

**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? \_\_\_\_\_

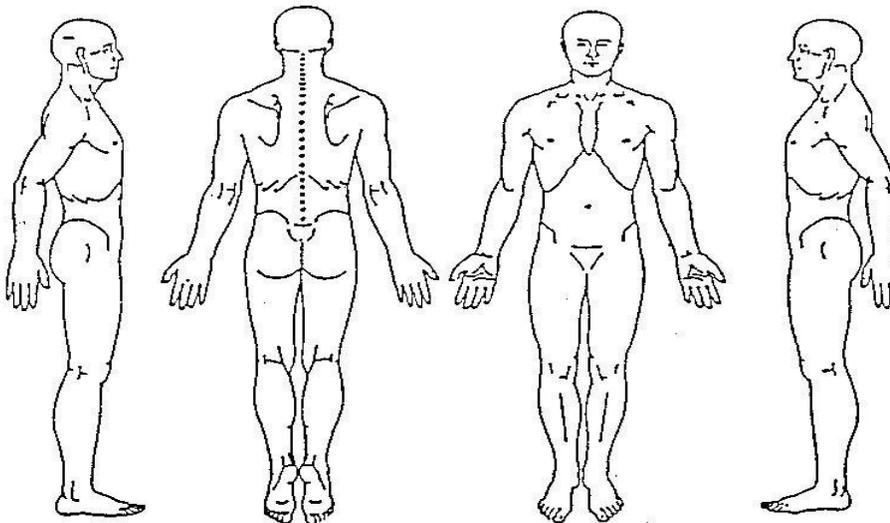
How many cups of caffeinated coffee, tea, or soda do you drink/day? \_\_\_\_\_

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.

\_\_\_\_\_

\_\_\_\_\_