).
8. Nerve damage, organ puncture, spontaneous miscarriage (extremely rare risks).

*****Special Situations:** Some herbs and acupuncture points are contraindicative under certain situations. *Please notify your practitioner,* **PRIOR TO TREATMENT,** *if you are or might be* **PREGNANT,** if you have **SEVERE BLEEDING DISORDERS,** if you have a history of **SEIZURES**, or if you are wearing a **PACEMAKER** or **OTHER ELECTRONIC MEDICAL DEVICES. *****

Cancellation Policy: We require a **24 hour notice of cancellation.** We reserve the right to charge the **regular fee** for that appointment to patients who cancel their scheduled appointment on the same day or do not show up for the appointment.

Notice of Privacy Practices: Describes the types of uses and disclosures of protected health information that will occur in a treatment, payment of my bills, or in the performance of health care operations of Healing Space Acupuncture. The Notice of Privacy Practices is provided at the locations of the licensed acupuncturist and at www.healingspaceacupuncture.com. This notice also describes patient rights and Healing Space Acupuncture's duties with respect to protected health information. Healing Space Acupuncture reserves the right to change the privacy practices that are described in the Notice of Privacy

Practices. Patients may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of the next appointment.

Consent Section:

I, __________________________ request and consent to the performance of acupuncture and other traditional Chinese medical practices. 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 the preceding information regarding my treatment, that it has been explained to me by my practitioner, and that I comprehend it. I understand that if I have any questions about this information, I should ask the treating practitioner. I understand the 24–hour cancellation policy and that if I should miss an appointment without calling, that I am liable for that appointment by paying the practitioner an $80.00 fee.

I, ___________________________release Rachel Weiss and associates from any and all liability that may occur in connection with the above-mentioned procedures.

I understand it may be necessary for my practitioner to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/ or to share appropriate medical information. My signature gives my practitioner permission to release my medical records for the reasons listed above.

Print Name____ **Date**__________________________________

Signature of Patient or Legal Guardian ____

Cancellation Policy:

The practitioners at Healing Space Acupuncture make every attempt to make acupuncture and Chinese medicine available to as many people as possible at the most affordable rates.

In respect for our intention to offer high quality health care at affordable prices, we ask for 24 hours notice in advance of an appointment if it is necessary to cancel or reschedule an appointment.

All appointments that are rescheduled or cancelled with less than 24 hour advance notice, and appointments missed without notice, will be subject to an $80 fee for private sessions and a $20-$40 fee for a scheduled community session. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Thank you for your understanding,

Rachel Weiss, MS, L.Ac., RN, BSN
Healing Space Acupuncture

Signature __________________________________ **Date** ________________________

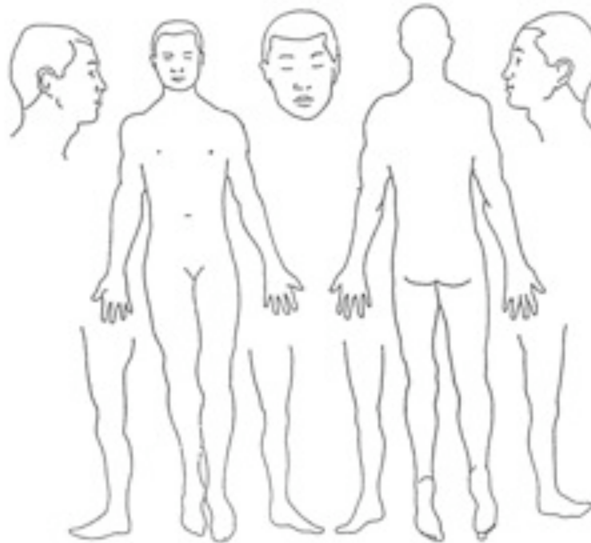
Healing Space Acupuncture

*******Personal and Confidential Information********

Name____ Date_____________
Home Address ____
City _____________________________________ State_________ Zip ____________
Home Phone____________ Cell Phone _____________ Work Phone________________
Gender ______ Height ______ Weight ______ Birthday ___________Age ___________
Marital Status _____________ Number of Children ________
EMAIL ____ Occupation ______________
Social Security #:________________________ Allergies _________________________
Who should we thank for referring you to this office? ____________________________
When was your last acupuncture visit? ____________ With whom? ________________
Primary Physician________________________Physician's Phone__________________
Emergency Contact & Tel #____

