

# Buckhead Acupuncture & Herbal Center

## Patient Health History

Name	Sex	M	F	Date / /			
Date of Birth	Age						
Address	Family Physician						
Email:	Marital Status		S	M	D	W	#of children:
Home Phone #	Cell Phone #						
In Emergency notify:	Emergency contact #						
Do you have Health Insurance?	Yes	No	Name of Insurance Company:				
Does your insurance cover acupuncture?	Yes	No	Have you ever been treated by acupuncture before?				
How did you hear about us? Friends/Relatives/Referred by _____							
Periodical	Direct Mail	Location/Walk By	Website	Yellow Pages			
Other (please specify)							

**Main Problems:** Reason for coming in \_\_\_\_\_

When did this problem begin?

What are the precipitating factors?

Have you been given a diagnosis for this problem?

If so, what?

What kind of treatment have you tried?

What makes this problem worse?

What makes this problem better?

Remarks and additional information:

**Past Medical History:**

Significant Illness:

<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Emotional Imbalance
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Digestive Disorders
<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Breathing Problems

Month /Year when diagnosis was established:

Other significant illnesses:

Surgeries/Hospitalization:

Significant trauma (auto accidents, sports injuries, etc.):

Allergies (drugs, chemicals, foods, plants/flowers):

**Family Medical History:** (please specify family member)

Cancer	Diabetes	Hepatitis	Hypertension	Stroke
Asthma	Alcoholism	Miscarriage	Heart Disease	Fibromyalgia
Other:				

**Medications:** including vitamins, over the counter medications, and herbs

**Occupation:** \_\_\_\_\_ Do you usually work indoors \_\_\_ or outdoors\_\_\_?  
Is work related stress high? Yes No

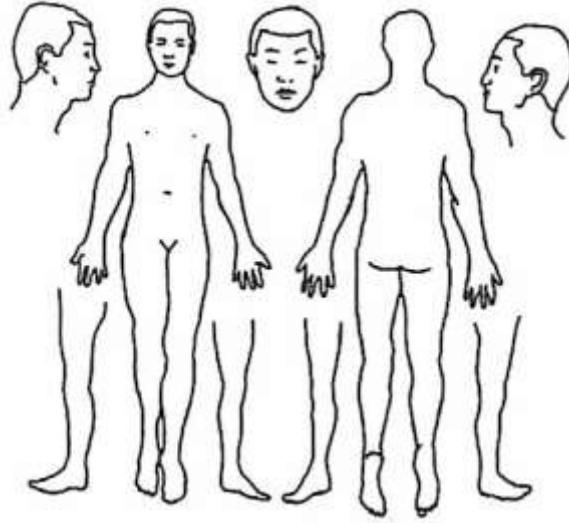
**Personal:** Height \_\_\_\_\_ Weight \_\_\_\_\_ One year ago \_\_\_\_\_  
Maximum weight \_\_\_\_\_ @ year \_\_\_\_\_

**Habits:** Do you smoke? Yes No How much? \_\_\_\_\_ Since when? \_\_\_\_\_  
Describe any recreational drug use:  
Do you exercise regularly? Yes No  
What type of exercise and how often:  
How many hours do you usually sleep? \_\_\_\_\_ Do you sleep soundly? Yes No

**Diet:** How much coffee/tea do you drink? \_\_\_\_\_ cups/day Colas? \_\_\_\_\_ number/day  
How many alcoholic beverages do you consume in a week? \_\_\_\_\_  
How much water do you drink in a day? \_\_\_\_\_  
Are you a vegetarian? Yes No Do you eat a lot of spicy food? Yes No  
Please describe your average daily diet:  
Morning \_\_\_\_\_  
Afternoon \_\_\_\_\_  
Evening \_\_\_\_\_  
Snacks \_\_\_\_\_

**Please indicate painful or distressed areas with:**

**N**=Numbness    **P**=Pins and Needles    **S**= Stabbing Pain    **A**= Achy    **T**= Tightness



Do you have any bleeding disorders (hemophilia etc.)?    Yes (specify) \_\_\_\_\_    No

Are you taking any blood thinners (coumadin etc.)?    Yes (specify) \_\_\_\_\_    No

Favorite time of year? \_\_\_\_\_ Worst time of year? \_\_\_\_\_

Do you have any history of seizures or epilepsy?    Yes    No

If female: Are you pregnant or trying to conceive?    Yes    No

**Please check if you have had (in the last 3 months) any of the following diseases or conditions.**

**General**

<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	Poor Balance	<input type="checkbox"/>	Easily Bleed/Bruise
<input type="checkbox"/>	Poor Sleep	<input type="checkbox"/>	Sweats Easily	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	Desire Hot/Cold Foods
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	Peculiar Tastes	<input type="checkbox"/>	Sudden Energy Drop
<input type="checkbox"/>	Fevers/Chills	<input type="checkbox"/>	Excessively Hungry	<input type="checkbox"/>	Strong Thirst	<input type="checkbox"/>	Dizziness

