Octagon Community Acupuncture

Informed Consent Agreement

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below 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, cupping, electrical stimulation, oriental massage (Tui-Na), oriental herbal medicine, and nutritional counseling.

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 and/or blistering are common side effects of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 Oriental 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 or applying herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.
By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been informed about the risks and benefits of acupuncture and other procedures, and have had the 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: _____
(Please print)
Representative's name: _____ Signature: _____ Date _____
(Please print)
Relationship to patient: _____

Please check off any of the following symptoms if you experience them frequently.

WATER ELEMENT
- ☐ Hearing Loss
- ☐ Dizziness
- ☐ Lower Back/Neck Pain
- ☐ Sinus Congestion
- ☐ Edema
- ☐ Dark under the Eyes
- ☐ Unstable Emotions
- ☐ Aversion to Cold
- ☐ Thinning Hair or Hair Loss
- ☐ Pre-mature Aging
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Weak Legs/Knees
- ☐ Asthmatic Cough
- ☐ Rapid Weight Change
- ☐ Loose Teeth
- ☐ Reduced Sex Drive
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Prespire Easily

FIRE ELEMENT
- ☐ Dry Scalp
- ☐ Rashes/Skin Eruptions
- ☐ Cysts or Tumors
- ☐ Ear Infections
- ☐ Sore Throat
- ☐ Lymphatic Swelling
- ☐ Hot Palms and Soles
- ☐ Heart Palpitations
- ☐ Aversion to Heart
- ☐ Bitter Taste in Mouth
- ☐ Gum Problems
- ☐ Nosebleeds
- ☐ Itchy/burning Skin
- ☐ Hot Hands/Feet
- ☐ Thirst
- ☐ Vivid Dreams
- ☐ Dark or Red Urine
- ☐ Scanty Urine
- ☐ Night Sweats
- ☐ Facial Redness

WOOD ELEMENT
- ☐ Headaches
- ☐ Migraines
- ☐ Ringing Ears
- ☐ Poor Eyesight
- ☐ Eye Infections
- ☐ Dry Eyes
- ☐ Eczema
- ☐ Shingles
- ☐ Herpes
- ☐ Warts
- ☐ Nervousness
- ☐ Irritability
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Hepatits
- ☐ Ulcers
- ☐ Vomiting
- ☐ Gall Stones
- ☐ Indecision
- ☐ Fullness below ribs
- ☐ Tense Shoulders
- ☐ Tense Neck
- ☐ Insomnia (11PM-3AM)
- ☐ Spasms/Convulsions

EARTH ELEMENT
- ☐ Indigestion
- ☐ Flatulence
- ☐ Belching
- ☐ Food Allergies
- ☐ Stomach ache/ulcer
- ☐ Diarrhea
- ☐ Anemia
- ☐ Bad Breath
- ☐ Mouth Sores
- ☐ Heartburn
- ☐ Prolapsed Organ
- ☐ Strong Appetite
- ☐ Nausea
- ☐ Abdominal Bloating
- ☐ Low Body Weight

METAL ELEMENT
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shallow Breathing
- ☐ Cough
- ☐ Sinus Congestion
- ☐ Nasal Infections
- ☐ Hay Fever/Allergies
- ☐ Respiratory Problems

OTHERS
- ☐ Fatigue
- ☐ Arthralgia
- ☐ Sciatica
- ☐ Cold Hands
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Genital Burning
- ☐ Anal Fissures
- ☐ Genital Herpes
- ☐ Urinary Tract
- ☐ Weak/Poor Appetite

Patient Information

Full Name: _____ Date: _____ Sex: □F □M

Date of Birth: ___/___/____ Age: ____ Occupation:_____

E-mail Address: _____

□ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed # of Children?_____

Home phone: (____)____-_____ Work phone: (____)____-_____ Other: (____)____-_____

Street Address: _____

City _____ State _____ Zip _____

In Emergency Notify: _____ Phone: (____)____-_____

Relationship: _____

Family Physician: _____

Have you ever been treated by acupuncture before? □Y □N If yes, for: _____

Patient Condition

What would like us to help you with? _____

When did this problem begin? _____

Have you been given a diagnosis for this problem? □Y □N If so, what? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

What kind of treatment have you tried? _____

What makes this problem worse?_____

What makes this problem better?_____

Is there anybody in your family with the same/similar problems? _____

Past Medical History (Please circle & include the month/year when the diagnosis was established)

Significant illness: Cancer Diabetes Hepatitis Thyroid Disease Seizures Fibromialgia Arthritis Tuberculosis Hypertension Emotional Imbalance Anemia Breathing Problems Heart Disease Digestive Disorders HIV/AIDS+ Veneral Disease

Other (pleased specify)

