Relief Acupuncture

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Patient Intake Form

Date: _____
Patient's Last Name_____ First Name_____
Birth Date _____ Sex_____ Marital Status _____
Address_____ City_____
Zip code_____ Tel:( )_____ Email: _____
Emergency contact ( ) _____ Name:_____ Relationship_____
Occupation_____ work phone:( )_____
Weight _____ Height_____

What is your main problem? _____
How long do you have this problem? _____
Have you seen your doctor for this problem? _____
If yes, what was the diagnose?_____
Are you taking any Medication? _____
If yes, what is the name of medications? _____
Do you have any allergy to any medication_____

Please check any of following conditions applies to you:

__Abdominal Pain/Cramp
__Allergy
__ Asthma
__ Arthritis
__Abnormal menstruation
__ Appetite changes
__ Bronchitis
__ Backache
__ Blurry Vision
__ Blocked Nose
__ Breathing Problem
__ Bad Breath
__ Belching
__ Blood in urine
__ Coughing
__ Cramp in muscles
__ Constipation
__ Chest pain
__ Cancer/Tumor
__ Dizziness
__ Difficulty walking
__ Diabetes
__ Diarrhea
__ Depression
__ Dry skin
__ Dribbling urine
__ Dry eyes
__ Eye diseases
__ Eczema
__ Eye pain
__ Frequent urination
__ Gastritis
__ Gas
__Hernia
__ Hemorrhoids
__ High Blood Pressure
__ Heart disease
__ Headache
__ Hepatitis
__ Hearing loss
__ Hormonal misbalance
__ HIV/AIDS
__ Insomnia
__Infertility
__ Irregular menstruation
__ Itching
__ Indigestion
__ Joint pain
__ Kidney disease
__ Leg pain
__ Loose stool

__ lack of coordination
__ Lack of concentration
__ Menstrual problems
__ Migraine
__ Nervousness
__ Night sweating
__ Nausea
__ Numbness of --------
__ Neck pain/stiffness
__ Nose bleeding
__ Nasal discharge
__ Overweight
__ Paralysis
__ Parkinson disease
__ Poor Balance
__ Poor memory
__ PMS
__ Panic attack
__ Prostate Enlargement
__ Ringing in ear
__ Rashes
__ Sore throat
__ Stroke
__ Stomach disease
__ Sinusitis
__ Sleepiness
__ Seizures
__ Tremor
__ Urinary problems
__ Vertigo
__ Vaginal discharge
__ Venereal disease
__ Weakness
__ Other

Did you have any surgery in the past? _____what _____ when_____

If female, are you pregnant_____ if yes, for how many months _____

At what age you had your first menstruation_____

Have you ever miscarried _____ if yes, how many times_____

Are you doing any diets _____ if yes, why_____

The diseases in your family_____

Do you wearing pace maker _____

Do you have contagious disease _____

Have you ever had Acupuncture treatment in the past _____

Relief Acupuncture
Consent for Acupuncture and Eastern Medicine

By signing below, I do Hereby voluntarily consent to be treated with acupuncture and/or other methods from Eastern medicine such as Herbs, Moxa, Blood letting, Gua sha, Tui Na, Oils and Ointments, Cupping, TDP/infrared lamp, diet and etc, by Jenick Toomassian, licensed acupuncturist.
Acupuncture: insertion of sterile needle through the skin. I understand that it could cause minor bruising, minor bleeding, fainting, temporary pain or discomfort, broken needle, infection.
Moxibustion: using heat by burning of Ai ye herb. In some cases it could be used with salt, ginger or other substances. I understand that it may cause minor burn.
Cupping/Gua sha: it performs by using designed glass or plastic cups on the skin by causing vacuum. "Gua sha" is scrubbing of skin by a round blunt instrument. I understand that by doing cupping/Gua sha I will have bruises and minor pain for few days.
TDP/Infrared lamp heat: warming the body by using lamp. It is safe but rarely it can cause over heat and minor burning.
Blood letting: I understand that it will be performed by using lancets and cups to take a little blood. It may cause some bruises and local pain for few days.
Herbal Treatment: I understand that herbs will prescribed from Chinese Materia Medica. I understand that some herbs side effect could include but not limited to cause allergy, Change in bowel movement, abdominal discomfort and etc. I am aware that if I decide to take the herbs I have to follow the direction of use and dosages.
I understand that I have the right to refuse some of the treatments offered by practitioner and it may effect on expecting results. I understand that I have the right to discontinue the treatment any time.
I read and understand all the possible risks and complications involved with treatment procedures and I give my permission and consent to the treatment.
Cancellation Policy: I understand that relief acupuncture requires 2-hours notice of cancellation, otherwise I may be charged for regular fee.

Authorization for release of information

I authorize my practitioner, Jenick Toomassian to contact my primary care physician and discus about my health issues or request my health information.

I understand that prior to treatment I have to inform my practitioner about my health specific conditions like, **wearing pace maker** or **any other electronic device, severe bleeding disorder (Hemophilia)** or **any contagious disease.**

Patient name_____
Date_____

Patient signature _____

Signature of patient's legal guardian_____
Relationship_____