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

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name</strong></td>
<td>_________________________________        Age _______     Sex ____</td>
</tr>
<tr>
<td><strong>Chief Complaint</strong></td>
<td>__________________________________________________________</td>
</tr>
<tr>
<td>a) Onset:</td>
<td>_________________________________________________________</td>
</tr>
<tr>
<td>b) Location:</td>
<td>______________________________________________________</td>
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<td>c) Duration:</td>
<td>______________________________________________________</td>
</tr>
<tr>
<td>d) Characteristic:</td>
<td>______________________________________________________</td>
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<tr>
<td>e) Alleviate:</td>
<td>______________________________________________________</td>
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<tr>
<td>f) Aggravate:</td>
<td>______________________________________________________</td>
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<tr>
<td><strong>Signs and Symptoms</strong></td>
<td>________________________________________________________________</td>
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<td>________________________________________________________________</td>
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<tr>
<td><strong>Tongue</strong></td>
<td>_____________________________  Pulse _________________________</td>
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<td>________________________________________________________________</td>
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<td>________________________________________________________________</td>
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<tr>
<td><strong>Etiology</strong></td>
<td>__________________________________________________________________</td>
</tr>
<tr>
<td><strong>Present Diagnosis</strong></td>
<td>__________________________________________________________________</td>
</tr>
<tr>
<td><strong>Treatment Principle</strong></td>
<td>__________________________________________________________________</td>
</tr>
<tr>
<td>**Points: **</td>
<td>Herbs:</td>
</tr>
<tr>
<td>Moxa</td>
<td>Tui Na</td>
</tr>
</tbody>
</table>
| **Comments & Suggestions for the patient:** | ________________________________________________________________ |}

**Signature of Acupuncturist:** __________________________     Date: __________

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**NEW PATIENT INTAKE FORM**

Innovative Wellness Center, 220 Forsgate Dr, Jamesburg, NJ 08831
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:_________________________________

☐ 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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<table>
<thead>
<tr>
<th>FATHER</th>
<th>MOTHER</th>
<th>BROTHER</th>
<th>SISTER</th>
<th>CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Blood Disorder/Anemia</td>
<td>Diabetes</td>
<td>Cancer or Tumors</td>
<td>Seizures</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>Kidney or Bladder Disorder</td>
<td>Stomach or Intestinal Disorder</td>
<td>Drug Abuse</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Heart Disorder</td>
<td>Stroke</td>
<td>Other</td>
<td>Age at Death</td>
<td></td>
</tr>
</tbody>
</table>

Hospitalization Year Operation/Illness Name of Hospital City & State
PERSONAL HEALTH HISTORY: Please check any disorder that you may have experienced.

- Diabetes
- Stroke
- Drug
- Thyroid Disorder
- Hepatitis
- Transplant
- Frequent/Severe Headache
- Allergies
- High Blood Pressure
- Musculo-Skeletal Disorder
- Kidney Disorder
- Tuberculosis
- Heart Disease
- Transfusion – before 1985
- Other: ____________________________

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 you have 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:

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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
  _____ years/months/days ago
  ______ began smoking
  ______ Stopped

☐ 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

☐ Happily
☐ Easily Irritable
☐ Difficulty making decisions
☐ Angry
☐ Cry

☐ Depression
☐ Stressed
☐ Restless
☐ Other

☐ Hurry to do things

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
FEMALES ONLY:

### Age
- Age menarche began __________
- Age menopause __________
- Date of last ob/gyn exam ____________

### Pregnancy History
- Total Pregnancies: _____
  - # Living: _____
  - # Ectopics: _____
  - # Miscarriages: _____
  - # Induced Abortions: _____
  - # Multiple Pregnancies: _____

### Reproductive Procedures
- Hysterectomy? Partial: [ ] Full: [ ]

### Hormone Replacement Therapy

### Gynecological History
- Headaches
  - Before menstrual cycle: [ ]
  - After cycle: [ ]

### Period
- How many days of flow? _______
- How many days between the period? _______

### Signs and Symptoms
- Irregular painful flow: [ ]
- Heavy flow: [ ]
- Dark color flow: [ ]
- Light color flow: [ ]
- Clotting: [ ]
- Spotting between periods: [ ]

### Vaginal Discharges
- Yellow: [ ]
- White: [ ]
- Thick: [ ]
- Bad odor: [ ]

### Allergies

### Medical History
- Father:
  - Allergies:
  - Blood Disorder/Anemia:
  - Diabetes:
  - Cancer or Tumors:
  - Seizures:
  - High Blood Pressure:
  - Kidney or Bladder Disorder:
  - Stomach or Intestinal Disorder:

### Previous Hysterectomy?

### Emotional Changes
- Before menstrual cycle: [ ]
- During: [ ]
- Sigh a lot: [ ]
- Constipation and/or Diarrhea: [ ]

### Innovative Wellness Center, 220 Forsgate Drive, Jamesburg, NJ 08831
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: ____________________________________________________________________________________

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