Patient Health History

Patient Information

Name:			Home phone:
Preferred Pronoun:			Work phone:
Date:			Cell phone:
Address:			Email:
City:	State:	Zip:	Would you like to be added email newsletter?
Age:	Date of birth:		Yes ☐ No ☐
Occupation:			***Emergency contact***
Company Name:			Name:
Primary care physician:			Relationship:
How did you hear about us?			Phone:

Health History

What are your primary concerns for coming in for treatment?
1)
2)
3)
How is your sleep?
How is your digestion?
How is your energy level overall?
How is your stress level?
When was your last complete medical exam?
List serious illnesses, accidents or surgeries:
1)
2)
3)
List any supplements or medications you are taking:
1)
2)
3)
4)
6)
7)
8)
9)
10)

Check conditions you have or have had in the past:
☐ AIDS/HIV
☐ Allergies
☐ Anemia
☐ Arthritis
☐ Bleeding disorders
☐ Cancer
☐ Diabetes

Check illnesses that have occurred in blood relatives:
☐ Heart Disease
☐ High blood pressure
☐ Kidney Disease
☐ Cancer
☐ Diabetes
☐ Stroke

Check symptoms you have or have had in the last year:
☐ Depression
☐ Difficulty focusing
☐ Dizziness
☐ Easily startled
☐ Excessive worry
☐ Excessive anger
☐ Excessive fear
☐ Fatigue
☐ Headaches
☐ Loss of sleep/poor sleep
☐ Weight gain or loss
☐ Irritability
☐ Anxiety
☐ Feeling overwhelmed

Check symptoms you have or have had in the last year:

Cardiovascular
☐ Chest pain
☐ Hardening of arteries
☐ High or low blood pressure
☐ Poor circulation
☐ Heart attack
☐ Rapid/irregular heart beat
☐ Swelling

Eyes/Ears/Nose/Throat/Respiratory
☐ Asthma
☐ Blurred or failing vision
☐ Difficulty breathing
☐ Earache
☐ Enlarged gland
☐ Eye pain
☐ Frequent colds
☐ Hay fever
☐ Hoarseness
☐ Gum trouble
☐ Nosebleeds
☐ Loss of hearing
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems

Skin
☐ Boils
☐ Bruise easily
☐ Dry skin
☐ Itching/rash
☐ Sensitive skin
☐ Sore won't heal
☐ Sweating

Genitourinary
☐ Frequent urination
☐ Blood in urine
☐ Urinary incontinence
☐ Kidney infections/stones
☐ Low libido

Gastrointestinal
☐ Belching, gas or bloating
☐ Constipation
☐ Diarrhea
☐ Difficulty swallowing
☐ Distension of abdomen
☐ Excessive hunger
☐ Gallbladder problems
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Stomach pain
☐ Poor appetite
☐ Vomiting

Reproductive
☐ Erectile dysfunction
☐ Prostate problems
☐ Bleeding between periods
☐ Painful periods
☐ Clots in menses
☐ Excessive menstrual flow
☐ Irregular cycle
☐ Menopausal symptoms
☐ PMS
☐ Previous miscarriage
☐ Scanty menstrual flow
☐ Infertility
☐ Could you be pregnant?

Pain/Weakness/Numbness
☐ Arms
☐ Hips
☐ Back
☐ Legs
☐ Shoulders
☐ Neck
☐ Hands
☐ Feet
☐ Other

Muscle/Joints/Bones
☐ Tremors
☐ Cramps
☐ Swollen joints

Signature - The information on this form is correct to the best of my knowledge.	
Patient signature:	**Date**

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from 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 that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: DR. CRAIG SWOGGER, LAC, DAOM #15008

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)

PACIFIC COAST COMMUNITY ACUPUNCTURE
ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the Pacific Coast Community Acupuncture Notice of Privacy Practices

Patient signature	**Date**