Art of Acupuncture
VENICE

New Patient Information

Here are some general guidelines regarding your appointment:

1. Please eat a moderate amount of food 1 to 1½ hours before your appointment.
2. Please dress comfortably or wear loose clothing so that your arms and legs may be accessible. If we need to have access to your back or other areas that require the removal of clothes, we will drape you appropriately with a sheet.
3. Whenever possible, arrange your schedule so you do not have to rush to or away from the clinic.
4. Please tell us if you are uncomfortable with physical touch or with discussing certain activities or parts of the body.
5. Any herbal prescription is intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.
6. Feel free to ask any questions that may arise during your treatment. It is important that you feel informed and understand your own health!

Payment for Services Rendered

Payment is due at the time of service. As a small business, cash & check is greatly appreciated, but credit cards (MasterCard, Visa or Discover) are also accepted. A $25.00 service charge will be added for returned checks.

Appointment Reminders and Health Care Information Authorization

At Art of Acupuncture protecting your privacy and health care information is fundamental in the course of our relationship.

The independent practitioners and any staff member of the Art of Acupuncture clinic may need to use your name, address and phone number to contact you with appointment reminders, information about your treatment alternatives, or other health related information that may be of interest to you. Appointment reminders, cards (thank you, birthday, etc.) and other correspondence may be sent to your address. By signing this form, you are giving us authorization to contact you with these reminders and information. Please let us know in person if you would like to change your preferences.

Further, in order to provide you with quality care and to comply with certain legal requirements, we create a record of the care and services you receive at the Art of Acupuncture clinic. We are committed to protecting, securing and keeping confidential your personal and medical information unless we have your written consent for its disclosure. There are instances, however, in which your personal health information may be disclosed without your expressed written consent according to the Health Insurance Portability & Accountability Act (HIPAA); these include 1) at your verbal request, 2) for default of payment, 3) as required by an agency of the government.

Cancellation Policy

Our physicians are in high demand and have reserved a space just for you. If you wish to cancel you must call no less than 24 hours prior to appointment time or you will be charged in full for the missed appointment. Please respect the physicians' time and the needs of fellow patients. Thank you.

Please initial here:_____

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Informed Consent to Oriental Medicine

I hereby request and consent to the performance of acupuncture, and other procedures within the scope of the practice of acupuncture, on me (or the patient named below for whom I am legally responsible) by my physician at Art of Acupuncture.

I understand that methods of treatment may include, but are not limited to, acupuncture; moxibustion; cupping; gua'sha (scraping therapy); needle retention; acupressure and/or shiatsu; electrical, laser, and/or magnetic stimulation; mild bleeding therapy; diagnostic palpation on various areas of my body; Chinese herbal medicine; and nutritional and/or lifestyle counseling. I understand that the herbal prescriptions may need to be prepared and that the resulting teas (decoctions) be consumed according to the instructions provided verbally and in writing.

I understand and am informed that in the practice of Oriental Medicine, as in the practice of allopathic medicine, there are some side effects and/or risks of treatment; I understand that although these are unlikely to occur, they are possible. Some of these effects include, but are not limited to: bleeding; bruising, numbness, tingling, pain or other strong sensation at the location where a needle is inserted or radiating from that location; aggravation of current symptoms; appearance of new symptoms; general aches or dizziness. Bruising is a common side effect of gua'sha and cupping. Burns and/or scarring are a potential risk of moxibustion and cupping. Unusual risks of acupuncture include nerve pain; organ puncture, including pneumothorax (punctured lung), or spontaneous miscarriage. Infection is another possible risk, although the acupuncturist uses sterile, single-use, 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 Chinese herbs (which are derived from plant, animal and mineral sources) that are recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea, headache, rashes and tingling of the tongue; some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I understand that some herbs may be inappropriate during pregnancy and will immediately notify the acupuncturist(s) if I know or suspect that I am pregnant. Further, I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption or application of any Chinese herbs.

I do not expect the acupuncturist(s) to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist(s) to exercise such judgment based on the known facts, during the course of my treatment, to be in my best interest. I understand that results are not guaranteed.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the benefits and risks of acupuncture treatments 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 condition(s) for which I seek treatment from this clinic.

_____

Patients' name (please print)

_____

Signature

_____

Date Signed

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Information Confidential: Please fill out this form carefully.

Name Date

Age Sex (M/F) Birth Date Occupation

Address

City State Zip Phone

Email

Emergency contact Phone

How did you hear about me?

Primary Physician

When did you last go to a doctor's office, medical clinic, or hospital?
What was the reason?

Please list any major illnesses and injuries you have had and approximate date of onset:

List major complaints

Whole Body Balance

REVIEW OF SYSTEMS

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue! Place one check next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and three checks next to a symptom that is particularly distressing to you.

