joysoma

...acupuncture...

# INFORMED CONSENT TO ACUPUNCTURE TREATMENT

Your first visit includes a comprehensive evaluation and formation of a comprehensive treatment plan. The treatment modalities performed may include, but are not limited to: acupuncture, electro stimulation, heat therapy/moxibustion, cupping, *gua sha*, abdominal massage, *Tuina* massage, traditional Chinese dietary therapy, lifestyle and behavior education, breathing techniques, exercise or other complementary therapies. I will immediately notify the practitioner of any unanticipated or unpleasant effects associated with treatment. _____ (Patient Initials here)

I understand that acupuncture is a generally safe method of treatment, however potential side effects may include bruising, numbness or tingling near the site of needle insertion, pain or discomfort at the site of needle insertion, dizziness, fainting, nausea, and the possible exacerbation of problematic symptoms existing prior to acupuncture treatment. Unusual risks include nerve damage and organ puncture. 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 or other heat therapies. I understand that while the major risks are described in this document that other possible side effects or risks may occur: _____ (Patient Initials here)

I understand the importance of providing a current and/or updated health history that includes notifying the licensed professional of any changes in the following: prescribed medications, over the counter medications, nutritional supplements, etc. that I might be taking or that have been prescribed to me: _____ (Patient Initials here)

It is my intention that this consent form functions to cover the entire course of treatment for any present and future condition(s) for which I may seek treatment from Joyce Kawalchuk, L.Ac. I acknowledge that no guarantee or assurance has been made to me regarding the acupuncture treatment that I have requested and authorized for myself. I have had full opportunity to discuss and ask questions regarding the treatment, and all questions have been answered to my satisfaction.

_____

Patient Printed Name

_____ _____

Patient Signature Date

## PRIVACY PRACTICES

I have received the Notice of Privacy Practices, and I have been provided an opportunity to review it.

_____

Patient Printed Name

_____ _____

Patient Signature Date

## FINANCIAL AGREEMENT

Full payment is due at the time of service. Cash, check, and all major credit cards are accepted. Joysoma Acupuncture does *not* accept insurance. If you have acupuncture coverage through your insurance policy, we would be happy to provide you with insurance receipts that can be submitted directly to your plan for reimbursement to you.

Please be advised that not all insurance companies cover a full course of acupuncture treatments and may have stipulations for the conditions covered. It is important to first call your insurance company to see if your policy covers acupuncture. In addition, deductibles, copayment, or other applicable fees may be involved depending on your insurance policy.

## CANCELLATIONS & RESCHEDULING

As a courtesy, please allow 48 hours notice for appointment changes or cancellations. *Cancellations or rescheduling within 24 hours of the appointment time are automatically charged the full appointment amount.*

Because we feel that proper patient care requires the full amount of time allotted for visits, patients arriving more than 10 minutes late may need to reschedule and will be charged the price of the visit. We will do our best to accommodate you, but the appointment is not guaranteed.

By signing below, I acknowledge that I have read and agree to the Financial Policy, Cancellation Policy, and Rescheduling Policy.

_____

Patient Printed Name

_____ _____

Patient Signature Date

**HEALTH HISTORY QUESTIONNAIRE**

*Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.*

**General Patient Information**

Name _____ Date_____

Address _____ City_____ State ____ Zip _____

Best contact phone (_____)_____ E-Mail _____

Date of Birth ___/___/___ Age____ Sex ☐F ☐M ☐Other Height ___'___" Weight _____lbs.

Emergency Contact & Phone _____

Occupation _____ Employer _____

Primary Care Physician _____Phone _____Date last seen_____

How did you hear about Joysoma Acupuncture?_____

**Patient Health Information**

What is the primary reason for your visit today? _____

How long has this been a problem? _____

What other treatments have you tried to address this concern_____

Please list any other health concerns you would like to address during your visit:

1._____ 2. _____ 3. _____

Please list (with approx. dates) any serious illnesses, injuries, hospitalizations, or current medical diagnoses: _____

_____

Please list any medications or supplements you are currently taking:

_____

_____

Please list any allergies (drugs, chemicals, food):

