Acupuncture Informed Consent

This disclosure statement states that Acu-Zen will comply with all the rules and regulations promulgated by the New York State Office of Professions: 89 Washington Avenue, Albany, NY 12234. AcuZen; Dr. Deborah Rothman, DACM, L.Ac.; Doctorate in Acupuncture and Oriental Medicine from Pacific College of Oriental Medicine. Master's Degree in Acupuncture and Oriental Medicine from NY College of Health Professions, Syosset NY, and all associates.

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 on the patient named below, for whom I am legally responsible) by the acupuncturist indicated 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, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (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 Chinese 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 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.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, and is in my best interest. I understand that results are not guaranteed.

I have been explained that while Acu-Zen is committed to patient's health and well being in the belief that Alternative Medicine has a great deal to offer as a health care system, but in no way is meant to replace the resources available through biomedical physicians. Consequently, I understand that I have the right to consult a physician regarding any condition (s) for which I am seeking Acupuncture and/or Oriental Medicine treatment. My signature below acknowledges that I have been advised by Acu-Zen to consult a physician regarding the condition(s) for which I am seeking Acupuncture treatment.

I understand the Acu-Zen clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Acupuncturist Name: Dr. Deborah Rothman Teresa Susko

Patient Signature: ____

Patient Name (Please Print):_____________________________________Date: _________________

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Office Policy

24 hour cancellation is required to respect other patients who may be in need of an appointment, as well as the practitioner's time.

**** Please note that appointment cancellations require 24 hour notice.**

**** No shows will be subject to a full office fee.** (Initial) _______

Bounced checks will be charged a $35 fee, and checks will no longer be accepted.

For confirmation of appointments, I give permission to be contacted by: ☐ Text Message ☐ E-Mail

I have read and understood the office policies.

Patient Signature: ____

Patient Name (Please Print):_____________________________________Date: _________________

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. If there is anything you wish to bring to our attention which is not asked on this form, please note it in the "Comments" section. Thank you.

Name____Date______________

Street___________________________City_________________State/Zip________________

Home Phone________________Cell Phone_______________E-Mail______________________

Age____Date of Birth___________Male____Female____Height______Weight___________

Marital Status: □ Married □ Never Married □ Widowed □ Divorced or Separated

Education: □ Grammar School □ High School □ College □ Masters □ Doctorate

Occupation:______________________Retired:______Disabled:________Unemployed:________

Family Physician:_____________________________Referred by: _________________________

Emergency Contact:____________________Emergency Contact Relation to you:_____________

Emergency Contact telephone:____

Have you ever been treated by acupuncture or Oriental medicine before? □ Yes □ No

Main Problem you would like us to help you with: _____________________________________

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____

____

How long ago did this problem begin? Please be specific: _____________________________

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Have you been given a diagnosis for this problem? If so, what diagnosis and by whom?

____

What other kinds of treatment have you tried? □ Western Medicine □ Acupuncture
□ Herbs □ Massage □ Physical Therapy □ Chiropractor □ Reiki □ Homeopathy
□ Other:____

How confident are you that Acupuncture and Chinese herbal medicine will be able to resolve the symptoms of your main complaint?

□ Not confident □ Slightly confident □ Moderately confident □ Confident □ Very confident

Secondary Complaints you would like us to help you with: ______________________________

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Past Personal Medical History of Significant Illnesses: □ Asthma □ Allergies □ Diabetes

□ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis

□ Rheumatic Fever □ Thyroid disease □ Venereal disease Other:_______________________

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____

Hospitalizations/Surgeries (including dates):____

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____

Significant Trauma (auto accidents, falls, etc.): _____________________________________

____

Allergies (drugs, chemicals, metals, foods):____

____

Family Medical History: (check all that are applicable) □ Asthma □ Allergies □ Diabetes

□ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures □ Thyroid

□ Hepatitis □ Rheumatic Fever □ Thyroid disease □ Venereal disease Other:____________

____

Medicines taken within the last two months (vitamins, drugs, herbs, etc.): __________________

____

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Are there any areas of your life that you find stressful? Please describe:___________________

____

Do you have a regular exercise program? □ No □ Yes If yes, please describe: ______________

