Personal Information

1. Date: _____/_____/_____

2. Name:_____

3. D.O.B:____/____/_____ Age: _____ 4. Gender: M / F

5. Marital Status: Single Married Divorce Widow

6. Address:_____

City:_____ State:_____ Zip Code:_____

7. Phone (____)_____-_____ Emergency:(_____)_____-_____

8. email: _____

9. Occupation:_____

10. How did you hear about us?

__ Internet __ website __ referred by _____

10. Chief Complaint:_____

_____

_____

_____

_____

Date symptoms began: _____

11. Pain level (optional)

Current: 0 1 2 3 4 5 6 7 8 9 10

Most: 0 1 2 3 4 5 6 7 8 9 10

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12. Do you have insurance (except Medicaid or Medicare) ? Y/N

Carrier:_____

ID#:_____

Contact #: (_____)_____-_____

(If yes, please show your insurance to the front desk)

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated by a licensed acupuncturist at the Smile Acupuncture. I understand that acupuncturists practicing in the state of Texas are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion*: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.*

Direct Moxibustion: *I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.*

Chinese Herbs*: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call SMILE ACUPUNCTURE as soon as possible.*

Acupressure/Tui-Na Massage: *I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.*

Electro-Acupuncture*: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.*

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Printed Name: _____

Signature: _____ Date: _____/_____/_____

Parents or Guardian's signature (for under 18 ages) :_____

Patient Health History

Name: _____ Date: _____/_____/_____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. Have you been evaluated by physician or chiropractor within 12 months? (Y or N)
   a. Date: _____
   b. Physician Name and Specialist:_____

2. **Please identify the health concerns that have brought you to Smile Acupuncture Clinic in order of importance below:**

	Condition	**Past Treatment**
a.	_____	_____
b.	_____	_____
c.	_____	_____
d.	_____	_____

3. If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

_____

_____

4. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

6. Do you have any infectious diseases? Y N

If yes, please identify: _____

7. Family History:

Cancer Diabetes Heart Disease Hypertension Kidney disease Others _____

8. Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

10. Hospitalizations and Surgeries:

Reason When Reason When

_____

_____

_____

_____

11. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason When Reason When

_____

_____

_____

12. Lifestyle:

a. Do you typically eat at least three meals per day? Y / N

If no, how many? _____

b. Exercise routine:_____

c. Spiritual practice:_____

d. Nicotine/Alcohol/Caffeine Use:_____

e. Have you experienced any major traumas?(mentally or physically) Y N

Explain:_____

_____

_____

_____

_____

f. How is your mood?

overjoyed Sad(Melancholy) Anger Fear(Fright) Worry

13. Questions

a. Do you think your body is cold or hot? or normal?

Cold, Hot, or alternate Cold & Fever or N/A

If you say yes, where is it? Whole Body Hands Feet others _____

b. Do you have abnormal sweating?: Profuse Sweating Night Sweating N/A

Others:_____

c. How is your sleep?

Good, difficulty in sleep, easiness to wake up, light sleep, or disturbed

Somnolence (sleepiness) others: _____

d. How is your energy? Good low energy (morning evening all day)

e. How is your appetite? Good Bad (often hunger poor appetite)

Others:_____

f. How is your digestion? Good undigested gas bloating acid reflux

Others: _____

g. Are you thirst often? Y N

h. What is your favorite temperature to drink?

Hot, Room Temperature or Cold

i. Is there abnormal taste in your mouth?

Bitter Sour Sweet Salty Pungent N/A

j. How is you urination?

Normal difficult to urine frequent urination incontinence hesitation

Others:_____

j. Do you have Diarrhea or Constipation?

(Women only)

k. Menopause: yes no

l. Menstruation:

a. Cycle:_____

b. Color: _____

c. Pain: _____

d. Quantity: _____

e. Quality: _____

m. Are you pregnant?