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 before? Yes No

Does it bother your Sleep_____Work_____other (what?)_____

Melissa Graf, L.Ac. * 608-301-5799 /503-956-1363
1861 Bus Hwy 18/151
Mount Horeb, WI 53572

originsacupuncture@gmail.com
2007 Atwood Ave
Madison, WI 53704

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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).

YEAR OPERATION/ ILLNESS

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Consent Form

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 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.

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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.

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. 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 _____

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Personal Lifestyle Questionnaire

Diet: What might you eat on a typical day?
Breakfast:
Lunch:
Dinner:
Snacks:
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.)

MEDICINES:
Prescription drugs you are currently taking: For what condition?
_____ _____
_____ _____
_____ _____

Over-the-counter medication(s) you are currently taking: For what condition?

Vitamins/Supplements/Herbs:

(how much, how many, or how often)
Cigarettes (packs) _____Coffee/Tea (cups)_____Alcohol (drinks per week)_____
recreational drugs_____

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