Surgeries: _____

Significant trauma: (auto accidents, sports injuries, etc): _____

Allergies: (drugs, chemicals, foods)_____

Family medical history: (Please specify family member) Cancer Diabetes Hepatitis Hypertension Heart Disease Stroke Asthma Alcoholism Miscarriage Other (please specify):_____

Medicines taken within the last two months (including Vitamins, OTC drugs, herbs) _____

Diet & Habits

Do you smoke? □Y □N What? _____ How many per day?_____ Since when? _____

Do you drink Coffee (or other caffeinated drinks)? □Y □N How many per day?_____

Do you drink alcoholic drinks? □Y □N What kind? _____ Average # of drinks per week?_____

Exercise: □None □Moderate □Heavy? How much water do you drink per day? _____

What time do you usually go to bed?_____ How many hours do you sleep in general? _____

Height_____ Weight now_____ One year ago _____ Weight max_____ @Year _____

Are you a vegetarian? □Y □N □Yes, but not so strict Do you eat a lot of spicy food? □Y □N Remarks and additional information (e.g. diet) _____

Please check if you have had (in the last three months) any of the following conditions.

General

□Poor appetite	□Fatigue	□Bleed or bruise easily	□Cravings
□Poor Sleeping	□Fevers	□Sudden energy drop	□Weight gain
□Poor balance	□Chills	□Strong thirst	□Weight loss
□Pain	□Night sweats	□Peculiar tastes	□Desire hot food
□Localized weakness	□Sweat easily	□Change in appetite	□Desire cold food

Skin & hair

□Rashes	□Ulcerations	□Hives	□ Itching
□Eczema	□Acne	□Dandruff	□Dry Skin
□Recent Moles	□ Hair Loss	□Change in Skin or Hair Texture	

Musculoskeletal

□Joint Injury	□Muscle Weakness	□Hip Pain	□ Hands/Feet Swelling
□Arthritis	□Tingling	□Knee Pain	□Cold Hands/Feet
□Difficulty Walking	□Paralysis	□Ankle Pain/Weakness	□Back Pain
□Tremors	□Neck pain/tightness	□Hand/Wrist Pain	□Spinal Curvature
□Numbness	□Shoulder pain/tightness	□Muscle Pain/Soreness	□Hernia

Head, eyes, ears, nose, and throat

□Dizziness	□Concussions	□Headaches	□Migraines
□Eye Strain	□Itching/Burning Eyes	□Night Blindness	□Poor Vision
□Blurry Vision	□Spots in front of Eyes	□Ringing in Ears	□Poor Hearing
□ Sores on Lips/Tongue	□Sinus problems	□Nose Bleeding	□Sore Throat
□Grinding Teeth	□Difficulty Swallowing	□Facial Pain	□ Earache

Cardiovascular & Respiratory

□High blood pressure	□Chest pain	□Palpitations	□Fainting
□Irregular heartbeat	□Rapid heartbeat	□Varicose veins	□Dry Cough
□Productive cough	□ Coughing Blood	□Shortness of Breath	□ Wheezing
□ Bronchitis	□Pneumonia		

Neurological & Psychological

□Loss of Balance	□Loss of Memory	□Lack of Coordination	□Depression
□Anxiety	□Stress	□Bad Temper	□Bipolar

Gastrointestinal

□Nausea	□Vomiting	□Belching	□Bad Breath
□Gas	□Indigestion	□Abdominal pain/cramps	□Loose Stools
□Diarrhea	□Constipation	□Hemorrhoids	□Gallbladder problems
□Parasites	□Chronic laxative use	Bowel Movement Frequency_____	

Genito-urinary

□Frequent urination	□Painful urination	□Urgent urination	□Incontinence
□Dribbling	□Blood in urine	□Genital Pain	□Genital Itching
□Genital Discharge	□Kidney Stones	□Frequent Urinary Tract Infection	
□Pelvic Infection	□Ovarian cysts	□Frequent Vaginal Infection	
□Prostate problems	□Impotence	□Excessively high/low libido	

Menstrual and Birth History

□Irregular periods	□Painful periods	□Breast tenderness	□Breast lumps
□Endometriosis	□Fibroids	□Hot Flashes	□Menopausal
□Clots in menstrual blood		□Moodiness related to periods	
Age of first menses: _____	Duration of periods: _____days, of cycle: _____ days		
Do you practice Birth Control? □Y □N	If yes, what type and for how long?		
Number of Pregnancies:_____	Number of Births: _____		
Miscarriages: _____	Abortions: _____	Premature Births: _____	
Cesareans: _____	Prolonged or Difficult Deliveries: _____		

I understand the above information and guarantee this form was completed correctly to the best of my knowledge.
Signature:_____ **Signature Date:**_____