What is the **MAIN REASON** for your visit today? Please describe in detail:
____
____
What Medical Diagnosis have you received, if any?______________________________
How long have you had this condition? ____________Was the onset sudden____ or gradual____? Other therapies tried? ____
Symptoms worse by (movement, immobility, damp days, stress, etc.):
____
Symptoms better by (heat, cold, rest, meditation, etc.):____________________________
How has this condition changed your life? ____________________________________
____

Please shade ANY areas of pain or distress on the diagram below:



Other issues you would like addressed:

____
____
____

Illness	**You**	**Relative**	**Date**	**Illness**	**You**	**Relative**	**Date**
Cancer Specify________ ______				Diabetes Type 1_______ Type 2_______			
Lung Disease Type__________				Heart Disease Type_________			
Emotional Disorders Specify________				Infectious Disease Specify_______			
High Blood Pressure				Asthma			

Please list the use and frequency of the following:

	Yes	**No**	**Amount**		**Yes**	**No**	**Amount**		**Yes**	**No**	**Amount**
Coffee				**Tobacco**				**Water**			
Drugs				**Alcohol**				**Soda**			

Please list any medications or supplements you are taking (continue on back…)

Medicine	**Dosage**	**Reason**	**How long**	**Physician**	**Date of last visit**

*Any history of **seizures**?____________ Do you have a **pacemaker**?_______________
Date and description of any **accidents, surgeries, hospitalizations**:

____
____

Food Cravings?____

Please **circle** current conditions. **Underline** former conditions. Add any additional information regarding when contracted, duration, how treated:
Lyme Disease/ Hepatitis A/B/C /HIV/AIDS / Syphilis/ Herpes /Tuberculosis / Alcoholism/ Drug Addiction/ Blood Clotting Diseases

____

Other health problems?

____

FOR WOMEN:

Are you Pregnant? ________ Are you trying to get pregnant?___________________
# of Pregnancies __________# of live births __________ # of abortions __________
# of miscarriages ________
At what age did you start menstruation? _________ Age of menopause ___________
# of days in cycle ___________ # of days of blood flow _________
Amount of blood flow? Excess __ Moderate __ Slight __
Color of flow? Fresh red ___ Dark red ___ Pale red ___ Purple ___ Brown ___
Clots? ______ Clot size ___________
Pain with period? Before ___ During ___ After ___
Nature of pain? Sharp/ Stabbing/ Burning/ Dull / Bloated/ Constant/ Intermittent
Location of pain? ____________________ (low ab, low back, thighs…)
Have you or are you seeking fertility support?___________Please describe history:
____
Are you currently using birth control?_________Used in past?__________For how many years?_______________ What type?_________________________________

Symptoms related to your cycle (Circle):

Yeast infections/ Vaginal Dryness/ Nausea/ Swollen Breasts/ Appetite Change/ Mood Swings/ Hot Flashes/ Night Sweats/ Libido Changes/ Headache/ Diarrhea/ Constipation/ Insomnia/ Dizziness/ Other _____________________________________

Please note any of the following that apply (Circle):

Uterine fibroids/ Fibrocystic Breasts/ Endometriosis/ Ovarian Cysts/ PID
Hysterectomy/ Tubal Ligation/ Menopausal symptoms:______________________
Reduced sexual energy/ Infertility/ Genital pain/ Genital sores

Results and Dates of last:

PAP Smear ________ Bone Density Scan _______ Mammogram ________

FOR MEN:

Frequency of Urination: Daytime ___________ Nighttime ___________
Date of last prostate exam ___________ results ________ PSA results _________
Do you experience any of the following symptoms related to the prostate: (**CIRCLE**):

Groin pain/ rectal dysfunction/ back pain/ delayed stream/ dribbling/ incontinence/ urine retention/ libido change/ premature ejaculation/erectile dysfunction/ testicular pain/ Other ____________________

Please CIRCLE if you experience frequently.
Please UNDERLINE if you experience sometimes/occasionally.
Please answer appropriate questions.