**Musculoskeletal**

<input type="checkbox"/>	Joint Disorders	<input type="checkbox"/>	Cold Hands/Feet	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Swelling of Hands/Feet
<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	Difficulty Walking
<input type="checkbox"/>	Hand/Wrist Pain	<input type="checkbox"/>	Spinal Curvature	<input type="checkbox"/>	Cramping	<input type="checkbox"/>	Neck Tightness/Pain
<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Knee/Hip Pain	<input type="checkbox"/>	Whole Body Soreness

Other: \_\_\_\_\_

**Skin/Hair**

	Rash		Itching		Dandruff		Loss of Hair
	Ulcerations		Eczema		Dry Skin		Purpura
	Hives		Pimples		Recent Moles		Other _____

**Head/Eyes/Ear/Nose/Throat**

	Concussion		Eye Strain/Pain		Cataracts		Blurry Vision
	Migraine		Night Blindness		Poor Vision		Difficulty Swallowing
	ringing In Ears		Poor Hearing		Sinus Problems		Spots in front of Eyes
	Nosebleeds		Sore Throat		Grinding Teeth		Teeth Problems
	Facial Pain		Jaw Clicking		Earaches		Sores on lips/tongue

Other: \_\_\_\_\_

**Cardiovascular**

	Chest Pain		Palpitations		Fainting		High/Low Blood Pressure
	Phlebitis		Irregular Heartbeat		Varicose Veins		Slow/Fast Heartbeat

Other: \_\_\_\_\_

**Respiratory**

	Cough		Bronchitis		Wheezing		Difficulty Breathing
	Coughing Blood		Pneumonia		Chest Pain		Production of Phlegm
Other: _____							Color of Phlegm _____

**Gastrointestinal**

	Nausea		Vomiting		Diarrhea		Constipation
	Gas/Bloating		Belching		Black Stools		Blood in Stool
	Indigestion		Bad Breath		Rectal Pain		Hemorrhoids
	Parasites		Chronic Laxative use		Ulcers		Abdominal Pain/Cramps
Other: _____							Gallbladder Problems

Bowel Movements: Frequency \_\_\_\_\_ times a day Color \_\_\_\_\_ Excessive Odor? Yes No

Texture \_\_\_\_\_

**Neuro-psychological**

	Concussion		Depression		Anxiety		Loss of Balance
	Stress		Bad Temper		Bipolar		Lack of Coordination
	ADD/ADHD		Schizophrenia		Addiction		Obsessive/Compulsive

Other: \_\_\_\_\_

**Genito-urinary**

	Pain on Urination		Blood in Urine		Urgent Urination		Frequent Urination
	Kidney Stones		Dark Urine		Dribbling		Pause of Flow
	Incontinence		Frequent UTI		Genital Pain		Genital Itching

Other: \_\_\_\_\_

**Female**

	Pelvic Infection		Endometriosis		Fibroids		Frequent Vaginal Infection
	Ovarian Cysts		Irregular Periods		Clotting		Vaginal Discharge
	Hot Flashes		PMS		Fertility Problems		Pain/Cramps at Period
	Mood Swings		Hysterectomy		Breast Lumps		Breast Tenderness

Other: \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Number of births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Premature births \_\_\_\_\_ Cesareans \_\_\_\_\_ Difficult Delivery \_\_\_\_\_

First date of last period \_\_\_\_\_ Age of first menses \_\_\_\_\_

Duration of periods \_\_\_days, cycle \_\_\_days

Do you practice birth control? Yes No What type and for how long? \_\_\_\_\_

If on birth control pills, what type and for how long? \_\_\_\_\_

**Male**

	Prostate Problems		Discharge		Impotence		Frequent Seminal Emissions
	Painful Swollen Testicles		Lack of sex drive		Genital Pain		Ejaculation Problems

Other: \_\_\_\_\_

Are there any other issues you want to discuss with us?

**I understand the above information and guarantee this form was completed to the best of my knowledge.**

Signature: \_\_\_\_\_ Adult Patient Spouse Parent/Guardian

## Acupuncture Informed Consent To Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Mark Schwartz, L.Ac. and/or Oscar Sierra, L.Ac. and/or other acupuncturists who now, or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturists named, including those working at the clinic/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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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 results are not guaranteed.

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.

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 risks and benefits of acupuncture 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.

**Patient Name (Print)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

### Cancellation Policy

If I need to reschedule or cancel my appointment, in order to avoid a \$45 cancellation fee, I must **CALL** the office with **at least 24 hours advance notice**. Patients who do not arrive for their appointments and have not called (“no call/no show”) will be charged the full price of the missed session, payable before the next appointment can be scheduled.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_