West Acupuncture Clinic

57 Long Beach Blvd., Long Beach, CA 90802

Please take a few moments to fill out this questionnaire carefully. All answers will be held strictly confidential. If you have any questions, please ask us. Thank you.

Date:_____ Name:_____ Sex: M / F Age:_____

Address:_____ City:_____ Postal Code:_____

Cell Phone: (_____)_____ Home Phone: (_____)_____

Date of Birth: _____ Occupation:_____

Health Insurance: Yes ( ), No ( ) If Yes, What company? _____

Chief Complaint

Reason for visit: _____

Location of your pain:

☐Head ☐Shoulder ☐Mid Back ☐Leg ☐ Ankle/Foot ☐Wrist/Hand

☐Neck ☐Headaches ☐Low Back ☐Knee ☐Hips/Buttocks ☐Arm

Diagnosis from MD: _____

When did it start? _____

When are the symptoms worst? _____

When are the symptoms better? _____

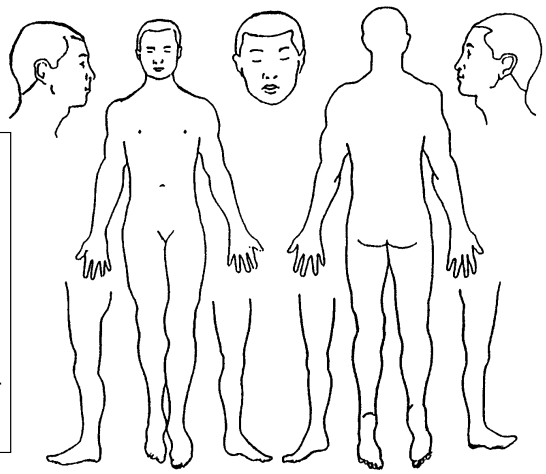
Does anything make it better? _____

_____

What makes it worse?_____

_____

Symbols	
Pain/pressure	X
Swelling	⌒
Tension	+
Weakness	–
Pulsing	*
Sore	O
Rashes	#
Spasm	→ ←
Temp. Cold	↓
Hot	↑



Have you tried other therapies for this condition? If so, what? _____

_____

Today's Pain Level is? 1 2 3 4 5 6 7 8 9 10 Blood Pressure:_____/_____ Height:_____

Weight:_____

Medical History

- ❑ Hospitalizations
- ❑ Pregnancy
- ❑ Allergies
- ❑ Dermatitis
- ❑ Heart Disease
- ❑ High / Low Blood Pressure
- ❑ Lung Disease
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Diabetes
- ❑ Cancer
- ❑ Hepatitis
- ❑ AIDS
- ❑ Thyroid Disease
- ❑ Seizure

West Acupuncture Clinic

57 Long Beach Blvd., Long Beach, CA 90802 Tel. 562. 436-8881

ARBITRATION AGREEMENT AND INFORMED CONSENT

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 at WEST ACUPUNCTURE CLINIC 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 at WEST ACUPUNCTURE CLINIC, including those working at the clinic or office or any other office or clinic whether signatories to this form or not.

I understand methods of treatments may include but are not limited to acupuncture, moxibustion, cupping, electric stimulation, Tui-Na (Oriental Massage), Oriental 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 in writing. The herbs may be 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental 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.

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

I understand the 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 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 form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature X **(Guardian)**	**Date**

Office Signature	**Date**