

I. TREATMENT INFORMATION AND INFORMED CONSENT

Please read this information carefully and ask your practitioner if there is anything you do not understand.

Acupuncture is performed by the insertion of pre-sterilized, disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to certain points on the body. Your acupuncture treatment may be combined with tui-na / acupressure, Chinese herbs, moxibustion, cupping, electric stimulation, derma-friction (Gua-sha), infrared heat lamp, seven-star needling, therapeutic exercises, and dietary recommendations based on the fundamentals of Chinese Medicine. Your practitioner will explain the nature of each type of treatment as needed.

Acupuncture is generally very safe. Although rare, certain side effects may result from acupuncture and each procedure or treatment has specific risks and benefits. These potential risks may include, but are not limited to:

- Discomfort or minor pain at the site of needle insertion during treatment.
- Localized, minor bleeding, bruising or swelling.
- Minor burns with the use of moxibustion
- Possible temporary aggravation of symptoms that existed prior to treatment, then rapid recovery, known as "healing crisis"
- Infection and the risks of needling in the vicinity of an infection. To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, single-use, disposable and made of surgical stainless steel. After each treatment, needles are disposed of as medical waste and never reused.
- Temporary dizziness, fainting and nausea ("needle sickness")
- Broken needles (rare with the use of disposable needles)
- Possible allergic reaction to Chinese herbal medicine, such as gas, stomachache, and nausea. All herbs dispensed at the clinic are GMP approved. Please be sure to let your practitioner know if you are taking prescription medication.
- Cupping therapy and derma-friction (Gua-sha) may produce petechiae (reddish purple marks) as part of the healing process. These will disappear in a few days.
- Seven-star needling is used to detoxify the body and stimulate the skin.

Some herbs and acupuncture points are contraindicated for certain conditions. Please inform your practitioner if you have any of the following conditions:

- If you are pregnant or breastfeeding
- If you have ever experienced seizures, fainting or panic attacks
- If you have a pacemaker or any other electrical implants
- If you have HIV/AIDS, hepatitis or a sexually transmitted disease

Your practitioner is unable to anticipate or explain all risks and complications that may occur during or after treatment. However, she will exercise judgment based on your best interests.

By voluntarily signing below, I show that I have read this consent to treatment, have been told 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 and future conditions for which I seek treatment.

X _____
Patient Signature

Date

Print Patient's Name

Helen Law, Licensed Acupuncturist

II. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

September 19, 2009

Patient Name _____

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been notified of how health information about me may be used and disclosed by this Practice, and how I may obtain access to and control this information. Furthermore, I consent to the use and/or disclosure of my health information to treat me and arrange for my medical care.

Signature of Patient

If this Notice is signed by a personal representative on behalf of the patient, complete the following:

Date

Personal Representative's Name

Relationship to Patient

Date

If you have any questions about this notice, please contact the office manager.

CHINESE ACUPUNCTURE HEALTHCARE



11 STATE ROAD, SUITE 300
PRINCETON NJ 08540
609.921.8980 (L)
609.921.8589 (F)

PATIENT INFORMATION				
NAME:				
ADDRESS:	(STREET)		(CITY, STATE, ZIP)	
TELEPHONE:	<input checked="" type="checkbox"/> <i>Check your preferred contact number.</i> <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE <input type="checkbox"/> MOBILE			
EMAIL:	<input type="checkbox"/> <i>Subscribe to eNewsletter for health tips and updates</i>			
SSN:		DATE OF BIRTH:	AGE:	HEIGHT:
WEIGHT:				
GENDER:	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	OCCUPATION/EDUCATION:		
MARITAL STATUS:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LIFE PARTNER <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			
DATE OF FIRST VISIT:			REFERRED BY:	
<i>Have tried the following treatments:</i> <input type="checkbox"/> ACUPUNCTURE <input type="checkbox"/> HERBAL MEDICINE <input type="checkbox"/> ACUPRESSURE (<i>tui na</i>) <input type="checkbox"/> CRANIOSACRAL				

EMERGENCY CONTACT	PHYSICIAN
CONTACT'S NAME: _____	PHYSICIAN'S NAME: _____
TELEPHONE: (____) _____	TELEPHONE: (____) _____
ADDRESS: (Street, City, _____ State, ZIP) _____	ADDRESS: (Street, City, _____ State, ZIP) _____

INSURANCE INFORMATION <i>(if applicable)</i>	
INSURANCE COMPANY: _____ POLICY NO.: _____ TELEPHONE: (____) _____ ADDRESS: (Street, City, _____ State, ZIP) _____	<u>FOR MEDICARE ONLY</u> POLICY NO.: _____ TELEPHONE: (____) _____ ADDRESS: (Street, City, _____ State, ZIP) _____

MAJOR COMPLAINT

1. _____
2. _____
3. _____

When did you first notice this problem? _____

How long have you experienced this condition? _____

What makes it better? What makes it worse? _____

On a scale of 1 to 10, with 10 being the worst, how would you rate the pain? _____

