Stephanie Massimini
ACUPUNCTURE

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Acupuncture Health History Questionnaire

Name_____Date_____

Address_____City_____

State_____Zip_____Occupation_____

Phone_____Email_____

Birth Date_____Age_____Ht_____Wt_____

Emergency Contact_____Phone_____

Is this your first time getting acupuncture? Y/N How did you hear about us?_____

GOALS: What would you most like to achieve with acupuncture treatments?

_____

_____

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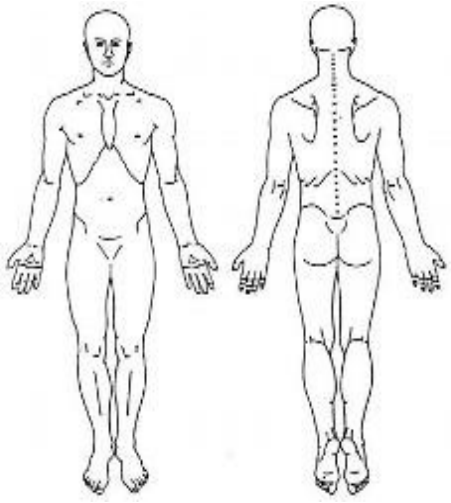
_____

Are you experiencing pain/discomfort in any area of your body? Y/N

Please rate your pain level (Circle one)
1 2 3 4 5 6 7 8 9 10

Use the illustration to indicate painful or distressed areas. Indicate the location of the discomfort by using the letters below that best describes the feeling:

X Sharp/Stabbing
P Pins & Needles
D Dull/Aching
N Numbness
T Tightness/Spasms



Medical History

Do you have or have you had any of the following conditions? If yes, please indicate date of diagnosis.

	Date Diagnosed		Date Diagnosed
Cancer Type_____	_____	HIV	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Seizures	_____
Hepatitis	_____	Stroke	_____
High Blood Pressure	_____	Hypo/Hyperthyroid	_____
High Cholesterol	_____	Contagious Disease	_____
Heart Attack	_____	Shingles	_____
Allergies	_____	Other	_____

Please list any surgeries, serious injuries or other medical conditions.

_____

_____

_____

Describe your exercise routine, if any_____

How many hours per night do you sleep on average?_____Do you wake rested? Y/N

Would you consider yourself to be under a tremendous amount of consistent stress? Y/N

If you answered yes, what do you do to relax? _____

Daily water intake_____Dietary Habits_____

Please list any other concerns that you would like to address

_____

_____

Women Only

Please check yes if symptom applies to you

Are you/could you be pregnant?	Yes____	Comments_____
Irregular Cycle	Yes____	Comments_____
Heavy Flow	Yes____	Comments_____
PMS	Yes____	Comments_____
Clots in Menstrual Blood	Yes____	Comments_____
Painful Periods	Yes____	Comments_____
Endometriosis	Yes____	Comments_____
Uterine Fibroids	Yes____	Comments_____
Ovarian Cysts	Yes____	Comments_____
Unusual Vaginal Discharge	Yes____	Comments_____
Frequent Yeast Infections	Yes____	Comments_____
Menopausal Symptoms	Yes____	Comments_____

Acupuncture Informed Consent For Treatment

I, (print name)_____the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, bleeding therapy, Tui Na medical massage, and dietary advice based on Chinese medical theory.

You will be treated with the insertion of sterile, one-time use disposable needles. After the needles are placed it is best not to change position or move without assistance. It is important to communicate freely to your acupuncturist if you are uncomfortable for any reason during your treatment.

Some of the rare side effects of acupuncture may include but are not limited to temporary bruising, bleeding, needle sickness (dizziness, light headedness, nausea), burning or scarring from moxibustion or soreness at the needling site. It is important to eat before coming to your treatment to prevent light headedness or dizziness.

Some of the potential benefits include drugless relief of presenting symptoms, improved general health, elimination of the presenting problem, reduction of pain and associated symptoms.

Please notify the acupuncturist should you become pregnant or if you are in the process of trying to become pregnant.

With this knowledge you voluntarily consent to the above procedures and are aware of the possible risks involved. You have the opportunity to discuss the consent with your acupuncturist at any time. There is no guarantee of success or effectiveness of a specific treatment or series of treatments. It is recommended that your physician be consulted for any medical concerns prior to receiving acupuncture. Your acupuncturist cannot provide a Western medical diagnosis. If you think you may have a serious health condition, you are encouraged to seek the care of your physician.

I, the patient, hereby release the clinic from any and all liability which may occur with the above mentioned procedures. My signature indicates that I have read and understand this consent carefully, having provided correct information about ALL of my known medical conditions to the best of my knowledge, asked any questions and have received satisfactory answers. I also understand that any illicit or sexually suggestive remarks made by a patient will result in immediate termination of the session, and the patient will be liable for payment of the scheduled appointment.

_____

Patient Signature Date

_____

Stephanie Massimini, L.Ac. Date

Financial and Cancellation Policies

Dear Patient,

Thank you for choosing acupuncture to help you reach your health and wellness goals. The following is our cancellation and financial policy. Our main concern is that you receive optimal care resulting in better health. Therefore, if you have any questions or concerns about our policies, please do not hesitate to ask.

Payment for services is due at the time services are rendered. Cash, checks and credit/debit cards are accepted for payment.

If you need to cancel your appointment, we kindly ask that you give12 hours notice. You can cancel via phone, text, or email. Of course, life is unpredictable at times and there will be exceptions. However, if you ′no show′ for an appointment and do not cancel, you will be responsible for the full amount which will be due at your next visit. We apologize for any inconvenience but this policy is made so other patients may benefit from your time slot if you should cancel. We appreciate your dedication to your health and the opportunity to serve you. Thank you for understanding.

Warm Regards,

Stephanie Massimini, L.Ac.

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Patient Signature Date