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INFORMED CONSENT TO ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT & CARE

I, the undersigned, herby request and consent to the performance of acupuncture procedures including, but not limited to moxibustion, cupping, plum blossom, gua sha, electroacupuncture, herbology, and Tuina, on me (or on the patient named below for whom I am legally responsible) by my acupuncturist, Patrice Hapke, L.Ac., and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with, or serving as back up for my acupuncturist named above, including those working at the clinic or office listed above or any other office visit, whether signatories to this form or not.

Potential Risks: discomfort, pain, infection, weakness, fainting, nausea, temporary discoloration at site of procedure, occasional aggravation of symptoms existing prior to the treatment, occasional mood changes
Potential benefits: drugless relief of presenting symptoms and improved balance of body's energies, which may lead to prevention or elimination of the presenting problem.

I have had the opportunity to discuss with the acupuncturist named above and/or with other office or clinic personnel the nature and purpose of acupuncture, moxibustion, cupping, electroacupuncture, herbology, physiotherapy, and other procedures. I understand that there are no guarantees regarding cure or improvement of my condition. I understand and am informed that there are some risks to acupuncture and oriental medicine, such as those listed above. There have also been instances reported of fainting, infections, scarring, spontaneous miscarriage, and pneumothorax. I understand that some herbs may be inappropriate during pregnancy. If I suspect that I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures. 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.

I hereby release Patrice Hapke, L.Ac. from all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation at any time.

I am fully aware that the clinic allots a specific amount of time for my treatment, and that if I arrive late, my treatment will be adjusted to fit into that schedule. I also understand that except in emergencies, I must give 48 hours notice of intent to cancel or reschedule an appointment unless I am in labor or assisting someone in labor. Late arrivals and appointments missed without proper notice will be billed at the current rates.

___________________________________	___________________________________	________
Signature of Patient or Person authorized to consent	Relationship or Authority of Representative	Date

____
Print Name of Patient or Patient's Representative

____
Signature of Witness

Patrice Hapke, L.Ac., M.Ac. Date ____________________

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If we sincerely believe your condition will not respond satisfactorily, we will not accept your case. If you have any questions, please ask. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank you.

Name ______________________________________ Date of Birth ________________ Age _________

Address ______________________________________ Height ________ Weight ________ Sex _______

______________________________________ Employer ______________________________

E-mail ______________________________________ Occupation ______________________________

Phone # (H) _______________ (W) _______________ ☐ Single ☐ Married ☐ Partnered

Spouse/Partner Name _______________________

Physician ______________________________________ Referred By ______________________________

In Emergency Notify __________________________ Relationship ____________ Phone ______________

Main problem you would like help with: ____

____

When did the problem begin (be specific): ____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? ___________

____

Have you been given a diagnosis for the problem? If so, what? ____________________________

What kinds of treatments have you tried? ____

Other concurrent therapies: ____

Past Medical History – please note dates:

Cancer ____________________ HIV/AIDS ____________________ Thyroid Disease ____________

Diabetes ____________________ High Blood Pressure ___________ Rheumatic Fever ____________

Hepatitis ____________________ Heart Disease _______________ Venereal Disease ____________

Surgeries (type & dates) ____

____

Significant Traumas ____

____

Significant Dental Work ____

Other ____

Allergies (drugs, chemicals, foods, etc.) ____

____

Occupational Stress (chemical, physical, psychological) ___________________________________

____

Birth History (prolonged labor, forceps, premature, etc.) ___________________________________

Family Medical History

☐ Cancer	☐ Heart Disease	☐ Asthma
☐ Diabetes	☐ Stroke	☐ Allergies
☐ High Blood Pressure	☐ Seizures	☐ Other ________________

Medications

What medications / supplements are you taking?____

____

Have you had many courses of antibiotics recently? ☐ Lots ☐ Moderate ☐ Few ☐ None

Habits

Do you have a regular exercise program? Please describe: ____

____

Are you or have you been on a restricted diet? What kind & why? ____________________________________

____

Please indicate usage per day or per week:

Cigarettes	________________	per ______	Tea	________________	per ______
Alcohol	________________	per ______	Soft Drinks	________________	per ______
Drugs	________________	per ______	Sugar	________________	per ______
Coffee	________________	per ______	Other	________________	per ______

Please describe your average daily diet:

Morning ____

Afternoon ____

Evening ____

Do you suffer from any of the following?

Please check all symptoms that apply:

General
☐ Recurrent infections
☐ Night sweats
☐ Sweating easily
☐ Bleed or bruise easily
☐ Strong thirst (hot or cold)
☐ Thirst, no desire to drink
☐ Fatigue
☐ Sudden energy drops
Time of day ___________
☐ Poor sleep
☐ Tremors
☐ Poor balance
☐ Edema
☐ Underweight
☐ Overweight

Skin
☐ Rashes
☐ Itching
☐ Eczema
☐ Oozing
☐ Pimples
☐ Dry skin/scalp
☐ Recent moles
☐ Change in hair/skin
☐ Other _______________

Head/Eyes/Ears/Nose/Throat
☐ Headaches
Where ________________
When ________________
☐ Migraines
☐ Dizziness
☐ Earache
☐ Discharge from ear
☐ Poor hearing
☐ Ringing in ears
☐ Blurry vision
☐ Night blindness
☐ Color blindness
☐ Spots in front of eyes
☐ Eye pain
☐ Excessive tearing
☐ Squint
☐ Glasses
☐ Sore eyes
☐ Facial pain
☐ Nose bleeds
☐ Nasal discharge
☐ Blocked nose
☐ Snoring
☐ Grinding teeth
☐ Teeth problems
☐ Recurrent sore throat
☐ Hoarseness
☐ Tonsillitis
☐ Swollen glands
☐ Sores on lips/mouth
☐ Other _______________

Cardiovascular
- ☐ Pacemaker
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands or feet
- ☐ Blood clots
- ☐ Spider veins
- ☐ Fainting
- ☐ Other ______________

Respiratory
- ☐ Difficulty breathing
- ☐ Pain with breathing
- ☐ Shallow breathing
- ☐ Shortness of breath
- ☐ Production of Phlegm
  color ______________
- ☐ Recurrent cough
- ☐ Coughing blood
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma/Wheezing
- ☐ Status asthmaticus
- ☐ Other ______________

Digestion
- ☐ Bad breath
- ☐ Change in appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion
- ☐ Belching
- ☐ Abdominal pain or cramps
- ☐ Weight gain
- ☐ Weight loss
- ☐ Loose stools/diarrhea
- ☐ Strong smelling stools
- ☐ Bloody stools
- ☐ Pale stools
- ☐ Green stools
- ☐ Black stools
- ☐ Constipation
  (not daily or difficulty)
- ☐ Pain with passing stools
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Anorexia nervosa
- ☐ Bulimia
- ☐ Other ______________

Genito-urinary
- ☐ Pain on urination
- ☐ Urgency with urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in urinary flow
- ☐ Unable to hold urine
- ☐ Incontinence at night
- ☐ Dribbling urination
- ☐ Kidney stones
- ☐ Prostate problems
- ☐ Impotency
- ☐ Change in sexual drive
- ☐ Rashes
- ☐ Do you wake to urinate?
  How many times? _____
- ☐ Other ______________

Gynecological

# of pregnancies __________
births ______________
premature births _________
abortions ______________
Age of 1st menses _________
days between menses _____
Duration of menses ________
1st day of last menses _______
Age of menopause _________
Date of last PAP __________

- ☐ PMS
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Light periods
- ☐ Heavy periods
- ☐ Clots
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Infertility
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Postcoital bleeding
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Other ______________

Do you practice birth control?
☐ yes ☐ no
what type & how long?
____

Are you now pregnant?
☐ yes ☐ no

Musculoskeletal
- ☐ Neck ache/pain
- ☐ Back ache/pain
- ☐ Knee ache/pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Foot/ankle pain
- ☐ Joint/Bone problems
- ☐ Torn tissues
- ☐ Prostheses
- ☐ Muscle pain/weakness
- ☐ Hernia
- ☐ Other ______________