Have you experienced this condition in the past? _____

YOUR MEDICAL HISTORY

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Birth Trauma |
| <input type="checkbox"/> Hepatitis A/B/C/D | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Vaccinations | <input type="checkbox"/> Childhood Illnesses | <input type="checkbox"/> Other (<i>please specify</i>): _____ |
| <input type="checkbox"/> Significant Trauma | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | |

FAMILY MEDICAL HISTORY *(Select all that apply and specify which relative)*

- | | |
|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Emotional Disorder _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other conditions: _____ |

LIFESTYLE *(Select all that apply and indicate frequency)*

- | | |
|--|---|
| <input type="checkbox"/> Coffee _____ | <input type="checkbox"/> Tobacco _____ |
| <input type="checkbox"/> Black Tea _____ | <input type="checkbox"/> Recreational Drugs _____ |
| <input type="checkbox"/> Caffeinated Beverages _____ | <input type="checkbox"/> Exercise _____ |
| <input type="checkbox"/> Alcohol _____ | |

MEDICATION, ALLERGIES, AND PAST HOSPITALIZATION

What medications, supplements or herbs are you currently taking? _____

Any allergies? (*food, drugs, etc.*) No Yes (*please specify*):

History of psychiatric treatment? No Yes

Have a cardiac pacemaker? No Yes

Hospitalized in the past year? No Yes (*please specify why*):

Had any major surgeries? No Yes (*list when and why*):

Date of last physical exam:

GENERAL HEALTH

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Large appetite | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sweat easily |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Bruise / bleed easily | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Catch colds easily | _____ |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Chills | |

SKIN AND HAIR

- | | | |
|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Neurodermatitis |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hives | _____ |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Dry skin | |

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Change in smell |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dry eyes or redness | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Facial pain or numbness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Difficulty in swallowing |
| <input type="checkbox"/> Trigeminal neuralgia | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Change in taste |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Oral ulcers |
| <input type="checkbox"/> TMJ or jaw clicking | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Hay fever / allergies | _____ |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Coronary heart disease | <input type="checkbox"/> Low blood pressure | _____ |
| <input type="checkbox"/> Chest pain / tightness | <input type="checkbox"/> Swelling of hands / feet | |

RESPIRATORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Frequent / chronic colds |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Coughing phlegm | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Shortness of breath | | _____ |

GASTROINTESTINAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Chronic gastritis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Frequent laxative use |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn / Acid reflux | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Abdominal pain / Cramps | <input type="checkbox"/> Bloody / black stools | _____ |

UROGENITAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Waking at night to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Genital sores |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> Blood in urine | _____ |
| <input type="checkbox"/> Increase in urine flow | <input type="checkbox"/> Impotence | |

MUSCULOSKELETAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Finger pain | <input type="checkbox"/> Chronic lumbar muscle strain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Sprained ankle |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Foot / ankle pain | <input type="checkbox"/> Cervical spondylopathy | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Tennis elbow | <input type="checkbox"/> Other joint/bone problems (<i>please specify</i>): |
| <input type="checkbox"/> Hand / wrist pain | <input type="checkbox"/> Acute lumbar sprain | _____ |

NEUROPSYCHOLOGICAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Concussion | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hemiplegia |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Stress | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Attempted suicide | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> History of psychiatric treatment | _____ |

METABOLISM, ENDOCRINE, AND IMMUNE

- | | | |
|---|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Simple obesity | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic arthritis | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Fibromyalgia | |

MALE REPRODUCTIVE SYSTEM / GENITALIA

- | | | |
|--|---|---|
| <input type="checkbox"/> Pain / itching of genitalia | <input type="checkbox"/> Lumps in testicles | <input type="checkbox"/> Enlarged prostate/prostatitis |
| <input type="checkbox"/> Genital lesions / discharge | <input type="checkbox"/> Impotence | <input type="checkbox"/> Other (<i>please specify</i>): |
| | | _____ |

FEMALE REPRODUCTIVE SYSTEM / GYNECOLOGICAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Painful menses | <input type="checkbox"/> Pelvic inflammatory disease | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> No menses | <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Scanty menstrual flow | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Vulvodynia |
| <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Breast lumps / swelling | <input type="checkbox"/> Vomiting during pregnancy |
| <input type="checkbox"/> Premenstrual syndrome | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Menstrual odor | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> STD | <input type="checkbox"/> Other (<i>please specify</i>): |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Urinary tract infection | _____ |

AGE AT:

(First Period)

(Menopause)

NO. DAYS:

(Period Flow)

(Length of Cycle)

COLOR:

 Brown Light red/pink Dark red Bright red

QUANTITY:

 Heavy Moderate Light

CLOTS:

 Big Small None

PMS SYMPTOMS:

NO. OF PREGNANCIES:

NO. OF LIVE BIRTHS:

NO. OF MISCARRIAGES OR ABORTIONS:

CURRENT SEXUAL ACTIVITY: No YesCONTRACEPTION (*if any*):

PERTINENT PREGNANCY HISTORY: