Appointment Date:

I General Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Married Single Partner Divorced Widowed Date of Birth _____ SS# _____

Work Phone _____ Home Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Referred By _____

Family Physician _____ Contact # _____ May we contact them? Y/N

Have you had Acupuncture or Oriental medicine before? Y/N

Are your presently under a doctor's care? Y/N Who and for what? _____

Are there any other therapies which you are involved? Y/N Who and for what? _____

II Focus

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

- ☐ Work
- ☐ Sleep
- ☐ Walking
- ☐ Sitting
- ☐ Standing
- ☐ Emotional
- ☐ Relationships
- ☐ Social Life
- ☐ Sexually
- ☐ Recreation
- ☐ Bending
- ☐ Stretching
- ☐ Other _____

What have you done about this? _____

Are you interested in:

- ☐ Pain Relief
- ☐ Performance Care
- ☐ Maintenance Care
- ☐ Other _____
- ☐ Preventative Care
- ☐ Holistic Health
- ☐ Stress Relief
- ☐ Oriental Nutrition
- ☐ Meridian Yoga
- ☐ Herbal Therapy

What are your health goals? _____

List any past or future surgeries. _____

_____

List any significant trauma. When did they occur? (auto accident, falls, emotional, sexual, etc...) _____

_____

List exercise and sport activities you have been or are currently involved in: _____

_____

IV Signs/Symptoms

- ❍ Abdominal pain/distention
- ❍ Abuse survivor
- ❍ Acid regurgitation
- ❍ Acne
- ❍ Asthma
- ❍ Bad breath
- ❍ Blood in stools
- ❍ Blood in urine
- ❍ Blurry vision
- ❍ Breast lump/pain
- ❍ Bruise easily
- ❍ Chest pains
- ❍ Chills
- ❍ Cold hands/feet
- ❍ Concussion
- ❍ Confusion
- ❍ Constipation
- ❍ Cough
- ❍ Coughing blood
- ❍ Dark stools
- ❍ Decreased libido
- ❍ Depression
- ❍ Dizziness/vertigo
- ❍ Dry throat/mouth
- ❍ Diarrhea
- ❍ Ear aches
- ❍ Enlarged thyroid
- ❍ Eye pain/strain/tension
- ❍ Excessive phlegm Color of
- ❍ Excessive saliva
- ❍ Fatigue
- ❍ Fever
- ❍ Frequent urination
- ❍ Gas/belching
- ❍ Grinding teeth
- ❍ Headache
- ❍ Hemorrhoids
- ❍ Heart palpitations
- ❍ Hiccup
- ❍ High blood pressure
- ❍ Impotence
- ❍ Increased libido
- ❍ Indigestion
- ❍ Intestinal pain/cramps
- ❍ Irritable
- ❍ Itchy eyes
- ❍ Itchy skin
- ❍ Joint pain
- ❍ Kidney stones
- ❍ Laxative use
- ❍ Limited range of motion
- ❍ Loss of hair
- ❍ Low back pain
- ❍ Migraine
- ❍ Mouth sores
- ❍ Mucous in stools
- ❍ Muscle cramps/pain
- ❍ Nasal congestion
- ❍ Neck/shoulder pain
- ❍ Night sweat
- ❍ Nocturnal emission
- ❍ Nose bleeds
- ❍ Numbness
- ❍ Odorous stools
- ❍ Pain upon urination
- ❍ Peculiar tastes
- ❍ Poor appetite
- ❍ Poor circulation
- ❍ Poor memory
- ❍ Poor sleep
- ❍ Premature ejaculation
- ❍ Psoriasis
- ❍ Rash
- ❍ Redness of eyes
- ❍ Seizures
- ❍ Seeing a therapist
- ❍ Short temper
- ❍ Shortness of breath
- ❍ Sinus pressure
- ❍ Skin fungal infection
- ❍ Spots in eyes
- ❍ Sweat easily
- ❍ Sore throat
- ❍ Sudden energy drop
- ❍ Swollen glands
- ❍ Teeth/gum problems
- ❍ Ulcerations
- ❍ Upper back pain
- ❍ Urgent urination
- ❍ Vomiting
- ❍ Wake to urinate
- ❍ Weight loss/gain
- ❍ Wheezing

V Female Concerns

Date of last menstruation _____ Is your cycle regular? Y/N Is your cycle painful? Y/N Have you ever been pregnant? Y/N

Birth control? Y/N How long? _____ ❍ PMS ❍ Clotting ❍ Vaginal sores ❍ Vaginal pain ❍ Discharge

VI Medical History

Do you have any allergies? Y/N _____ If so, to what? _____

Do you take medication? Y/N _____ If so what types and how often _____

Do you take supplements? Y/N _____ If so what types and how often _____

Please indicate if you or any family members have or had any of the following conditions:

- ❍ Pneumonia
- ❍ Tuberculosis
- ❍ Hepatitis
- ❍ Diabetes
- ❍ Epilepsy
- ❍ Kidney Stone
- ❍ Drug reaction
- ❍ Heart attack
- ❍ Blood transfusion
- ❍ Anemia
- ❍ Arthritis
- ❍ Obesity
- ❍ Mental breakdown
- ❍ Jaundice
- ❍ Parasites
- ❍ Measles
- ❍ Mumps
- ❍ Syphilis
- ❍ Gonorrhea/Herpes
- ❍ HIV/Aids
- ❍ High/low blood pressure
- ❍ Heart disease
- ❍ Gout
- ❍ Cancer
- ❍ Mental illness
- ❍ Hypo/hyper thyroid
- ❍ Premature graying
- ❍ Seizures
- ❍ Multiple Sclerosis

Do you sleep well? Y/N Do you dream? Y/N

Do you have a high point during the day? Y/N When? _____ Do you have a low point during the day? Y/N When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

VII Web of Wellness

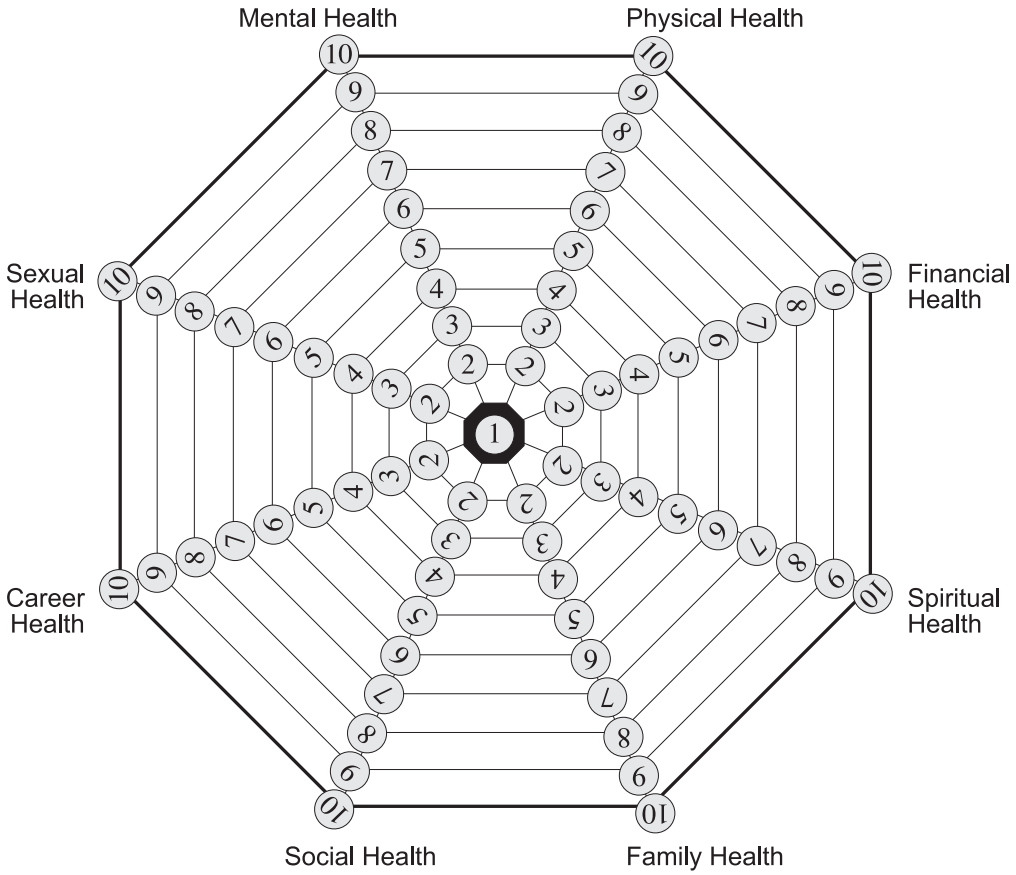
Health and wellness is a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well being.

Using the diagram below, starting at the center, choose your level of satisfaction in each of the areas.

For example: if you are extremely satisfied with your career, shade in the #10 in career line.

1 = Not happy

10 = Extremely satisfied



VIII Pain

Please indicate areas of pain/tension/tightness/discomfort on chart.

Pain intensity levels (please indicate below which best describe)

No pain	Moderate pain	Severe pain	Terrible pain

Sleeping

No problem	Mildly disturbed	Greatly disturbed	Cannot sleep

Work - Can do:

Usual work	25% of work	50% of Work	No work

Frequency of pain

25% of time	50% of time	75% of time	100% of time

Travel

No problem on long trips	Moderate pain on trips	Severe pain

Recreation - Can do:

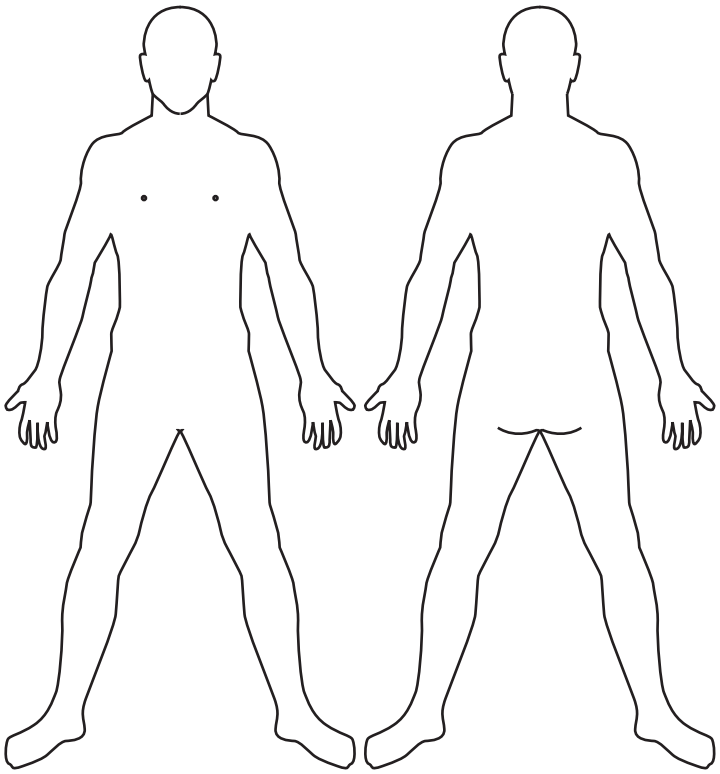
All activities	Some activities	No activities

Walking

Can walk any distance	Pain after 1/2 mile	Cannot walk

Sitting

No pain sitting	Some pain while sitting	Cannot sit



Stress: ☐None ☐Moderate ☐Severe **What causes it?**

Appetite: ☐Excessive ☐Poor ☐Appetite keeps changing

☐Feel tired or weak if a meal is missed

☐Excessive thirst ☐Never thirsty ☐Other

Specific food cravings:

☐Yes ☐No **If yes, what are they?** _____

_____

Nutrition: **List some of your favorite foods**_____

_____

Do you: ☐Skip breakfast ☐Eat a snack

☐Eat a hearty breakfast

How many meals a day do you eat? _____

When is your biggest meal? _____

Do you eat when you are worried or rushed? _____

How often?_____

Do you plan your meals according to the four basic food groups? _____

How many glasses of water do you drink a day?_____

☐Filtered ☐Bottled

Do you use: **Alcohol** ☐Yes ☐No **Amount per week**_____

Tobacco? ☐Yes ☐No **Pack per day**_____**How many years?**___

Drugs? ☐ Yes ☐ No **If yes, which ones?**_____

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INFORMED CONSENT AND DISCLOSURE FORM

INFORMED CONSENT: Lucy Postolov, L.Ac.

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations, to me (or my legal charge) by the licensed acupuncturist named above. I understand that the acupuncturist will explain all known risks and complications, and I wish to rely on the acupuncturist to exercise judgement during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is in my best interests. I may request another person to be present in the treatment room during treatment.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunction of the body. I understand the results are not guaranteed. While it is a safe method of treatment, it can occasionally cause microhemorrages in the tissues. This bleeding usually resolves with pressing dry cotton on the local spot. There may also be a sensation of warmth, tightness, soreness, or tingling when the needle reaches the acupuncture point. This sensation is called 'de qi' and is considered to be a normal response. It usually subsides soon after the needle is removed. There have been very rare instances reported of fainting, infections and scarring as a result of the needle insertion.

The acupuncturist is licensed by the California Acupuncture Board to practice acupuncture as defined by the State. She is not a licensed medical doctor. Her practice is limited to acupuncture and traditional Chinese herbal supplements.

If any procedure is to be used in conjunction with acupuncture, such as those listed below, the acupuncturist will discuss them with me before my treatment begins. I understand that they may be beneficial in my treatment, but that there is a particular risk to their use. I have read the information below and agree to the acupuncturist's use of this treatment (if indicated).

- **Traditional Chinese Herbal Supplements.** The supplements recommended are traditionally considered safe. However, I understand that some patients may experience gastro-intestinal upset or other reactions to the herbs. I will inform the acupuncturist immediately if I experience any side effects. I understand that some herbs may be inappropriate during pregnancy. Recognizing these risks, I accept full responsibility to inform the acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.
- **Indirect Moxibustion.** This technique involves burning/smoldering an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and burn exists.
- **Cupping.** This technique involves a localized suction produced by heating a small glass cup. Local bruising may result from the suction and can last a few days. There is also a minimal possibility of burning or blistering due to the heat involved in the technique.
- **Electrical Stimulation/TENS.** This form of therapy uses microcurrent electricity to stimulate acupuncture points. A mild sensation of electric tingling or slight 'pins and needles' will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the acupuncturist may recommend treatment using acupuncture points near the genital organs. If this is necessary, the acupuncturist will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points.
- **Treatment of Pediatric Patients <3 years.** I understand that treatment of young children has some risk and should be coordinated with the child's pediatrician.

I have read, or have had read to me, the above consent, and have also had the opportunity to ask questions and discuss this with the acupuncturist. By signing below I agree to acupuncture treatment, including the above named procedures for treatment of my present condition and any future condition(s) for which I seek treatment. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may effect the expected results.

_____ _____ _____

Signature of Patient (or guardian) Patient's Name (please print) Date