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

Patient Signature: _____

Patient Name (Please Print):_____Date: _____

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.

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 there is anything additional you wish to bring to our attention, 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:_____

Primary Care Physician:_____Referred by: _____

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

_____

_____

_____

_____

_____

How long ago did this problem begin? _____

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

_____

What other kinds of treatment have you tried? □ Acupuncture □ Western Medicine
□ Herbs □ Massage □ Physical Therapy □ Chiropractor □ Pain Management □ Other

How confident are you that Acupuncture will be able to resolve your symptoms?
Not confident □ Slightly confident □ Moderately confident □ Confident □ Very confident

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

_____

_____

_____

Allergies: _____

Medicines and Vitamins taken within the last two months:_____

_____

_____

Hospitalizations/Surgeries (Date):_____

_____

Significant Trauma: _____

_____

Past Personal Medical History of Significant Illnesses: □ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease □ High Blood Pressure □ Seizures □ Hepatitis □ Thyroid disease □ Other:_____

Family Medical History: (check all that apply) □ Asthma □ Allergies □ Diabetes □ Cancer □ Stroke □ Heart disease □ Low Blood Pressure □ High Blood Pressure □ Thyroid disease □ Other: _____

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

_____

Do you exercise regularly? □ No □ Yes If yes, please describe: _____

Do you follow any type of special diet? □ 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/ day? _____

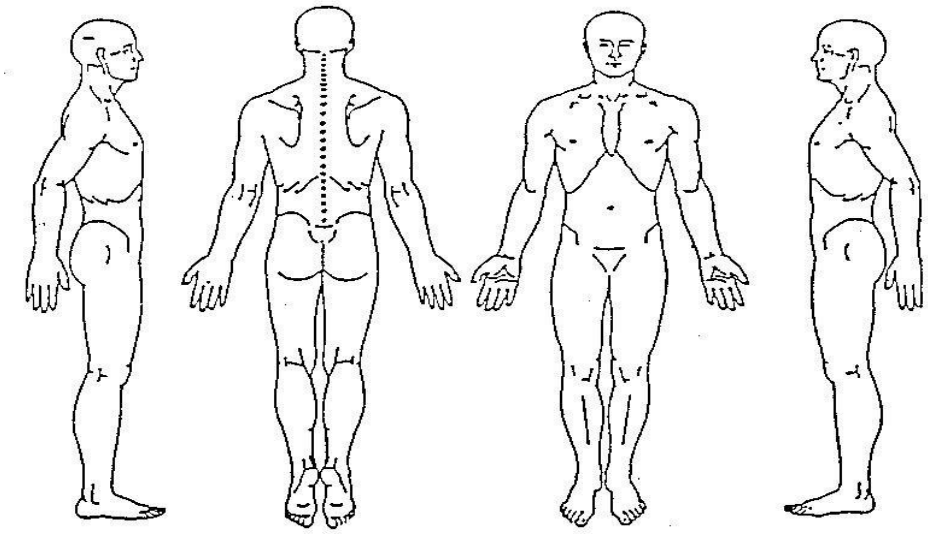
How many cups of caffeinated coffee, tea, or soda do you drink/day? _____

How many ounces of water do you drink/day? ____ Do you prefer cold or room temperature? ____

How many alcoholic beverages do you drink/week? _____

Do you use and drugs for non-medical purposes? □ No □ Yes. If yes, please specify_____

Please indicate any painful or distressed body areas by marking the particular area:



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

GENERAL:

□ Fevers □ Chills □ Sweat easily □ Night sweats □ Weight loss □ Weight Gain □ Cravings
□ Poor sleeping □ Fatigue □ Sudden energy drop □ Bleed or bruise easily

SKIN & HAIR:

□ Rashes □ Itching □ Eczema/ Psoriasis □ Acne □ Hair loss □ Change in hair or skin texture

HEAD, EYES, EARS, NOSE & THROAT:

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

CARDIOVASCULAR & RESPIRATORY:

□ High Blood Pressure □ Low Blood Pressure □ Fainting □ Palpitations □ Irregular Heart beat
□ Blood Clots □ Varicose or spider veins □ Cold hands or feet □ Swelling / Edema in hands or feet
□ Chest Pain or tightness □ Difficulty breathing □ Asthma □ Bronchitis □ Pneumonia □ Cough
□ Coughing blood □ Phlegm production, what color? _____

GASTROINTESTINAL:

□ Nausea □ Vomiting □ Constipation □ Diarrhea □ Gas □ Belching □ Indigestion □ Bad breath
□ Acid reflux/GERD □ Excessive appetite □ Poor appetite □ Slow digestion □ Abdominal pain/cramps
□ Abdominal Bloating/edema □ IBS/Crohn's disease □ Colitis □ Chronic laxative use □ Hernia
□ Black stools □ Blood in stools □ Rectal pain □ Hemorrhoids

GENITO-URINARY:

□ Frequent Urination □ Urgency to urinate □ Urinary leakage □ Pain upon urination □ Blood in urine
□ Decrease in flow □ Kidney Stones □ Impotency □ Genital sores
Do you wake up at night to urinate? □ No □ Yes. If yes, how many times per/ night? _____

REPRODUCTIVE & GYNECOLOGIC (Female)

Are you Pregnant? □ Yes □ No
□ Number of Pregnancies: _____ Live Births:_____ Miscarriages: _____ Abortions: _____
□ Irregular periods □ Painful periods □ Clots □ Unusual character of blood (heavy, scanty)_____
□ Breast lumps □ Vaginal sores □ Vaginal discharge □ Vaginal dryness
□ Endometriosis □ Uterine fibroids □ Polycystic Ovarian disease
Do you practice birth control? □ Yes □ No If yes, what type?_____How long? _____

MUSCULOSKELETAL:

□ Neck pain □ Rotator cuff □ Shoulder pain □ Elbow pain □ Knee pain □ Foot/ankle pain
□ Bursitis □ Tendonitis □ Sprains/strains □ Muscle pain □ Muscle spasm □ Muscle weakness
□ Hand/wrist pain □ Carpal tunnel □ Hip pain □ Sciatica □ Back pain: □ Low □ Middle □ Upper

NEUROLOGICAL & PSYCHOLOGICAL:

□ Stress □ Anxiety □ Nervousness □ Depression □ Bad Temper □ ADD/ADHD □ Manic Depression
□ Loss of balance □ Dizziness or Vertigo □ Concussion □ Poor Memory □ Areas of Numbness
□ Poor Coordination □ Seizures
Have you ever been treated for emotional problems? □ Yes □ No
Have you ever considered or attempted suicide? □ Yes □ No

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

_____

_____