Tang Acupuncture

Patient Information

Name: ____ Today's Date: _____________________

Address: ____

City: _____________________________ State: __________________ Zip: ___________________

Primary Phone: (_________) _________ ___________ Other Phone: (_________) _________ ___________

Email: ____

Birthdate: _______________________ Sex: ◯ Female ◯ Male

Are You: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other

Who referred you? ____

Occupation: ____________________________________ Employer: _________________________________

Business Address: ____

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* IF DIFFERENT FROM ABOVE*

Client Name: ____

Address: ____

Birthdate: ______________________________ Sex: ◯ Female ◯ Male

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Emergency Contact Information:

Name:

____

Address:

____

Primary Phone: (_________) _________ ___________ Alternate Phone: (_________) _________ ___________

Relation to you: _______________________________

INITIAL VISIT

Please describe current health problem(s) for which you are seeking treatment:

____

____

____

Date problem(s) began (mm/dd/yy): ____________________________________

How often are your symptoms present?

Constantly ___ Frequently ___ Intermittently___ Occasionally___

Describe your current health condition. Good ____ Fair ____ Poor ____ Chronical ill ____

Indicate any significant illness(es) you have:

___ Cancer ___ Diabetes ___ Hepatitis ___ Seizures

___ Heart Disease ___ High Blood Pressure ___ Rheumatic Fever

___ Emotional Disorder ___ Infectious Disease ___ STD

Other_______________

What treatment(s) have you been receiving for the above condition(s)? (surgeries, injections, chiropractic, massage, etc.)

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List any accidents, surgeries, or hospitalizations (include date):

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Please list any medications being taken currently, including dosage:

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Please indicate the use and frequency of the following:

Tobacco ___________________________________

Alcohol ____________________________________

Exercise___________________________________

Coffee/Tea_________________________________

Non-medical drugs, vitamins, supplements

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Patient Name: ____

Patient Signature: ____

Date: ____________________________

Medical History

Please check any of the following symptoms you currently or have previously experienced

VERY IMPORTANT INFORMATION

Pacemaker ____ **Metal Support____** **Infectious Disease ____**

General Symptoms

__ Poor appetite __ Poor sleep __ Body heaviness __ Chills __ Shortness of breath
__ Heavy appetite __ Heavy sleep __ Cold hands or feet __ Night sweats __ Muscle cramps
__ Dream disturbed sleep __ Poor circulation __ Fatigue __ Sweat easily __ Vertigo/Dizziness

Head, Eyes, Ears, Nose, Throat

__ Glasses/Contacts __ Night Blindness __ Recurrent sore throat __ Headaches __ Migraines
__ Eye strain __ Glaucoma __ Dry mouth __ Swollen glands __ Concussions
__ Eye pain __ Cataracts __ Excessive saliva __ Nose bleeds __ Sinus problems
__ Red eyes __ Itchy eyes __ Spots in eyes __ Poor Vision __ Blurred vision
__ Teeth problems __ Grinding teeth __ TMJ __ Facial pain __ Gum problems
__ Ringing in ears __ Poor hearing __ Earaches __ Excessive phlegm

Respiratory

__ Difficult breathing when lying down __ Asthma/wheezing __ Pneumonia __ Cough w/blood
__ Tight chest __ Cough __ Cough w/phlegm

Cardiovascular

__ High blood pressure __ Chest pain __ Fainting __ Blood clots __ Palpitations
__ Low blood pressure __ Irregular heartbeat __ Difficult breathing __ Phlebitis

Gastrointestinal

__ Nausea __ Vomiting __ Diarrhea __ Constipation __ Gas
__ Intestinal pain/cramp __ Acid reflux __ Hiccup __ Bloating __ Bad breath
__ Hemorrhoids __ Bloody stool __ Mucous in stool __ Rectal pain

Musculoskeletal

__ Shoulder pain __ Neck pain __ Upper back pain __ Low back pain __ Muscle pain
__ Joint pain __ Rib pain __ Limited use __ Limited range of motion

Genito-urinary

__ Painful urination __ Blood in urine __ Frequent urination __ Urgent urination __ Bedwetting

__ Incomplete urination __ Unable to hold urine __ Wake to urinate __ Kidney stone __ Impotence

__ Premature ejaculation __ Nocturnal emission __ Increased libido __ Decreased libido

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Gynecology

__ Irregular Periods __ Painful Periods __ Vaginal discharge __ Blood clots

__ PMS __ Breast lumps __ # of pregnancies __ # of miscarriage

__ Menopause

Neuropsychological

__ Seizures __ Numbness __ Poor memory __ Depression __ Anxiety __ Irritability

__ Easily stressed __ Tics

Skin and Hair

__ Rashes __ Eczema __ Psoriasis __ Acne __ Dandruff

__ Ulcerations __ Hives __ Itching __ Fungal infection __ Hair loss

PATIENT INFORMATION AND CONSENT FORM

What is Acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

What is the role of acupuncturists in Georgia?

The Georgia Code 360-6-16 states that an acupuncturist is not licensed to practice medicine in the State of Georgia. Accordingly, an acupuncturist is not able to make a medical diagnosis of the person's disease. Therefore, if you are seeking to obtain a medical diagnosis, then you should see a licensed physician and seek medical advice from a licensed physician.

Does acupuncture have side effects?

Acupuncture is generally very safe.

- Serious side effects are rare—less than 1 per 10,000 treatments
- Drowsiness occurs after treatment in a small number of patients
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments
- Pain during treatment occurs in about 1% of treatments
- Symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign
- Fainting can occur in certain patients, particularly at the first treatment

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

- If you have ever experienced a seizure, dizziness, or fainting episode
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medications
- If you have damaged heart valves or have any other particular risk of infection

Single-use, Sterile, Disposable Needles are used by acupuncturists

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STATEMENT OF CONSENT

I am seeking to be treated with acupuncture for the condition of ______________________________. I confirm that I have read and understand the information and I consent to having acupuncture treatment. I understand that I can refuse treatment at any time.

Signature: ________________________________

Print Name in Full: ____________________________________

Date: _________________________