

6. Height: _____ Weight: Currently: _____ Past maximum weight: _____ When? _____

7. Blood Pressure: What is your most recent blood pressure reading? _____ When? _____

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

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles Chicken Pox

9. Hospitalizations, Surgeries, X-Rays, CAT scans, MRI's (please state the reason and when):

10. Family History: Mother Father Brothers Sisters Spouse Children

Age if living: _____ _____ _____ _____ _____ _____

Health:
(G=good, P=poor) _____ _____ _____ _____ _____ _____

Age at death:
(if deceased) _____ _____ _____ _____ _____ _____

Cause of death: _____ _____ _____ _____ _____ _____

Have any members of your family had any of the below diseases? If so, which ones?

Cancer: _____

Diabetes: _____

Heart Disease: _____

High Blood Pressure: _____

Stroke: _____

Mental Illness: _____

11. Emotional (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

Mood Swings Nervousness Mental Tension

12. Energy and Immunity (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

Fatigue Slow Wound Healing Chronic Infections

13. Head, Eye, Ear, Nose, Throat

(please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Frequent Sore Throats

Sinus Problems Hay Fever Nose Bleeds Teeth Grinding TMJ/Jaw Problems

14. Respiratory (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

Pneumonia Frequent Common Colds Persistent Cough Difficulty Breathing

Emphysema Pleurisy Asthma Tuberculosis Shortness of Breath

15. Cardiovascular (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):

Heart Disease Chest Pain Heart Murmurs Palpitations/Fluttering

High Blood Pressure Stroke Varicose Veins Swelling of Ankles Rheumatic Fever

16. Gastrointestinal (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):
- Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas
- Heartburn Belching Gallbladder Disease Liver Disease Hepatitis B or C
- Hemorrhoids Abdominal Pain Diarrhea Constipation
- Undigested Food in Stool Mucous in Stool Blood in Stool

17. Genito-Urinary Tract (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):
- Kidney Disease Painful Urination Frequent Urinary Tract Infections
- Frequent Urination Sexually Transmitted Disease Kidney Stones
- Impaired Urination Frequent Urination at Night Blood in Urine

18. Menstrual/Birthing History:

Age of First Menses: _____ Number of Days of Menses: _____ Length of Cycle: _____

Birth Control: _____ Number of Pregnancies: _____ Number of of Live Births: _____

Number of Miscarriages: _____ Number of Abortions: _____

19. Musculoskeletal (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):
- Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain
- Mid Back Pain Low Back Pain Leg Pain Joint Pain

20. Neurological (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):
- Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

21. Endocrine (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):
- Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus
- Night Sweats Feeling Hot or Cold

22. Other (please check ✓ any that you experience now, and put an X next to any that you have experienced in the past):
- Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