____

Do you follow any type of special diet (e.g. vegetarian, vegan, medical related, or other)?
□ No □ Yes If Yes, what type of diet? ____

Describe your average daily diet:
Morning:____
Afternoon:____
Evening: ____

Do you smoke? □ No □ Yes If Yes, how many cigarettes or cigars per day? ____________

How many cups of caffeinated coffee, tea, or cola do you drink per day? __________________

How many 8 oz. glasses of water do you drink per day?_________________________________

How many alcoholic beverages do you drink per week? _________________________________

Please describe any use of drugs for non-medical purposes: ______________________________
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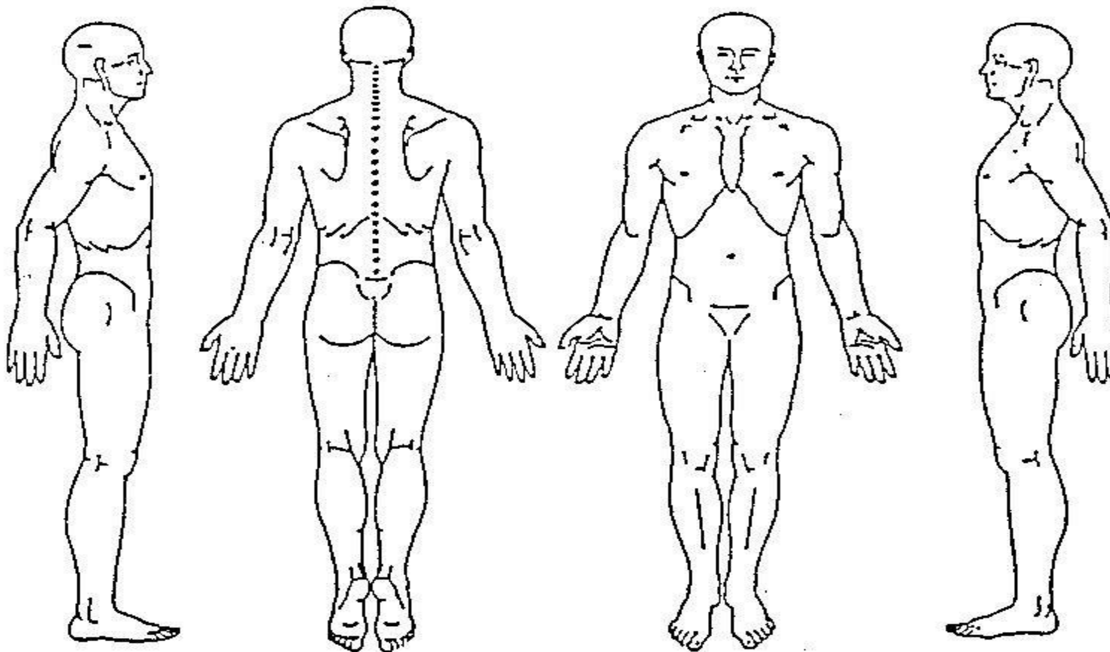
Please indicate any painful or distressed body areas by circling the particular area:



Please check if you have had any of the following, particularly if in the last three months:

GENERAL:

□ Fevers	□ Chills	□ Fatigue	□ Sweat easily
□ Poor sleeping	□ Night sweats	□ Weight loss	□ Cravings
□ Weight gain	□ Change in appetite	□ Strong thirst for: □ Hot drinks □ Cold drinks	

□ Sudden energy drop, if so what time of day?_________________________________
□ Bleed or bruise easily □ Peculiar tastes or smells

SKIN & HAIR:

□ Rashes	□ Ulcerations	□ Hives	□ Itching
□ Eczema	□ Pimples	□ Dandruff	□ Loss of hair
□ Recent moles	□ Psoriasis	□ Dermatitis	□ Acne

□ Change in hair or skin texture
□ Any other skin or hair problems?____

HEAD, EYES, EARS, NOSE & THROAT:

□ Dizziness	□ Concussions	□ Migraines	□ Glasses
□ Eye strain	□ Eye pain	□ Poor vision	□ Night blindness
□ Color blindness	□ Cataracts	□ Blurry vision	□ Earaches
□ Ringing in ears	□ Spots in front of eyes	□ Poor hearing	□ Sinus problems
□ Nose bleeds	□ Recurrent sore throats	□ Grinding teeth	□ Clenching jaw
□ Facial pain	□ Sores on lips or tongue	□ Teeth problems	□ Jaw clicks

