New Patient Information

Name _____ Today's Date _____

Street Address _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____ Gender _____

Height _____ Weight _____

Occupation _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____ Phone _____

Health History:

Have you had acupuncture before? _____ If so, for what reason? _____

Main issue(s) you are seeking treatment for and length of time experiencing each: _____

_____

_____

_____

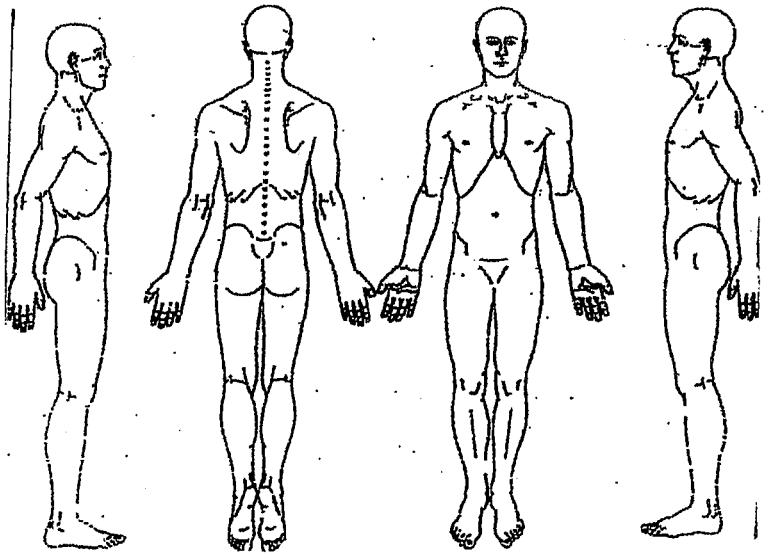
Diagnoses from a medical professional and approximate dates of diagnosis (if applicable):

_____

_____

_____

Please mark any areas of pain or discomfort:



Please list areas of pain or discomfort below with the 1-10 pain scale and a brief history:

(1: barely noticeable pain, 10: excruciating pain)

_____

_____

_____

What is your major complaint or concern? _____

_____

When did your symptoms appear? _____

Are your symptoms ☐ constant? ☐ coming and going? ☐ getting worse? ☐ getting better?

What treatment have you already received for your condition? ☐ Medications ☐ Surgery

☐ Physical Therapy ☐ Chiropractic ☐ None ☐ Other _____

Other doctor(s) that treated you for this condition:

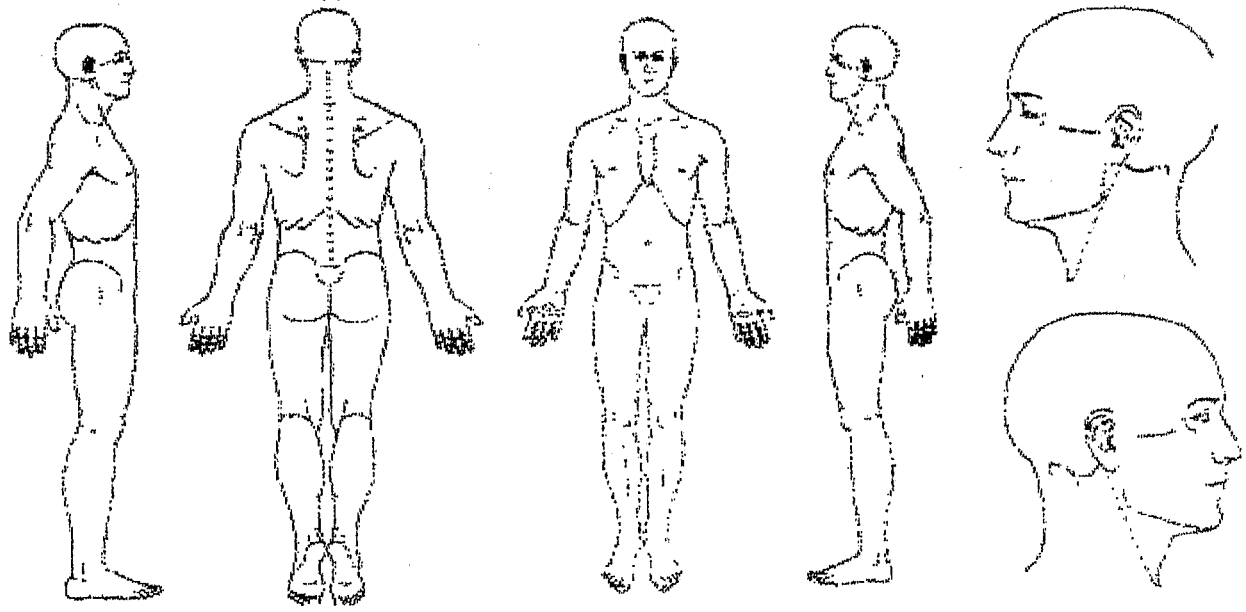
Rate the severity of your pain on a scale from 1 (least pain) to 10 (most pain) _____