23. Menstrual/Fertility/Birthing History

At what age did you start your first period? _____

Have your cycles changed since they began? Yes No

How? _____

How many days are there from one period to the next? _____

Are your menstrual cycles spaced irregularly? Yes No

What day of your cycle are you on now? _____

24. Pre-menstruation:

Do you have premenstrual tension (irritable, emotional)? Yes No

Does your face break out before or during your period? Yes No

Do your breasts become tender premenstrually? Yes No

Do you get premenstrual low back pain? Yes No

Do your bowel movements become loose at the beginning of your period? Yes No

25. Ovulation:

Do you ovulate on your own? Yes No Unknown

If yes, on what day of your cycle? _____

Do you have cervical fluid midcycle? Yes No

Do your breasts get tender at/during ovulation? Yes No

Do you bleed or spot between periods? Yes No

26. Menstruation:

How many days do you normally bleed? _____

Are your periods painful? Yes No

How many days does the pain last? _____

How heavy is the bleeding? Light Normal Heavy

What color is the blood? Light red Red Dark red Purple Brown

Is there clotting? Yes No

27. Pregnancy History:

How many pregnancies have you had? (number and years) _____

How many children do you have? (number and years) _____

How many abortions have you had? (number and years) _____

How many miscarriages have you had? (number and years) _____

28. Medical Diagnoses and Treatments:

Date of last Pap smear _____

Have you ever had an abnormal pap smear? Yes No

Have you ever had a sexually transmitted disease? Yes No

Do you get yeast infections regularly? Yes No

Do you have chronic vaginal discharge? Yes No

Do you have any sores on your genitalia? Yes No

Have you ever had pelvic inflammatory disease? Yes No

Were you treated for it? Yes No

How? _____

Have you ever been diagnosed with uterine fibroids or polyps? Yes No

Have you ever been diagnosed with endometriosis? Yes No

Have you been diagnosed with pelvic adhesions? Yes No

Have you taken any medications for gynecological conditions other than contraceptives? If so, please list them.

Medication	Reason	How long

Have you had a diagnosis relating to infertility? Yes No

What was it? _____

Have you had fertility treatments? Yes No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? Yes No

When? _____

How long? _____

Have your fallopian tubes been evaluated medically? Yes No

What were the results? _____

Have you had any tubal operations? Yes No

Have you had any hormone laboratory tests performed? Yes No

What were the results? _____

Have you taken oral contraceptives? Yes No

When? _____

How long? _____

Have you ever had an IUD? Yes No

When? _____

How long? _____

How long have you and your partner been married or living together? _____

Has your partner had a fertility workup? Yes No

What were the results? _____

Is your partner supportive of your wish to conceive? Yes No

How long have you been trying to conceive? _____

Do you know how to determine when your peak fertile day is? _____

Do you record your Basal Body Temperature? Yes No

If so, please remember to bring your charts to your first appointment.

How is your sexual energy? Low Medium High

Do you use vaginal lubricants? Yes No

Do you douche regularly? Yes No

With what? _____

Are you more than 20% over your ideal body weight? Yes No

Are you more than 20% below your ideal body weight? Yes No

Do you have a stressful occupation? Yes No

Do you exercise regularly? Yes No

Do you have excessive facial hair? Yes No

Have you experienced excessive loss of head hair? Yes No

Have you noticed discharge from your nipples? Yes No

Have you been exposed to any known environmental toxins/hormones? Yes No

29. Is there anything else I should know? _____

30. Lifestyle:

a. Have you experienced any major traumas? If yes, explain: _____

b. Interests and Hobbies: _____

Acupuncture Wellness Center

INFORMED CONSENT TO ACUPUNCTURE CARE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or patient named below, for whom I am legally responsible) by acupuncturist Nicole Peterson, L.Ac. and/or other acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for Nicole Peterson, L.Ac, including those working at the Acupuncture Wellness Center 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 be an unpleasant smell or taste. I will immediately notify Nicole Peterson, L.Ac. or any 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 and 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 Nicole Peterson, L.Ac. or a clinical staff member if I am or become pregnant.

I do not expect the acupuncturist or the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist and the clinical staff to exercise judgment during the course of treatment which the acupuncturist or clinical staff thinks at the time, based on 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'S NAME

SIGNATURE

DATE

MINOR'S NAME

GUARDIAN'S SIGNATURE & RELATIONSHIP

DATE

Acupuncture Wellness Center

FINANCIAL POLICIES

Please read carefully and then acknowledge your understanding by signing where indicated. If you need clarification or have any questions, please ask.

PAYMENT OF SERVICES

Payment is due at the time of service unless arrangements are made in advance. Payment can be made with cash, check, debit card, Visa or Mastercard. The standard fee is \$130 for the initial visit and \$75 for follow up visits. If you foresee any financial challenges, be sure to address them with me prior to your appointment.

APPOINTMENT CHANGES

A minimum of 24 hours advance notice is required in order to cancel or reschedule your appointment. Please note that a charge of \$75 will be billed to your account for all missed appointments and all appointments cancelled or changed without 24 hours notice.

OFFICE HOURS

My office hours are Tuesday through Friday from 10am to 6pm.

I have read, I understand, and I agree to the above information.

Signature: _____ Date: _____