# Consent to Treatment

I, (print full name)_____, voluntarily consent to be treated with acupuncture. I understand that the acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by the application of heat, or by some combination of the foregoing, at certain points on my body, and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I accept that no guarantee is made concerning the results of my acupuncture treatment, and I have been informed that I may stop treatment at any time.

# Release of Information

I (initial)_____consent to the use and disclosure of my protected health information for treatment, payment, clinic operations. Also, I have given my written consent that my health information be shared with the people, their addresses and/or contact numbers on the "Client Contact Information" form. I understand that I have the right to revoke this consent, in writing, at any time. However, the revocation will not affect any disclosures made in reliance of my prior consent.

## NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

I (initial)_____acknowledge that I have received a copy of the "Notice of Privacy Practices and Patient's Rights" and that I have had the opportunity to ask questions about it. All questions I have asked have been fully answered.

**Please sign and date below pertaining to above: "**Consent to Treatment", "Release of Information", and "Notice of Privacy Practices and Patient Rights".

_____ _____

**Patient's Signature** **Date Signed**

_____ _____

**Guardian's Signature** **Date Signed**

# Client Contact Information

**Patient's Name** (please print) _____

**1. Patient's Home Address**:_____

**2. Patient's Mailing Address (if different from home address)**:

_____

**3. Must correspondence from this office be sent in a sealed envelope marked "confidential"**: Yes ◯ No ◯

**4**. **Please print numbers that can be called for appointment, health matters**

Home _____ Office_____ Cell_____

**5. Can this office leave telephone voice-mail messages concerning scheduling?**
Yes ◯ No ◯

**6. Can Country Well email to you related services and seminars sponsored by us?**
Yes ◯ No ◯

**8. Your email address** _____

**9. Please list the persons with whom we may inform about your health condition and your treatment including family, physicians, friends:**

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

**Patient's Signature _____ Date_____**

In the Case of a Minor

**Legal Guardian's Name (print)_____**

**Legal Guardian's Signature_____DATE_____**

# CLINIC POLICIES

**Payment of Services**: Payment for acupuncture or qigong treatment is due at the time rendered. Cash and personal checks are accepted to: Robin Bonazzoli or Country Well Acupuncture. **Insurance is not accepted at this time.**

**Cancellation of Appointments**: Except for in cases of illness, acts of nature, and other emergencies, the cancellation of a clinic appointment less than 24 hours prior to the scheduled visit will be charged at the full rate.

**Acknowledgment**: **I understand and accept the terms of "Payment of Services", "Cancellation of Appointment" as stated above.**

**1. Patient's Name (please print): _____**

**2. Signature of Patient _____ Date _____**

**(In the case of a minor)**

**1. Patient's Name (please print)_____**

**2. Legal Guardian's Name (please print)_____**

**4. Legal Guardian's Signature _____ Date_____**

**5. Legal Guardian's address_____ Phone_____**

**Country Well Healing Clinic**

# Patient Health History

## Your Personal Information

**Name:** _____ **Date of First Treatment** _____
**Address:** _____
**Phone** (Please indicated number to call first for appointment changes):
Work: _____ Cell: _____ Home: _____
**Email Address:** _____
**Date of Birth:** _____ **Place of Birth:** _____
**Marital Status:** _____
**Please describe living situation** (i.e. living with husband Dave and daughter: Nicole 8)
_____
**Occupation** (if retired, please describe prior work): _____

**How did you find Country Well Acupuncture?**
Referral ____ Yellow Pages _____ Web search_____ Newspaper Ad_____ Other_____
**Have you tried acupuncture or qigong therapy before?** (And if so, length of treatment and your experience):

---

## Your Main Reason for Seeking Treatment:

****What is your main reason for seeking treatment?**
_____
When did you first notice symptoms? Has your condition been diagnosed by a physician?
_____
List medical testing done toward above diagnosis (i.e. MRI, X-Ray, psychological testing):
_____
Describe medical treatment thus far ( i.e. physical therapy, drugs, surgery, diet/nutrition, psychotherapy, chiropractic), noting if you are still using a treatment:
_____
Describe alternative medical therapies tried for main problem noting results and if you are still using a particular therapy:
_____
How has your condition/symptoms changed since its onset?
_____
Does your condition adversely affect daily life?
_____
Describe anything that worsens your condition (i.e. heat, cold, massage, exercise, weather changes, stress, lack of sleep, diet/foods):
_____
Describe anything that improves your condition (i.e. heat, cold, massage, meditation, exercise, rest, diet/foods):