_____

**Family Medical History**

*Please indicate any history of illness in your family below. If deceased, please indicate cause of death:*

Mother_____ Grandmother_____
Father_____ Grandfather_____
Siblings_____ Children_____
Spouse_____

## OVERALL REVIEW OF SYSTEMS

Please check all that apply:

SKIN
___Rash
___Hives
___Psoriasis
___Eczema
___Dry
___Change in Pigmentation
___Lumps
___Itchy
___Warts
___Moles
___Excessive Perspiration
___Lack of Perspiration

EARS
___Impaired Hearing
___Ear Ringing
___Earaches
___Ear Infections

RESPIRATORY
___Persistent Cough
___Phlegm
___Shortness of breath
___Wheezing
___Pneumonia
___Asthma
___Dry throat
___Frequent Common Colds
___Frequent Sore Throat
___Difficulty Breathing
___Painful Breathing
___Emphysema
___Pleurisy
___Tuberculosis

HEAD
___Headaches
___Migraine
___Head injury
___Dandruff
___Oily/Dry hair
___Hair loss
___Teeth grinding
___TMJ Disorder

CARDIOVASCULAR
___Pacemaker
___Heart Disease
___Heart Attack
___High Blood Pressure
___Low Blood Pressure
___Chest Pain
___Arrythmias
___Rheumatic Fever
___Murmurs
___Palpitations
___Stroke
___Varicose Veins
___Edema

GASTROINTESTINAL
___Bloating
___High Appetite
___Low Appetite
___Nausea/ Vomiting
___Abdominal Pain
___Heartburn
___Belching
___Frequent Hiccups
___Gall Bladder Disease
___Gall Bladder Stones
___Hemorrhoids
___Indigestion
___Constipation
___Diarrhea
___Ulcers

NOSE
___Sinus Problems
___Polyps
___Nose Bleeds
___Dry Nose
___Seasonal Allergies
_____
___Nasal Discharge
(Color: _____)

ENDOCRINE
___Hypothyroid
___Hyperthyroid
___Hypoglycemia
___Diabetes Type I
___Diabetes Type II
___Night Sweats
___Unusual Sweating
___Feeling hot or cold

GENITOURINARY
___Urgency
___Frequent Urination
___Kidney Disease
___Kidney Stones
___Painful Urination
___Frequent UTI
___Blood/Discharge
___Incontinence
___Strong Odor
___Cloudy Urine

Energy & Immunity
___Fatigue
___Slow Wound Healing
___Easy Bruising
___Chronic Infections
___Frequent Allergies
___Food Allergies

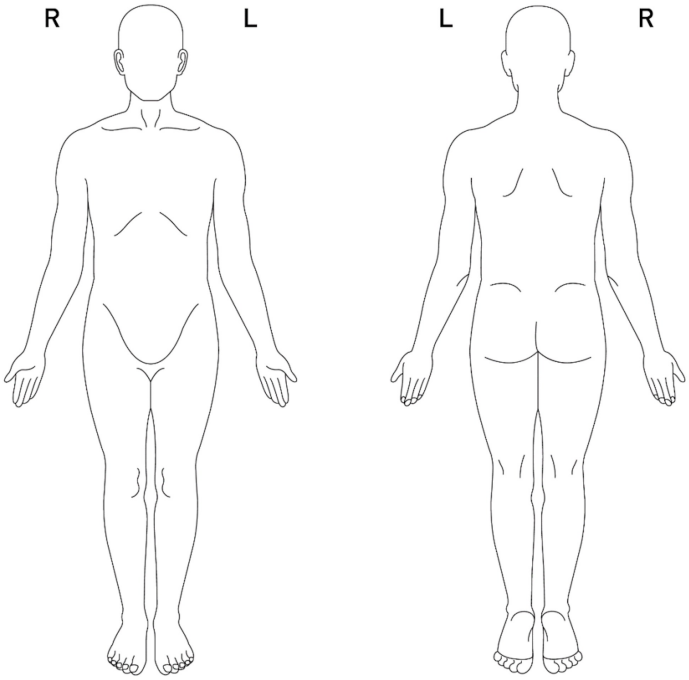
EYES
___Dry/Tearing
___Impaired vision
___Glaucoma
___Pain/Strain
___Itchy
___Glasses/ Contacts
___Styes
___Cataracts