Type of pain:

☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Shooting

☐ Burning ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Other

Place appropriate highlighted letters to mark the areas of discomfort



How often do you have this pain? _____

Does it interfere with Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐

Activities or movements that are painful to perform:

Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐

Who else have you seen for this problem? _____

Other comments or concerns regarding your condition:

_____

Please check any symptoms that you have experienced in the past or currently experience:

General	Past	Current		Past	Current
sweating easily during the day	☐	☐	loss of appetite	☐	☐
weight loss/gain	☐	☐	increase in appetite	☐	☐
brain fog or confusion	☐	☐	trouble falling asleep	☐	☐
dizziness/vertigo	☐	☐	trouble staying asleep	☐	☐
fatigue during the day	☐	☐	swollen/sore lymph nodes	☐	☐
fevers	☐	☐	bleed or bruise easily	☐	☐
chills	☐	☐	autoimmune disease	☐	☐

Please elaborate:

Skin and Hair	Past	Current		Past	Current
rashes/hives	☐	☐	psoriasis	☐	☐
eczema	☐	☐	itchy skin	☐	☐
dry skin	☐	☐	acne	☐	☐
oily skin	☐	☐	loss of hair/thinning hair	☐	☐

Please elaborate:

Head, Ears, Eyes, Nose & Throat	Past	Current		Past	Current
earaches/pressure in the ears	☐	☐	headaches/migraines	☐	☐
ringing in the ears	☐	☐	sinus pressure	☐	☐
hearing loss	☐	☐	nose bleeds	☐	☐
eye floaters	☐	☐	dizziness/vertigo	☐	☐
itchy eyes	☐	☐	teeth/jaw clenching	☐	☐
blurry vision	☐	☐	sore throat	☐	☐
vision loss	☐	☐	swollen throat	☐	☐

Please elaborate:

Cardiovascular/Circulatory	Past	Current		Past	Current
chest pain	☐	☐	swelling/edema	☐	☐
fainting	☐	☐	high blood pressure	☐	☐
lightheadedness	☐	☐	low blood pressure	☐	☐
cold hands & feet	☐	☐	palpitations	☐	☐
heart arrhythmia	☐	☐	heart murmur	☐	☐
shortness of breath	☐	☐			

Please elaborate:

Respiratory	Past	Current		Past	Current
pain on inhaling	☐	☐	sneezing	☐	☐
chest tightness	☐	☐	seasonal/other allergies	☐	☐
cough	☐	☐	phlegm production	☐	☐
asthma	☐	☐	nasal congestion	☐	☐
wheezing	☐	☐	difficulty swallowing	☐	☐
pain behind the eyes	☐	☐			

Please elaborate:

Genito-Urinary	Past	Current	Past Current	Past	Current
difficulty urinating	☐	☐	urgent/frequent urination	☐	☐
blood in urine	☐	☐	sores on genitals	☐	☐
pain upon urination	☐	☐	genital pain	☐	☐
STD	☐	☐	yeast infections	☐	☐
bacterial vaginosis	☐	☐			

Please elaborate:

Neurological/Psychological	Past	Current		Past	Current
anxiety	☐	☐	poor memory	☐	☐
depression	☐	☐	quick temper	☐	☐
loss of balance/coordination	☐	☐	easily susceptible to stress	☐	☐
areas of numbness/paralysis	☐	☐	mood swings	☐	☐
irritability	☐	☐	ADD/ADHD	☐	☐
Parkinsons	☐	☐	Multiple Sclerosis	☐	☐

Please elaborate:

Digestive	Past	Current		Past	Current
heartburn	☐	☐	gas	☐	☐
belching	☐	☐	diarrhea	☐	☐
bloating	☐	☐	constipation	☐	☐
nausea	☐	☐	abdominal pain/cramps	☐	☐
vomiting	☐	☐	mucus in stool	☐	☐
chronic bad breath	☐	☐	blood in stool	☐	☐
sores on lips/tongue	☐	☐	hemorrhoids	☐	☐

Please elaborate:

For Women Only:	**Past**	**Current**		**Past**	**Current**
irregular periods	☐	☐	breast pain	☐	☐
painful periods	☐	☐	vaginal discharge	☐	☐
bleeding between periods	☐	☐	vaginal sores	☐	☐
period clots	☐	☐	hot flashes	☐	☐
menstrual cramping	☐	☐	night sweating	☐	☐

age of first menses _____ duration of typical period _____

duration of typical cycle _____ date of last PAP _____

# of pregnancies _____ # of live births (+ years) _____

# of miscarriages _____ # of abortions _____

Are you currently pregnant or breastfeeding? _____

Have you been through menopause? Age? _____

Did you experience a difficult menopause?

_____

_____

_____

_____

Have you ever taken birth control pills? When and for how long? _____

Other premenstrual & menstrual symptoms (bloating, breast tenderness, irritability, mood swings, fatigue, loose stools, acne, etc.)

_____

_____

_____

Please elaborate:

_____

_____

_____

For Men Only:	**Past**	**Current**		**Past**	**Current**
erectile dysfunction/impotence	☐	☐	ejaculatory pain	☐	☐
varicocele	☐	☐	BPH	☐	☐

Please elaborate:

_____

_____

_____

Lifestyle:

Current medications/herbs/supplements (please list dosages and how long you have been taking each):

_____

_____

_____

_____

Do you follow any certain diet or way of eating? (vegetarian, gluten-free, paleo, etc.)

_____

_____

How much water do you drink per day? Is it filtered and if so, which type of filter do you use?

_____

What is your current exercise routine?_____

_____

Do you or have you ever used tobacco? If so, how often?_____

Approxinatley how many alcoholic drinks do you consume per week? _____

Approximatley how many vegetable servins do you consume per day?_____

Approximatley how may fruit servings do you consume per day? _____

How would you describe your current diet?

Poor Fair Good Very Good Excellent

Do you have any allergies to medications/food/chemicals?ect? If so, which ones?

_____

_____

Please circle any significant illnesses and indicate date:

Cancer Hepatitis Diabetes

High Blood Pressure Epilepsy Heart Attack

Stroke Ulcer Liver Disease Colon Polyps Other _____

What are your health goals?

_____

_____

Please list any other relevant information or issues you would like to discuss

_____

_____

I give consent to ..... Susan Lorentzen LAc., and/or any other Acupuncturist licensed in South Carolina who now or in the future may be employed by, working or associated with the treating Acupuncturist named above, including those working at this clinic or any other office or clinic.

I understand that the methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tuina, Chinese or Western herbal medicine, nutritional counseling, cold laser, lymphatic enhancement therapy, biopuncture, and/or acupuncture injection therapy. I also understand that I will not be given an allopathic (western) medical diagnosis For an Allopathic medical diagnosis, I will seek the services of an allopathic physician. Any diagnosis referred to by the above listed practitioners of this office is related to the Traditional Chinese or East Asian medicine. Further, if my condition(s) has not demonstrated clinical improvement within three consecutive months of initial treatment, I understand that I may need to seek a medical diagnosis from a licensed allopathic medical doctor before continuing acupuncture treatments.

I have had the opportunity to discuss with the acupuncturist named above, and/or with other office or clinic personnel. the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perceptions of pain, and to treat certain disease or dysfunctions of the body. I have been informed the acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the sites of needle insertion that may last a few days. There have been very rare instances reported of fainting, infections and scarring. There have been extremely rare instances of spontaneous miscarriages, which may or may not have resulted in from treatment, and pneumothorax. There may be some bruising after cupping.

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 Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience gastrointestinal upset or allergic reaction to the herbs, I will inform the Acupuncturist immediately.

I do not expect the Acupuncturist to be able to explain all the risks and complications, and I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure prescribed by the acupuncturist at the time. based upon 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 release without my written consent.

I have read or have had read to me, the above consent. I have also had an 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 conditions and any future conditions for which I seek treatment.

To be completed by the Patient:

Patients Name (Please print) Patient's representative if applicable (please print)

Patient's signature Date Patient's representative signature Date