---

## Your Doctor's Diagnoses: From Childhood to Present

****Circle** symptom within the past 2 years**, Check and date** notable conditions from your past

| | | |
|---|---|---|
| Addiction | AIDS | Allergies |
| Anemia | Anxiety | Arthritis |
| Asthma | Attention Deficit Disorder | ADHD |
| Bipolar Syndrome | Birth Trauma | Broken Bones |
| Bronchitis | Cancer | Chemical Sensitivity or Toxicity |
| Chronic Fatigue | COPD | Crohn's Disease |
| Depression | Diabetes | Eating Disorder |
| Endometriosis | Epstein Barr Virus | Fibromyalgia |
| Headaches | Heart/Vascular Disease | Hepatitis |
| Hemorrhoids | Hernia | High Blood Pressure |
| Hypoglycemia | Hyperactivity | Infertility |
| Irritable Bowel Syndrome | Kidney Disease | Lyme's Disease |
| Migraine Headaches | Muscle tear | Miscarriage |
| Neuralgia | Osteoporosis (-penia) | Panic Disorder |
| Parkinson's Disease | Pneumonia | Polio |
| Postpartum Depression | Post Traumatic Stress Disorder | Premenstrual syndrome |
| Prostate inflammation | Prostatitis | Repetitive stress injury |
| Rheumatic Fever | Seizures | Sexually transmitted disease |
| Skin Condition (specify) | Sinus infection | Sleep disorder (specify) |
| Strep Throat | Stroke | Tendon or ligament tear |
| Thyroid Disease | Tropical Disease | Tuberculosis |
| Tumor (benign) | Ulcers | ***Other (specify)** |

## Family Medical History

*__Indicate__ family member

Allergies Asthma

Cancer Heart Disease

High Blood Pressure Mental or Emotional Condition (specify)

Stroke Other

***Are your parents still living**?

## Surgeries, Traumas

* **Include** date/age

Surgeries_____

Accidents_____Shock/Emotional Trauma_____

## Occupational Stress

How many hours do you usually work/week? _____ # of days vacation/year? _____

Describe any physical or psychological stress at your work? _____

Have you ever been subjected to chemical toxins at work? _____

## Sleep

How is your sleep? Do you wake up feeling rested?

What time do you go to bed? How many hours do you typically sleep?

**Please check if any of the following apply:

Difficulty falling asleep____ Light sleeper _____ Sleep walking _____
Heavy dreaming ____ Nightmares ____ Waking mid-sleep cycle _____
Hypersomnia ____

## Your Diet

*Please describe a typical meal:

Breakfast Lunch

Snack(s) Dinner

Do you feel that you over or under eat? How does stress affect this?

Do you crave particular food(s) or flavors? Do you skip meals?

Do you eat breakfast regularly? How late do you eat/have dinner?

What beverages do you typically consume/day? How much water do you drink?

Do you eat junk food? Please describe:

How much caffeine do you consume/day (in oz.) of coffee, teas, sodas or chocolate?

Do you smoke? If so, how much do you smoke/day?

Do you drink alcohol? If so, kind and quantity/day?

## Exercise

What do you do to stay physically fit?_____

If you are not presently exercising regularly, when was the last time you consistently exercised? _____

Do you easily feel winded? _____

Are you as flexible and coordinated as you would like to be for your age? _____

## General Health

**Circle** if condition is within the last 2 years, **Check and date** if a past concern

Tendency to feel hot _____
Tendency to feel cold _____
Always thirsty _____
Rarely thirsty? _____
Bleeding or bruising _____
Weight gain _____
Weight loss _____
Fluctuating weight_____
Hair loss _____
Exhaustion _____
Feverish over-activity _____

Have you taken antibiotics over a long period of time? Specify:

_____

Have you taken steroids over an extended period of time (i.e. steroid inhaler, predinosone, sports?

