# ACUPUNCTURE HAPPY HOUR

MAKHA PHETPHOMMASOUK, LAC

NEW PATIENT REGISTRATION AND HEALTH QUESTIONNAIRE

## PATIENT INFORMATION

Date of first visit_____

Name_____

Address_____

City State Zip_____

Age_____Birthdate_____/____/_____

Occupation_____

Where do you work?_____

PrimaryPhysician_____

## CONTACT INFORMATION

Home phone_____

Cell/ Other Phone_____

Email_____

Another person we may contact if needed:

Name/Relationship_____

Phone_____

How did you hear about us?_____

Are you new to acupuncture? Yes_____ No____

## HEALTH HISTORY

What are your primary concerns/complaints?

1)_____

Onset:_____Severity_____

2)_____

Onset:_____Severity_____

3)_____

Onset:_____Severity_____

How is your sleep?_____

How would you describe your energy level?

_____

How is your digestion?_____

_____

List medication, supplements or herbs you are taking:_____

_____

_____

_____

Are you pregnant? Yes_____ No ____wks_____

List serious accidents or surgeries and dates:

_____

_____

_____

Are you interested in taking any Chinese Herbs?

Yes_____ No_____Maybe_____

Check conditions you have now or have had in the past:

- o HIV +/AIDS o Anemia
- o Arthritis o Asthma
- o Cancer_____
- o Autoimmune disorder_____
- o Bleeding disorder o Diabetes I - II
- o Heart disease o Hepatitis B -C
- o High blood pressure Controlled?Y_N_
- o Pacemaker o Stroke
- o Erection Difficulties o Low libido
- o Prostrate trouble o Herpes
- o Fibroids o Hemorrhoids
- o Meno/Perimenopause symptoms_____
- o Severe allergies_____

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## INFORMED CONSENT TO TREATMENT

I, _____ , do give consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Joshua Margolis, LAc, Makha Phetphommasouk, LAc, or any guest Licensed Acupuncturist, tutorial students, or clinic assistants working under their supervision.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, scraping (gua sha), electric stimulation, massage, stretching, exercises, herbal medicine, and/or nutritional and dietary counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including, but not limited to bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and scraping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the Licensed Acupuncturist to be able to anticipate a possible complications from treatment, but I do wish to rely on the Licensed Acupuncturist to exercise judgment during the course of the procedure which the Licensed Acupuncturist feels at the time, based upon the facts then known, is in my best interests.

The herbs and nutritional supplements (which are from synthetic, plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue, and spontaneous miscarriage.

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

I will notify my practitioner if I am or become pregnant.

It is agreed With regard to medical care and services, the attending Licensed Acupuncturist will provide services to the patient and to the best of his skill and knowledge, medical care appropriate to the situation. The patient will cooperate fully with the Licensed Acupuncturist by following his instructions and adhering to such treatment plan or course of action as may be set forth and agreed. It is the patient's right to accept or reject any diagnostic procedure, or any part of it, before or during the diagnosis or treatment.

By voluntarily signing below, I show that I have read, or have had read to me, this 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 conditions for which I seek treatment at this clinic.

| _____ | _____ | _____ |
|---|---|---|
| Signature Of Patient | Printed Name Of Patient | Date |
| _____ | _____ | _____ |
| Signature Of Patient Representative | Printed Name Of Patient Representative | Date |
| _____ | _____ | _____ |
| Signature Of Witness | Printed Name Of Witness | Date |

POLICIES FOR CANCELLATIONS AND LATE APPOINTMENTS

Twenty four hour notice for cancellations will be required. Less than 24 hours cancelation notice or missed appointments will be billed at full rate. If an emergency prevents you from keeping your appointment special arrangements can be made. Please be on time. If you know that you will be late, please call. We will make every effort to reschedule you for a later time.

Patient's Signature & Date _____

I have received this office's HIPPA/Privacy Polices: Patient Signature_____Date_____