Neurological
- ☐ Seizures
- ☐ Nerve damage
- ☐ Paralysis
- ☐ Stroke
- ☐ Sleep disorder
- ☐ Concussion
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Difficulty in concentrating
- ☐ Other ______________

Behavioral
- ☐ Vacant
- ☐ Moody
- ☐ Easily susceptible to stress
- ☐ Aggressive/Bad temper
- ☐ Lose control of emotions
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Depression
- ☐ Fear
- ☐ Substance abuse
- ☐ Other ______________

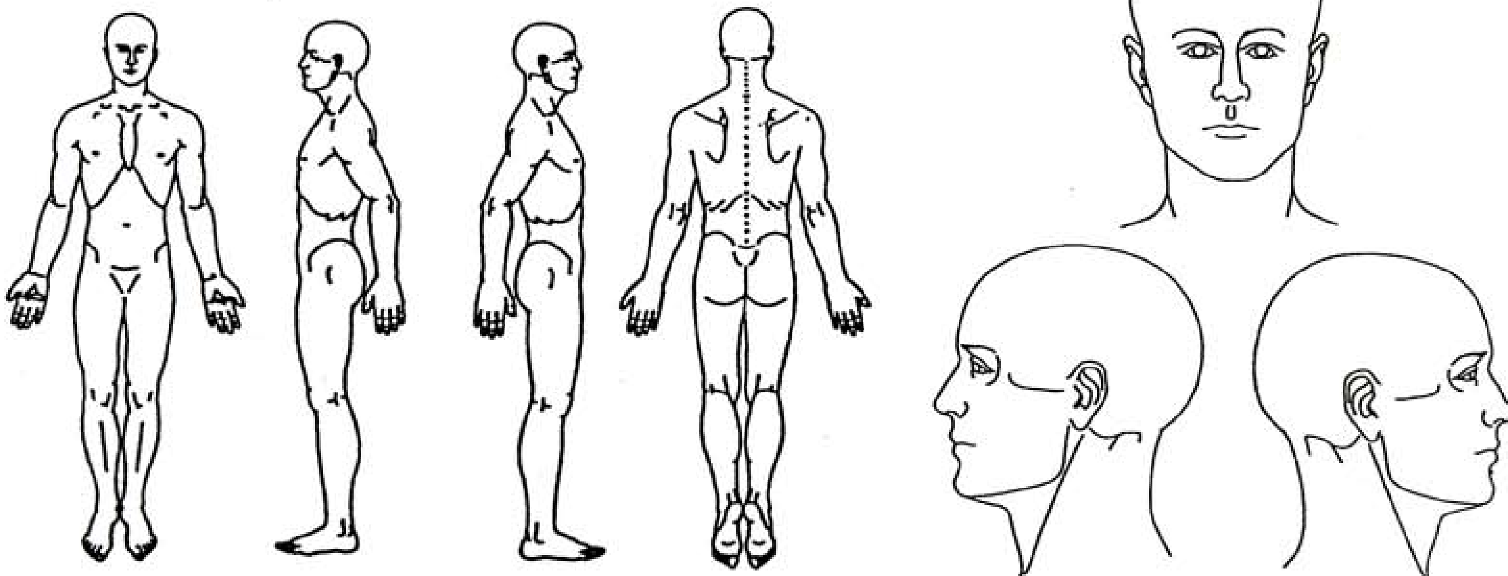
Have you ever been treated for emotional problems?
☐ yes ☐ no

Have you ever considered or attempted suicide?
☐ yes ☐ no

Please note the degree of severity of your problem now:

Please note the greatest degree of severity of your problem within the last week:

Indicate areas of pain or distress:



Comments: ____

____

____

____

____

____

____

Optional:

What is your annual household income bracket? *Please check one*

- ☐ less than $15,000
- ☐ $15,000 – $29,999
- ☐ $30,000 – $44,999
- ☐ $45,000 – $59,999
- ☐ $60,000 or more