□ Headaches, where and when?____
□ Any other head or neck problems?____

CARDIOVASCULAR:

□ High blood pressure	□ Low blood pressure	□ Chest pain	□ Fainting
□ Irregular heart beat	□ Difficulty in breathing	□ Blood clots	□ Phlebitis
□ Cold hands or feet	□ Swelling of hands	□ Swelling of feet	
□ Varicose or spider veins	□ Palpitations	□ Palpitations at rest	

□ Any other heart of blood vessel problems?_____________________________________

RESPIRATORY:

□ Cough	□ Coughing blood	□ Asthma	□ Bronchitis
□ Pneumonia	□ Pain with deep breath	□ Chest tightness	

□ Difficulty breathing when lying down
□ Phlegm production, what color?____

GASTROINTESTINAL:

□ Nausea	□ Vomiting	□ Diarrhea	□ Constipation
□ Gas	□ Belching	□ Black stools	□ Blood in stools
□ Indigestion	□ Bad breath	□ Rectal pain	□ Hemorrhoids
□ Bleeding gums	□ Food stagnation	□ Bloating/edema	□ Acid reflux/GERD
□ Hernia	□ Excessive appetite	□ Poor appetite	□ IBS/Crohn's disease
□ Colitis	□ Slow digestion	□ Abdominal pain/cramps	
□ Chronic laxative use		□ Loose stools, more than 2 per day	

□ Any other problem with Stomach or intestines____________________________________

GENITO-URINARY:

□ Frequent urination	□ Blood in urine	□ Pain upon urination
□ Urgency to urinate	□ Unable to hold urine	□ Kidney stones
□ Decrease in flow	□ Impotency	□ Sores on genitals

□ Any particular color to your urine? _____________________________
□ Do you wake up at night to urinate? If yes, how many times a night? ________________
□ Any other problems with your genital or urinary systems?____________________________

REPRODUCTIVE & GYNECOLOGIC:

Are you pregnant? ☐ Yes ☐ No

Is it possible that you are pregnant? ☐ Yes ☐ No

Number of pregnancies:____________ Live Births:__________ Miscarriages: __________

Abortions:________________________ Premature births:________________________________

Age at first menses: _______________ Time period between menses:_____________________

Duration of menses:_______________ Last PAP: ______________________________________

☐ Irregular periods ☐ Painful periods ☐ Clots ☐ Breast lumps

☐ Vaginal sores ☐ Vaginal discharge ☐ Vaginal dryness ☐ Endometriosis

☐ Uterine fibroids ☐ Polycystic Ovarian disease ☐ Fibrocystic breast tissue

☐ Unusual character of blood (heavy, scanty)____

Do you practice birth control? ☐ Yes ☐ No If yes, what type?__________How long? __________

MUSCULOSKELETAL:

☐ Neck pain ☐ Rotator cuff ☐ Knee pain ☐ Foot/ankle pain

☐ Muscle pain ☐ Muscle spasm ☐ Muscle weakness ☐ Shoulder pain

☐ Hip pain ☐ Sciatica ☐ Bursitis ☐ Hand/wrist pain

☐ Carpal tunnel ☐ Sprains/strains ☐ Tendonitis

☐ Back pain: Low_____Middle______Upper______

☐ Soreness/weakness of lower body (back, hip, knee, ankle, foot)

NEUROLOGICAL & PSYCHOLOGICAL:

☐ Seizures ☐ Dizziness ☐ Loss of balance ☐ Areas of numbness

☐ Poor memory ☐ Concussion ☐ Poor coordination ☐ Bad temper

☐ Anxiety ☐ Depression ☐ Easily susceptible to stress

☐ Nervousness ☐ ADD/ADHD ☐ Manic depression

Have you ever been treated for emotional problems? ☐ Yes ☐ No Have you ever considered or attempted suicide? ☐ Yes ☐ No

Any other neurological or psychological problems? ____

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COMMENTS: Please tell us briefly of any other problems you would like to discuss.

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