Head and Face
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory Loss
- ☐ Other

Eyes
- ☐ Blurry Vision
- ☐ Eyelid Twitching
- ☐ Floaters
- ☐ Pain

Nose
- ☐ Frequent Colds
- ☐ Sinus Trouble
- ☐ Bleeding

Mouth
- ☐ Dental Problems
- ☐ Gum Problems
- ☐ Teeth
- ☐ Grinding/TMJ
- ☐ Other

Throat
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Dryness
- ☐ Other

Respiration
- ☐ Difficulty
- ☐ Inhaling
- ☐ Pain
- ☐ Cough
- ☐ Congestion
- ☐ Shortness of Breath
- ☐ Other

Heart and Chest
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Chest Tightness
- ☐ Difficulty Lying Down
- ☐ Other

Circulation
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Cold Limbs-Hands or Feet
- ☐ Reynaud's Syndrome

Gastrointestinal
- ☐ Always Thirsty
- ☐ Never Thirsty
- ☐ Excessive Appetite
- ☐ Low Appetite
- ☐ Gas/Bloating
- ☐ Stomach or Abdominal Pain
- ☐ Nausea
- ☐ Diarrhea/Loose Stools
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Colon Problems

Urination
- ☐ Frequent
- ☐ Difficult
- ☐ Painful
- ☐ Nocturnal
- ☐ Bleeding
- ☐ Other

Skin
- ☐ Acne
- ☐ Dryness
- ☐ Moles that Change
- ☐ Lumps
- ☐ Excessive
- ☐ Night Sweats
- ☐ Rarely Sweat
- ☐ Other

Neurological
- ☐ Nervousness/
- ☐ Tremors
- ☐ Numbness or
- ☐ Lack of
- ☐ Nerve
- ☐ Pain

Sleep
- ☐ Insomnia
- ☐ Drowsiness
- ☐ Excessive
- ☐ Waking Easily
- ☐ Other

Pain -Please Describe

_____

_____

_____

Are there any other health concerns you'd like to address?

_____

_____

Whole Body Balance

WOMEN ONLY

Are you, or could you be pregnant?_____ If so, how far along?_____

Number of pregnancies_____ Births _____ Abortions_____Miscarriages _____

What form of birth control do you use?_____

Do you have regular PAP smears?_____How Often?_____

Age of first menses _____Age of menopause, if applicable_____

Do you bleed between periods?_____ Do you bleed after intercourse?_____

Have you ever had any gynecological surgeries or any abnormal findings on any tests?

_____

Are your periods uncomfortable or painful, either emotionally or physically?_____

Are your periods:

Short (Less than 28 days)____.Long (28+ days)_____Varied,_____Regular_____

Painful? If so Before_____During_____ After_____

Do you bleed heavily_____? Lightly_____? Very little?_____

Do you have clots ?_____ Early in the cycle_____ or throughout?_____

Relative to the blood that comes from a wound, is your menstrual blood: The same

color_____More pale _____ Purple _____ More Red _____ More Brown _____

How many days do you bleed?_____

Do you have any of the following Pre-Menstrual Symptoms? (Emotions are not judged in Chinese Medicine, they are neither good nor bad. They are, however, important diagnostic tools. Please answer honestly.)

Irritability_____ Depression_____Crying _____Rage _____ Nausea _____

Any other symptoms around the time of your period? _____

_____

Any you experiencing any lower or high sexual desires?_____ Do you have any

concerns surrounding this?_____

_____

Do you have any other gynecological concerns or complaints?_____

_____

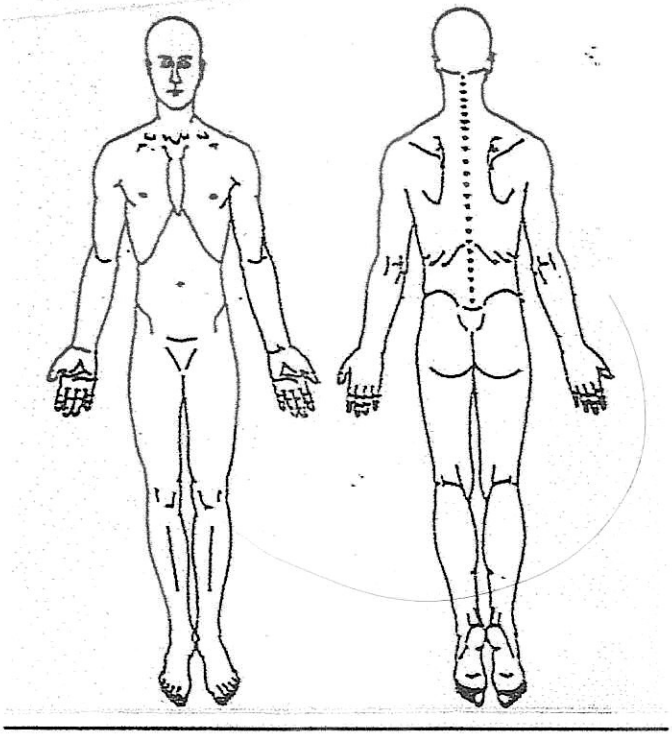
Pain Diagram and Pain Rating

Name: _____ **Date:** /____/____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles	**= 000000**	**Stabbing**	**= //////**
Burning	**= xxxxxx**	**Deep Ache**	**= zzzzzz**



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

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Men Only

Do you experience any of the following:

Reduced Libido _____Excessive Libido _____Impotence _____

Urinary Frequency ____ Premature Ejaculation _____Discharge _____

Genital/ Testicular pain _____

Any other concerns? _____

_____

I have provided correct and complete information to the best of my knowledge.

_____ _____

Patient's or Guardian's Signature **Date**