_____

## Respiratory System

*Do you feel that you easily susceptible to respiratory illness? _____

****Circle** conditions within the last 2 years, **Check and date** notable past conditions:

Asthma_____
Allergies_____
Sinus infections_____
Cough_____
Coughing up blood_____
COPD_____
Nose bleeds_____
Bronchitis_____
Pneumonia_____
Strep Throat_____
Recurrent sore throats _____
Sinus infections_____
Sinus headaches_____
Excessive phlegm_____
Postnasal drip _____
Dry nose or throat _____
Difficulty inhaling _____
Pain with inhalation _____
Difficulty exhaling _____
Pain with exhalation _____
Respiratory Flu _____

_____

## Skin

Do you feel that you are easily susceptible to skin conditions? _____

****Circle** conditions within last 2 years, **Check and date** notable past conditions:

Itching _____
Eczema _____
Hives_____
Skin Ulcerations_____
Rashes_____
Moles_____
Skin Pain_____
Dandruff_____
Oily skin____
Dry skin _____
Sweating _____
Scanty sweating _____
Night sweats _____
Dry fever at night _____
Body odor _____
Easily chilled _____
Skin infection _____
Sunburn _____

_____

## Cardiovascular

**Circle** conditions within last 2 years, **Check and date** notable past conditions:

High blood pressure _____
Left shoulder/arm pain _____
Fainting _____
Swelling of feet _____
Phlebitis _____
Low blood pressure_____
Irregular heartbeat _____
Blood clots _____
Cold hands _____
Palpitations _____
Chest pains _____
Dizziness _____
Swelling of hands _____
Cold feet _____
*Other _____

## Upper Digestion

Are you tired or energized after eating a normal meal? _____

List any foods you feel bother your upper abdominal digestive organs: _____

**Circle** condition within the last 2 years, **check and date** notable past conditions

Nausea _____
Belching
Heartburn _____
Sluggish digestion _____
Poor appetite/lack of hunger _____
Fixed pain/cramps upper abdomen_____
Stomach Flus _____
Vomiting _____
Bad breath _____
Acid reflux _____
Lack of taste_____
Indigestion _____
Gall stones _____
Blood in stools (red) _____
Difficulty deciding what to eat _____
Migrating pain upper abdomen/sides_____

## Intestines/Lower Digestion

Frequency of bowel movement? _____ Are your stools often hard, dry, soft or watery? _____

Do you take a stool softener? _____ Do you take a fiber supplement? _____

List any foods you feel bother your lower abdominal digestive organs: _____

****Circle** symptoms within the last 2 years, **check and date** notable past conditions:

Black stools _____
Lower abdominal fixed pain/cramps _____
Rectal pain_____
Diarrhea_____
Chronic laxative use _____
Worms _____
Lower digestive Flus _____
Passing gas (mild or strong odor?) _____
Lower abdominal migrating pain _____
Hemorrhoids_____
Constipation_____
Irregularity _____
Bacterial Bowel infection _____
Undigested food in stools
*Other _____

## Head and Face

***Do you experience migraine or other headaches?** Describe age of onset, frequency, duration, location, circumstance of arising, mood, and notate if accompanied by nausea or vomiting.

_____

**Check if any of the following conditions apply to you:

Bell's Palsy_____
Dizziness_____
Jaw pain_____
Jaw clicks_____
Other head and face _____
Other Stroke of Head or Face_____
Concussion_____
Jaw Clenching_____
Teeth Grinding_____

## Teeth, Gums, Mouth

How often do you brush your teeth?_____ Do you use an electric toothbrush?_____

*Please indicate with a check if you have experienced any of the following:

Teeth Grinding_____
Broken teeth_____
Root Canals
False Teeth_____
Sores on lips_____
Other teeth, gums, mouth (describe) _____
Cavities_____
Soft teeth_____
Tooth Implants_____
Gum disease_____
Sores on tongue or in mouth_____

## Eyes

Do you wear glasses (since when? For reading or distance?)_____

Please check any of the following symptoms that apply, indicating which eye:

Spots in front of eyes____
Eyes strain____
Color blindness____
Macular Degeneration_____
Watery Eyes_____
Visual acuity fluctuations____
Eye pain____
Cataract(s)____
Dry eyes_____
Eye Infections_____
Blurred vision____
Poor night vision____
Glaucoma_____
Itchy eyes_____
*Other (specify)_____

## Ears

****Circle** conditions within the last 2 years, **Check and date** significant past conditions

Earaches _____ Ringing in ears _____ Ear infections _____
Itchy ears Damp ears _____ Diminished hearing ___
Other ear conditions (describe) _____

## Urinary Bladder and Kidney

How often do you urinate/day? _____ Do you wake nightly to urinate (#of times)? _____