MUSCULO-SKELETAL
___Weakness
___Stiffness
___Tremors
___Muscle Spasm/ Cramps
___Osteoporosis
___Arthritis
___Joint Pain

NEUROLOGICAL
___Vertigo/ Dizziness
___Paralysis
___Numbness/ Tingling
___Loss of Balance
___Seizures/ Epilepsy
___Poor Memory
___Diagnosed Sciatica
___Fainting

EMOTIONAL/MENTAL
___Anxious feelings
___Anger/ Irritable
___Fear
___Panic Attacks
___Grief / Sadness
___Lack of Joy / Mania
___Worry/ Overthinking
___Depressive feelings
___Poor memory/ concentration
___ADD or ADHD
___Alzheimer's
___Dementia
___Suicidal
___Eating disorder

**Patient Profile**
Please clearly mark any areas of pain AND any scars:




Please rate the pain on a scale of 1-10 (10 being the most): _____
Does the following lessen the pain? ☐ Pressure/Massage ☐ Cold ☐ Heat ☐ Exercise
☐ Other: _____
Does the following worsen the pain? ☐ Pressure/Massage ☐ Cold ☐ Heat ☐ Exercise
☐ Other: _____
Is the pain:
☐ Sharp ☐ Burning ☐ Aching ☐ Cramping ☐ Dull ☐ Moving ☐ Fixed ☐ Other: _____

**Review of Systems**
Any recent significant weight loss/ gain?_____
Do you have any infectious diseases? ☐ yes ☐ no If yes, please list:_____
Do you have a history of addiction or substance abuse? ☐ yes ☐ no
If yes, please explain:_____

**Men's Health**
___Testicular Pain/Swelling ___Hernia
___Discharge ___Impotency
___Prostate Disease ___Feeling of coldness or numbness in external genitalia

**Women's Health**
Age Period Began_____
Are you still having regular monthly menstrual periods? ☐ yes ☐ no
If no, when and why did it stop?_____
Are you currently pregnant or nursing? ☐ yes ☐ no
If pregnant, when is the expected due date?_____

Number of days between periods?_____ Number of days period lasts? _____

**Women's Health Cont.**

Do you experience any of the following?

___Menopausal Symptoms ___Dry vagina
___Recurring yeast infections ___Recurring UTI's
___Pain w/ intercourse ___Heavy menstrual bleeding
___Clotting ___Menstrual Pain
___Food cravings ___Irregular Cycles
___Breast lumps/ tenderness ___Nipple discharge
___Vaginal discharge ___Bleeding between cycles
___Breakouts, if so, where?_____

Number of Pregnancies _____ Number of Miscarriages_____ Number of Abortions_____
Date of last Pap Smear_____ Any abnormal Paps (date & diagnosis)?_____
Are you currently on any kind of hormone therapy? If so, please list name and how long you've been taking them_____

**Exercise & Diet**

How often do you exercise?_____What type of exercise?_____
For how long?_____
Do you typically eat at least 3 meals a day? ☐ yes ☐ no
If no, how many?_____
Describe your food intake on an average day, along with any dietary restrictions:_____
_____
_____

**Sleep**

How many hours per night?_____
If you wake up frequently, what is the reason?_____
Do you experience any of the following?

___Nightmares ___Grinding teeth during sleep
___Vivid dreaming ___Difficulty falling asleep
___Sleep Walking ___Difficulty staying asleep
___Wake often/easily ___Snoring

**Lifestyle**

Hours worked per week?_____ Do you enjoy work? Why or why not?_____
Highest level of education:_____ Hobbies:_____
What is your greatest health concern?_____
How does it limit you the most?_____

How committed are you towards making valuable changes in regards to your health?
Little Moderate Very

Other Comments:_____
_____

Patient Signature:_____ Date_____

Acupuncturist Signature:_____ Date_____