



# origins

ACUPUNCTURE & WELLNESS

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Living with \_\_\_\_\_

Occupation \_\_\_\_\_ Location \_\_\_\_\_

Referred by \_\_\_\_\_

Reason for visit today \_\_\_\_\_

Other problems \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you ever experienced this before? \_\_\_\_\_

What seemed to be the initial cause? \_\_\_\_\_

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Have you ever been treated with acupuncture and/or Chinese herbal medicine for this condition?      Yes      No

Does it bother your    Sleep \_\_\_\_\_ Work \_\_\_\_\_ other (what?) \_\_\_\_\_

Medications (prescription, supplements and/or over the counter) you are currently taking:      For what condition?

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**Family Medical History-** please indicate if history applies to self, mother, father, sibling, and or children

- cancer or tumors-\_\_\_\_\_
- diabetes-\_\_\_\_\_
- blood or bleeding disorders/anemia-\_\_\_\_\_
- seizures-\_\_\_\_\_
- high blood pressure/heart disease-\_\_\_\_\_
- allergies-\_\_\_\_\_
- stroke-\_\_\_\_\_
- drug abuse-\_\_\_\_\_
- depression or mental illness-\_\_\_\_\_
- age of death-\_\_\_\_\_
- hepatitis-\_\_\_\_\_
- kidney disorders-\_\_\_\_\_
- thyroid disorders-\_\_\_\_\_
- musculo-skeletal disorder-\_\_\_\_\_
- blood transfusion (if before 1985)-\_\_\_\_\_

**MAJOR HOSPITALIZATIONS** If you have ever been hospitalized for any serious medical illness or operation, write the most recent one below: (do not include normal pregnancies).

### Personal Lifestyle Questionnaire

**Diet:** What might you eat on a typical day?

Do you crave any certain foods?

Any diet restrictions?

**Exercise:** **How often?**

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)

Cigarettes (packs) \_\_\_\_\_ Coffee/Tea (cups) \_\_\_\_\_ Alcohol (drinks per week) \_\_\_\_\_  
recreational drugs \_\_\_\_\_





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## Consent Form

### ACUPUNCTURE & WELLNESS

**Nature of Treatment:** Your treatment may include acupuncture, tui-na massage, moxibustion, cupping, electric or magnetic stimulation, acupressure, dermal friction (Gua Sha), infra-red (heat lamps), essential oil recommendations and/or application, Chinese herbs, therapeutic exercises and dietary counseling, cold laser therapy based on the fundamentals of Chinese medicine.

**Purpose of Treatment:** The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders.

**Benefit of Treatment:** Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treated by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, reproductive health issues, etc. We cannot guarantee the outcome of any course of treatment.

**Risks of Treatment:** Acupuncture and Oriental medicine have been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:

- Discomfort during and after the insertion of a needle
- “Needle sickness” (dizziness, fainting, nausea)
- Localized, minor bruising or swelling
- Minor burns with the use of Moxa
- Gastro-intestinal upset with the use of Chinese herbs (if this occurs, please consult with your practitioner so that your formula can be modified)
- Possible, temporary aggravation of symptoms that existed prior to treatment
- A broken needle (rare with the use of disposable needles)
- Bruising with use of cups

Please notify your practitioner if you have any adverse effect from treatment.

**Special Situations:** Some herbs and acupuncture points are contra-indicated during pregnancy. Please notify us if you might be pregnant. Additionally, please inform us if you have severe bleeding disorders or if you are wearing a pacemaker or other electronic medical device.

**Use of Disposable Needles:** To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your acupuncturist has had training in Clean Needle Technique and Universal Precautions.

I understand that all of my patient records as well as information I share with my acupuncturists will be kept confidential. No records or information will be released without my written consent.





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### Consent

I request and consent to the performance of acupuncture and this Oriental Medicine procedure. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I, hereby release Melissa Graf, L.Ac. and Megan Dettloff-Meyer, L.Ac. from any and all liability that may occur in connection with the above-mentioned procedures, except for failure to perform the procedures with appropriate medical care.

Client's name (Please print) \_\_\_\_\_ Date \_\_\_\_\_

Client's Signature \_\_\_\_\_

Practitioner's Name \_\_\_\_\_ Date \_\_\_\_\_

Practitioner's Signature \_\_\_\_\_