General:

Difficulty falling asleep. Difficulty staying asleep. If you wake up with insomnia in the middle of the night, what usual time?________________
How many hours of sleep per night? _____________ Usual bedtime_______________
Frequent nightmares. Fatigue. Fevers. Chills. Night sweats. Sweats easily.
Bleed/bruise easily. Peculiar tastes/smells. Dental/gum problems.
Sudden energy drop---what usual time?____
Aversion to hot weather. Aversion to cold weather.
Please circle preference: hot beverages. cold beverages.
hot weather. cold weather.
Recent use of antibiotics.
Other____

Skin and Hair:

Rashes. Ulcerations. Hives/Allergic dermatitis. Itching.
Eczema/Psoriasis. Dandruff. Loss of hair. Recent moles.
Skin discoloration. Acne. Change in skin/hair texture. Face flushing.
Dermatitis. Warts. Fungal infection. Weak or ridged nails.
Other____

Head, Eyes, Ears, Nose and Throat:

Dizziness. Difficulty swallowing. Decreased sense of smell.
Eye pain. Poor vision. Night Blindness. Color blindness. Cataracts. Blurred vision.
Migraines/headaches. If you have frequent migraines/headaches please describe location, frequency, intensity:
____
Earaches. Ringing in ears. If ringing, is it high-pitched or low-pitched? Poor hearing.
Spots in front of eyes. Sinus problems. Nose bleeds. Recurrent sore throats/ colds. Grinding teeth. Facial pain.
Sores on lips/tongue. Dental problems. Jaw clicks/locks.
Other____

Cardiovascular:

Chest pain or pressure. Irregular heart beat. Palpitations. Fainting.
Cold hands/feet. Swelling of hands/feet. Blood clots. Phlebitis.
Shortness of breath. Varicose/spider veins. Pressure in chest. High blood pressure.
Low blood pressure. Spontaneous sweating. Dizziness. Edema/swelling of limbs.
Other____

Respiratory:

Chronic cough. Wheezing. Coughing blood. Asthma. Bronchitis.
Pneumonia. Pain with deep inhalation. Tight sensation in chest. Shortness of breath. Difficulty inhaling/exhaling. Difficult to breathe when lying down.
Frequent colds. Production of phlegm… what color? ________________________
Other____

Gastrointestinal:

Nausea. Vomiting. Diarrhea. Constipation. Flatulence/gas. Belching.
Bloated after meals. Black stools. Blood in stool. Food retention.
stools per day?___________________. Loose stools (>2 per day).
Indigestion. Bad breath. Rectal pain. Hemorrhoids.
Chronic laxative use. Abdominal pain/cramps.
Changes in appetite. Poor appetite. Excessive appetite. Heartburn/ Acid reflux/ GERD. Hernia. Recent weight loss. Recent weight gain.
Significant thirst. IBS. Crohn’s Disease. Ulcerative colitis.
Other____

Genito-Urinary:

Frequent urinary tract infections. Pain on urination. Burning urination.
Frequent urination. Blood in urine. Urgent urination. Unable to hold urine.
Kidney infections. Kidney stones. Scanty flow. Copious flow.

Night urination… What time?______ How often?______ Excessive libido.
Other____

Musculoskeletal:

Neck pain. Hand/wrist pain. Carpal Tunnel.
Knee pain. Sprains/Strains. Sciatica. Foot/ankle pain.
Hip pain. Muscle pain. Muscle weakness. Tendonitis.
Back pain. Low___ Middle___ Upper___ Herniated discs.
Bursitis. Shoulder pain. Rotator Cuff. Osteoarthritis. Rheumatoid arthritis.
Soreness/weakness in lower body (back, knee, hip, ankle, foot)
Other____

Neuropsychological:

Seizures. Loss of balance. Vertigo/Dizziness. Lack of coordination. Poor memory.
Areas of numbness. If so, where?___________________________
Concussion. Depression. Anxiety/Panic attacks. Bad temper/irritable. Easily susceptible to stress. Seasonal Affective Disorder. Nervousness. ADD/ADHD. Manic-depression (bipolar). Mentally restless. Mood swings.
Have you ever been physically or emotionally abused? Yes No
Have you ever been treated for emotional problems? Yes No
Have you ever considered or attempted suicide? Yes No
Have you ever been treated for substance abuse? Yes No

	Great	**Good**	**Fair**	**Poor**	**Bad**	**Comments**
Partner						
Family						
Diet						
Sex						
Self						
Work						
Exercise						
Spirituality						