

Innovative Wellness Center, PC
220 Forsgate Drive, Jamesburg, New Jersey 08831
(732) 656-1740

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist.

I understand the methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), bleeding and Chinese herbal medicine.

I have had the opportunity to discuss with the above named acupuncturist the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, with possible dizziness or fainting. Bruising is common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I understand that the risk of infection is negligible when all needles are sterile.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe, 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, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately inform the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interests.

I understand the 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.

I have read, or have read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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.

Patient's Name _____

Patient's Signature _____

Date Signed _____

INTAKE AND TREATMENT FORM

Patient Name _____ Age _____ Sex _____

Chief Complaint _____

- a) Onset: _____
- b) Location: _____
- c) Duration: _____
- d) Characteristic: _____
- e) Alleviate: _____
- f) Aggravate: _____

Signs and Symptoms _____

Tongue _____ Pulse _____

Etiology _____

Present Diagnosis _____

Treatment Principle _____

Points: Herbs:

Moxa Tui Na Bleeding Gua Sha Cupping Electrical
Stimulation

Comments & Suggestions for the patient: _____

Signature of Acupuncturist: _____ Date: _____

NEW PATIENT INTAKE FORM

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IDENTIFICATION DATA: Please fill in completely. Please print.

Name (last, first): _____ Date: _____

Address: _____ Date of Birth: _____ Age: _____ Place of Birth: _____

_____ Gender: Male Female

Home Phone: () _____ Cell Phone: () _____ E:mail: _____

Married Single Divorced Widowed

SS#: _____ Occupation: _____ Place of Employment _____

Employer Address: _____ Phone: _____

Ethnic Background

American Indian/Alaskan Native Black (non-Hispanic) Hispanic Other: _____
Asian/Pacific Islander White (non-Hispanic)

FAMILY HISTORY: Please complete for each member. Place an X in the box indicating any of the illnesses that they have ever had.

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	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
Allergies					
Blood Disorder/Anemia					
Diabetes					
Cancer or Tumors					
Seizures					
High Blood Pressure					
Kidney or Bladder Disorder					
Stomach or Intestinal Disorder					
Drug Abuse					
Tuberculosis					
Heart Disorder					
Stroke					
Other					
Age at Death					
Hospitalization	Year		Operation/Illness	Name of Hospital	City & State

PERSONAL HEALTH HISTORY: Please check any disorder that you may have experienced.

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Asthma or Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Drug	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	Stomach/Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Skin Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Transplant	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	Urinary Tract Disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Frequent/Severe Headache		Allergies		High Blood Pressure
Disorder					Musculo-Skeletal
	Kidney Disorder	Tuberculosis	Heart Disease		Transfusion – before 1985
	Other: _____				

FATHER	MOTHER	BROTHER	SISTER	CHILDREN
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Allergies

Blood Disorder/Anemia

Diabetes

MAJOR HOSPITALIZATIONS: If you have been hospitalized for any serious medical illnesses/operations, please list your most recent hospitalizations. Do not include normal pregnancies.

<input type="checkbox"/>	<input type="checkbox"/>	Check here if you have had more than three such hospitalizations.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

MEDICINES: Please check any of the following that you are now taking:

- | | | | |
|-----------|--------------------|-------------------|--------------|
| Aspirin | Oral Contraceptive | Tranquilizer | Cold Tablets |
| Ibuprofen | Diet Pills | Sleeping Pills | Vitamins |
| Antacid | Laxative | Hay Fever Tablets | Herbs |

Please list the names of any medications you are currently taking:

Please list any medication allergies you have:

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HABITS: Please check any of the habits below which apply to you now or in the past.

Use of tobacco
 ___ # of cigarettes/day ___ # of packs/day ___ Age began smoking Stopped
 ___ years/months/days ago

Use of marijuana
 ___ use per day ___ Age began using Stopped ___ years/months/days ago

Use of alcohol
 ___ # of drinks/week ___ Age began drinking Stopped ___ years/months/days ago

Use of caffeine
 ___ # of coffees/day ___ # of teas/day ___ # of colas/day Stopped ___ years/months/days ago

ago

Use of crack/cocaine
 Please specify frequency: _____ Stopped ___ years/months/days ago

Use of street drugs
 Please specify drugs: _____ Stopped ___ years/months/days ago

Please specify frequency: _____

EXERCISE:

Never Little Moderate Heavy Type of Exercise

EMOTIONALLY:

Happy easily Easily Irritable Difficulty making decisions Angry Cry

Depression Stressed Restless Other Hurry to do things _____

APPETITE:

Up and down taste Poor Good Hungry a lot Loss of

Do you eat three meals per day? Yes No

Do you eat at regular hours? Yes No

Cravings _____

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Age menarche began _____ Age menopause _____
 Date of last ob/gyn exam _____

Water retention
 Abdominal bloating
VAGINAL DISCHARGES:

Breast lumps Yellow

FEMALES ONLY:

FATHER MOTHER BROTHER SISTER CHILDREN

Allergies

Blood Disorder/Anemia

Diabetes

Cancer or Tumors

Seizures

High Blood Pressure

Kidney or Bladder Disorder

Stomach or Intestinal Disorder

Previous Hysterectomy? Partial Full
 Hysterectomy replacement therapy

fill in completely.

Headaches cycle

Before menstrual cycle After cycle

Emotional changes
 Backache Bad odor
 Painful or tender breasts

During Tightness in chest

Sigh a lot

Constipation and/or

Total Pregnancies: _____

flow? _____

How many days of _____
 How many days between the period? _____

Spotting between periods _____

_____ # Living

_____ # Ectopic

_____ # Miscarriages

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Diarrhea

Irregular painful

Heavy flow

_____ # Incontinently flow

Dark color flow

Abortions _____ #

Multiple Pregnancies _____ #

Clotting

Light color flow

PERSONAL INFORMATION: Please fill in completely.

Date of Last Physical Exam: _____ Name of Physician: _____

Address of Physician: _____ Phone number of Physician: (_____) _____

Emergency Contact:

Name: _____ Address: _____

Phone Number: (_____) _____

Signature: _____