Innovative Wellness Center, PC

220 Forsgate Drive, Jamesburg, New Jersey 08831
(732) 656-1740

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist.

I understand the methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui Na (Chinese Massage), bleeding and Chinese herbal medicine.

I have had the opportunity to discuss with the above named acupuncturist the nature and purpose of acupuncture treatments and other procedures.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, with possible dizziness or fainting. Bruising is common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). I understand that the risk of infection is negligible when all needles are sterile.

The herbs and nutritional supplements (which are from plant, animal and mineral sources) that may be recommended are traditionally considered safe, 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, diarrhea, rashes, hives and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately inform the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, based on the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I have read, or have read to me, the above consent. I have also had the 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.

Patient's Name ____

Patient's Signature ____

Date Signed ____

INTAKE AND TREATMENT FORM

Patient Name ____________________________________ Age _______ Sex ____

Chief Complaint ____
a) Onset: ____
b) Location: ____
c) Duration: ____
d) Characteristic: ____
e) Alleviate: ____
f) Aggravate: ____

Signs and Symptoms ____
____
____
____
____

Tongue ________________________________ Pulse ____________________________
_________________________________ ____________________________
_________________________________ ____________________________
_________________________________ ____________________________

Etiology____
Present Diagnosis ____
Treatment Principle ____

Points: Herbs:

Moxa Tui Na Bleeding Gua Sha Cupping Electrical Stimulation

Comments & Suggestions for the patient: ____
____
____
____

Signature of Acupuncturist: _________________________________ Date: ___________

NEW PATIENT INTAKE FORM

IDENTIFICATION DATA: Please fill in completely. Please print.

Name (last, first): ____________________________ Date: ________________

Address: ____________________ Date of Birth: ________ Age: ____ Place of Birth: __________

____________________ Gender: Male ☐ ☐ Female

Home Phone: ( ) ____________Cell Phone: ( ) ______________E:mail:______________________

☐ ☐ ☐ ☐ ☐ ☐

Married Single Divorced Widowed

SS#:____________________ Occupation: ____________________Place of Employment______________

Employer Address:______________________________________Phone:_________________________

☐ ☐ ☐ ☐ ☐

Ethnic Background

American Indian/Alaskan Native Black (non-Hispanic) Hispanic Other: ______________
Asian/Pacific Islander White (non-Hispanic)

FAMILY HISTORY: Please complete for each member. Place an X in the box indicating any of the illnesses that they have ever had.

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	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
Allergies					
Blood Disorder/Anemia					
Diabetes					
Cancer or Tumors					
Seizures					
High Blood Pressure					
Kidney or Bladder Disorder					
Stomach or Intestinal Disorder					
Drug Abuse					
Tuberculosis					
Heart Disorder					
Stroke					
Other					
Age at Death					

Hospitalization	Year	Operation/Illness	Name of Hospital	City & State

PERSONAL HEALTH HISTORY: Please check any disorder that you may have experienced.

Diabetes
Stroke

Asthma or Bronchiti
Seizures

Drug

Allergies
Stomach/Intestinal I rder
Thyroid Disorder
Skin Disorder

Hepatitis
Cancer
Organ
Transplant
Urinary Tract Disor

Frequent/Severe Headache Allergies High Blood Pressure Musculo-Skeletal Disorder

Kidney Disorder Tuberculosis Heart Disease Transfusion – before 1985

Other: ____

	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
Allergies					
Blood Disorder/Anemia					
Diabetes					

MAJOR HOSPITALIZATIONS: If you have been hospitalized for any serious medical illnesses/operations, please list your most recent hospitalizations. Do not include normal pregnancies.

Check here if yc ave had more than three such hospitalizations.

MEDICINES: Please check any of the following that you are now taking:

Aspirin Oral Contraceptive Tranquilizer Cold Tablets

Ibuprofen Diet Pills Sleeping Pills Vitamins

Antacid Laxative Hay Fever Tablets Herbs

Please list the names of any medications you are currently taking:

Please list any medication allergies you have:

HABITS: Please check any of the habits below which apply to you now or in the past.

☐ Use of tobacco
___ # of cigarettes/day ___ # of packs/day ___Age ☐ began smoking Stopped ______ years/months/days ago

☐ Use of marijuana
___ use per day ___ Age began using ☐ Stopped ______ years/months/days ago

☐ Use of alcohol
___ # of drinks/week ___ Age began drinking ☐ Stopped ______ years/months/days ago

☐ Use of caffeine
___ # of coffees/day ___ # of teas/day ___ # of colas/day ☐ Stopped ______years/months/days ago

☐ Use of crack/cocaine
Please specify frequency: ________________________ ☐ Stopped ______years/months/days ago

☐ Use of street drugs
Please specify drugs: ____________________________ ☐ Stopped ______years/months/days ago

Please specify frequency: ________________________

EXERCISE:

☐ Never ☐ Little ☐ Moderate ☐ Heavy ☐ Type of Exercise ______________________

EMOTIONALLY:

☐ Happy ☐ Easily Irritable ☐ Difficulty making decisions ☐ Angry ☐ Cry easily

☐ Depression ☐ Stressed ☐ Restless ☐ Hurry to do things ☐ Other ____________

APPETITE:

☐ Up and down ☐ Poor ☐ Good ☐ Hungry a lot ☐ Loss of taste

Do you eat three meals per day? ☐ Yes ☐ No

Do you eat at regular hours? ☐ Yes ☐ No

Cravings ____

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Water retention

Age menarche began ___________ Age menopause __________ Abdominal bloating

VAGINAL DISCHARGES:

Date of last ob/gyn exam ________________

FEMALES ONLY:

Breast lumps Yellow

	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
Allergies					
Blood Disorder/Anemia					
Diabetes					
Cancer or Tumors					
Seizures					
High Blood Pressure					
Kidney or Bladder Disorder					
Stomach or Intestinal Disorder					

Previous Pregnancies: Please fill in completely.

Hysterectomy? Partial Full

Hormone replacement therapy

Emotional changes White Thick

Backache Bad odor Other

Painful or tender breasts ______________________

Headaches Before menstrual cycle During cycle After cycle

Tightness in chest

Sigh a lot

Constipation and/or

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Total Pregnancies: ______

How many days of flow? ___________ How many days between the period? __________

Spotting between periods

Diarrhea

______# Living

______# Ectopics

______ # Miscarriages

Please check any signs and symptoms that you have experienced during your period:

Other ______________________

____

____

____

___

Irregular painful Heavy flow

Scanty flow Dark color flow

Light color flow Clotting

______ # Induced Abortions

______ # Multiple Pregnancies

PERSONAL INFORMATION: Please fill in completely.

Date of Last Physical Exam: ______________ Name of Physician: __________________________________

Address of Physician: ____________________ Phone number of Physician: (_____) __________________

____

Emergency Contact:

Name: __________________________________ Address: ____

Phone Number: (_____) __________________ ____

Signature: ____