What color is your urine upon waking? _____

***Circle** conditions within last 2 years, **Check and date** significant past conditions

Pain on urination _____ Frequent urination _____ Blood in urine _____
Cloudy urine _____ Urgency to urinate _____ Unable to hold urine _____
Decreased urine flow _____ Bladder infection(s)_____ * Other Urinary Bladder _____
Kidney stones _____ Kidney Disease _____ *Other Kidney _____

## Musculoskeletal: Pain, Numbness or Weakness

***Circle** conditions within the last 2 years, **Check and date** significant past conditions.

* **Indicate if injury** Describe condition as ***pain, numbness or weakness**

*Is Condition concentrated in the **flesh, muscle body, joint or bone?**

Head/Skull _____ Face _____
Jaw _____ Neck _____
Shoulders_____ Back _____
Hip _____ Leg _____
wrist_____ knee _____
Arm _____ ankle _____
Hand _____ foot _____
Chest _____ Groin _____
Side of Torso _____ Other _____

## Concentration

**Check any of the following that pertain to you at present:

| | | |
|---|---|---|
| Poor concentration____ | Poor long term memory ____ | Poor short term memory ____ |
| Block in creativity ____ | Excessive thinking ____ | Difficulty finishing projects ____ |
| Difficulty planning _____ | Difficulty making decisions ____ | Difficulty prioritizing ____ |

## Neuropsychological

Have you ever been in counseling with a psychotherapist or social worker?

_____

Have you ever been diagnosed with a mental or emotional condition? If so, what was the diagnosis? How were you treated?

_____

Have you ever seriously considered or attempted suicide? Explain:

_____

**Please check if any of the below apply to you:

| | | |
|---|---|---|
| Tremors ____ | Seizures ____ | Dizziness ____ |
| Lack of coordination ___ | Areas of numbness ___ | Concussion ____ |

*Other neurological or psychological issues (specify)

## Emotional

**Check if any of the following emotional states predominate in your personality/life at present:

| | | |
|---|---|---|
| Anxiety _____ | Bad temper _____ | Depression _____ |
| Unresolved grief _____ | Lack of joy _____ | Excessive Worry _____ |
| Excessive jealousy _____ | Boredom _____ | Fearfulness _____ |
| Lack of inspiration _____ | Pessimism _____ | Excitability _____ |
| Lack of self esteem ____ | Heartbroken _____ | Critical of self and others _____ |
| Excessive risk-taking ____ | Feelings of guilt _____ | Other _____ |

## Free Time/Relaxation

How do you spend your free time?

_____

Is it easy for you to relax? What do you do to promote relaxation?

## Male Reproductive

Please check if any of the following apply to you and describe where necessary:

Erectile dysfunction _____ Low sex drive_____ Sores on genitals _____
Penile discharge _____ Pain of genitalia _____ Sexually transmitted disease _____
Prostate condition _____ Vasectomy _____
Other genital or sexually related symptoms _____

## All Women: Reproductive and Gynecologic

**Please fill in the following as pertains to you:

Age of first menses _____ Age at menopause (indicate if hysterectomy) _____

Indicate birth control methods used now and in past _____

Indicated number of: Pregnancies ____ Miscarriages _____ Abortions _____

****Circle** conditions present in last 2 years, **Check and date** significant past conditions:

Fibroids ____ Endometriosis _____
Sexually transmitted disease_____ Vaginal dryness _____
Vaginal yeast infections _____ Vaginal discharge (color and smell?)_____
Pain with intercourse _____ Lack of interest in sex _____
Hot Flashes _____ Night sweats _____
Dry Fever _____ Uterine prolapse
Other, please describe _____

## For Menstruating Women Only

*Please indicate:

# of days menstruating _____ Time between cycles _____

****Circle** conditions within the last 2 years, **Check and date** significant past conditions:

Menstrual clots _____ Thin, bright red blood _____ Thick brownish blood ____
Pre-menses breast tenderness ___ Pre-menses bloating ___ Pre-menses mood changes___
Pre-menses cramping ____ Pre-menses exhaustion ___ Painful menses ___
Irregular menses ____ Heavy menstrual flow ____ Scanty menstrual flow ____
Bleeding mid-cycle ___ Exhaustion after menses _____
*Other (describe _____

## Medications

**List medications, herbs, vitamins and supplements **presently taking**:

| Condition | Medication/herb/supplements | Since when |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

List medications, herbs, vitamins and supplements taken **in the past:**

| Condition | Medication/herb/supplements | Since when |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |