

Confidential Patient Information Sheet

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell _____

Email _____

Would you like to receive a free email newsletter (your email information is held in complete confidence)? Yes NoHeight _____ Weight _____ Age _____ Sex: Male Female Dominate hand: Left Right

Date of birth: _____ Marital Status: _____

Number of children: _____ Ages of children: _____ Number who live with you: _____

Occupation _____ Employer _____

In emergency notify (name): _____ Emergency phone number: _____

Primary Care Doctor _____ Last seen: _____

How did you hear about Oasis Acupuncture: Yellow Pages Google Search Yahoo Search Other Web Brochure Business Card Psych Today Ad Referred by: _____

Medical History

Reason for your visit here today: _____

How long have you had this condition? _____

Are you being treated for this condition by anyone else: Yes No

If Yes, who? _____ Phone number: _____

Has this condition been diagnosed by a MD? Yes (Diagnosis: _____) NoHave these treatments helped? Yes Somewhat Not much Not at allHave you had acupuncture before? Yes No Name of Acupuncturist: _____Do you currently have any infectious diseases? Yes No Possibly

If Yes, please identify: _____

Health Inventory

<p>Cardiovascular Conditions :</p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	<p>Emotional / Mental:</p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	<p>Energy & Immunity:</p> <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies	<p>Respiratory:</p> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
<p>Musculo-Skeletal:</p> <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain	<p>Head, Eye, Ear, Nose & Throat:</p> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever	<p>Genito-Urinary Tract:</p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence	<p>Gastrointestinal:</p> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Irritable Bowl Syndrome <input type="checkbox"/> Leaky Gut Syndrome
<p>Endocrine :</p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold	<p>Other:</p> <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hand / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin / Graying hair	<p>Liver Conditions :</p> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	<p>Men Only:</p> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions

Women Only:

Are you pregnant right now? Yes No Trying Maybe Method of Birth Control: _____

Age at first period: _____ Date of last menses: _____ Age at menopause: _____

Typical length of menses (days): _____ Typical length of cycle (from 1st day to 1st day of menses): _____

Number of: Pregnancies: _____ Births: _____ Abortions: _____ Miscarriages: _____

Hysterectomy: Yes No Date: _____

Check all that apply: Low libido Excessive libido Painful Intercourse Clotting Painful Periods

Heavy Flow Scanty Flow Bleeding Between Cycles Irregular Cycles Vaginal Discharge Breast Lumps / Tenderness Nipple Discharge Infertility Menopausal Symptoms Premenstrual Problems

Endometriosis Fibroids Fibrocystic Breasts Ovarian Cysts Abnormal Pap Smear

Medications

Please list the medications and supplements you are currently taking:

Drug / Supplement	Reason for taking	For how long	Dose	Frequency

I am taking Coumadin / Warfarin Yes No

I have a pacemaker Yes No

Lifestyle

Are you vegetarian or vegan? Yes No

How would you rate the following areas of your health in the past month:

- Energy: Great Good Fair Poor Comments: _____
- Digestion: Great Good Fair Poor Comments: _____
- Urination: Great Good Fair Poor Comments: _____
- Sleep: Great Good Fair Poor Comments: _____
- Appetite: Great Good Fair Poor Comments: _____
- Diet: Great Good Fair Poor Comments: _____
- Exercise: Great Good Fair Poor Comments: _____
- Immunity: Great Good Fair Poor Comments: _____

How do you feel about the following areas of your life in the past month:

- Significant Other: Great Good Fair Poor N/A Comments: _____
- Family: Great Good Fair Poor N/A Comments: _____
- Sex Life: Great Good Fair Poor N/A Comments: _____
- Self: Great Good Fair Poor N/A Comments: _____
- Work: Great Good Fair Poor N/A Comments: _____

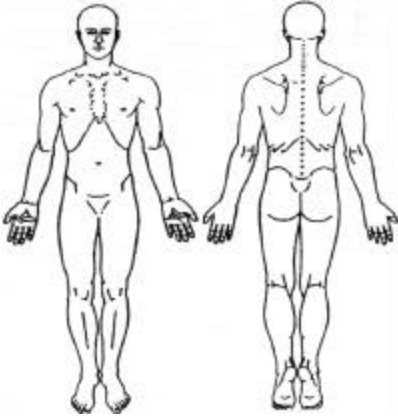
How would you rate your current stress level? Extreme Very High High Moderate Low

Did you feel safe and nurtured as a child? Always Usually Sometimes Never

Pain

Please answer the following questions if you have pain.

Indicate on the diagram on the left areas of pain:



Quality of pain: Dull Sharp Stabbing Sore Cramping
 Burning Constant Fixed Moves about

On a scale of 1 – 10 (10 being worst) how strong is your pain? _____

Does the pain radiate? Yes No Where? _____

What helps the pain? Ice Heat Rest Movement Pressure
 Moisture Massage Nothing Other: _____

What aggravates the pain? Ice Heat Rest Movement Pressure Moisture Massage
 Nothing Other: _____

Other treatments you have had for your pain? _____

Cause of pain? Injury / Accident Disease Unknown

Anything you wish to add?

The above information is true to the best of my knowledge. I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Oasis Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

X Signed: _____ Date: _____

Parent / Guardian (if applicable) _____

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine by a Licensed Acupuncturist at Oasis Acupuncture. I understand that acupuncturists practicing in the state of Arizona are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Initial here _____ Acupuncture / Moxibustion: I understand that acupuncture is performed by the insertion of single use sterile needles through the skin, application of low intensity laser light on the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

Initial here _____ Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

Initial here _____ Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, *there will likely be burning or scarring the skin from its use.* In fact, burning and scarring may even be a part of the therapeutic action, and may be intentional, on the part of the practitioner. I understand that I may refuse this therapy.

Initial here _____ Chinese Herbs: I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Oasis Acupuncture as soon as possible.

Initial here _____ Acupressure / Tui-Na Massage: I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Initial here _____ Cupping / Gua Sha: I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. *I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful.* However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

Initial here _____ Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect Christopher Vedeler or the Oasis Acupuncture staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: _____ **Date:** _____