



### Family History

- Asthma Cancer High blood pressure Diabetes Heart Disease Seizures Hepatitis  
Arthritis Infectious disease STD Emotional disorder High Cholesterol

### Symptom Survey

- Asthma Cancer High blood pressure Diabetes Heart Disease Seizures Hepatitis  
Arthritis Infectious disease STD Emotional disorder High Cholesterol

- Back Pain Abdominal Pain Chest Pain Headache Sciatic Pain Neck Pain Leg Pain

- Dizziness Eye Problems Gallstones Soft brittle nails Easily angered Hyperthyroid Spasm  
or muscle twitching Difficulty making decisions

- Insomnia Sleeping Problems Heart Palpitations Cold Hands & Feet Vivid Dreams  
Nightmares Mentally restless Sweat easily Poor Memory Anxiety

- Low energy Lack of appetite Excessive appetite Loose stool Diarrhea Indigestion  
Belching Heartburn/reflux Bloating Edema Bruise easily Worry Stress

- Frequent colds Cough Shortness of Breath Nasal problems Skin Problems Bronchitis Sore  
throat Mucus/Phlegm Constipation Hemorrhoids Colitis/Diverticulitis IBS

- Low back ache Knee weakness Hearing impairment Ear ringing Kidney stones  
Urinary problems Decreased sex drive Hair loss Depression Hypothyroid

### For Women

Are you pregnant? Yes No      Are you trying to get pregnant? Yes No  
# of Pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_  
Age of 1<sup>st</sup> period \_\_\_\_\_ Age of last period (Menopause) \_\_\_\_\_  
Number days between periods \_\_\_\_\_ Number of days of flow \_\_\_\_\_ Color  
\_\_\_\_\_ Clots \_\_\_\_\_ Date of last gynecologic exam \_\_\_\_\_

Menstrual symptoms: Pain Bloating Discharge Nausea Swollen breasts Constipation Mood  
Swings Hot Flashes Libido Change Headache Insomnia Fibroids Endometriosis Fibrocystic  
Breasts Ovarian Cysts PID Hysterectomy Osteoporosis Breast Cancer

### For Men

Date of last prostate check up \_\_\_\_\_ Results \_\_\_\_\_ Prostate  
problems Frequent Urination Delayed urination Dribbling Incontinence Retention of urine  
Increased libido Decreased libido Impotence Premature ejaculation Groin Pain Testicular  
pain Back pain

## CONSENT TO ACUPUNCTURE & EAST ASIAN MEDICINE

~ I understand that acupuncture and East Asian medicine involve the insertion of fine, sterile needles at specific points on the body, and may also include related techniques such as moxibustion, cupping, manual therapy, and lifestyle or dietary recommendations.

~ I understand that this is a medical system with its own methods of diagnosis and treatment, and that responses to treatment vary from person to person. No guarantee has been made regarding the outcome of treatment.

~ I understand that after treatment I may experience temporary effects such as soreness, fatigue, lightheadedness, or increased awareness of symptoms. These effects are generally short-term and part of the body's natural response to treatment. I understand that acupuncture is not intended to worsen any condition.

~ I understand that serious complications are rare, and that I have the right to ask questions about my treatment at any time. I may discontinue treatment at my discretion.

## FINANCIAL & INSURANCE RESPONSIBILITY

~ I understand that I am responsible for payment for services provided and that speaking with the practitioner or an insurance company representative does not guarantee coverage or payment.

~ I understand that copays, co-insurances and cash patient payments are due at the time of service.

~ If I am using insurance, I understand that insurance coverage is not a guarantee of payment. While benefits may be verified when possible, final determination of coverage is made by the insurance company after services are rendered. For this reason, I understand that I am ultimately responsible for all charges not paid by insurance.

~ I understand that in some cases — including out-of-state or uncommon plans — coverage may not be verifiable. In these situations, payment is due at the time of service. Claims may be submitted to insurance, and reimbursement will be provided if payment is received.

**Patient Initials:** \_\_\_\_\_

## APPOINTMENT & MISSED APPOINTMENT POLICY

~ I understand that appointments are reserved specifically for me and that at least 24 hours' notice is required for cancellations or rescheduling. Missed or late-cancelled appointments may be subject to a fee.

~ I understand that repeated missed appointments may require prepayment or may affect my ability to schedule future visits.

**Patient Initials:** \_\_\_\_\_

## CONSENT & SIGNATURE

I consent to acupuncture and related treatments as described above. I certify that the information I have provided is accurate and complete to the best of my knowledge.

**Patient Name (Print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_