Universal Family Wellness Clinic

Acupuncture & Chinese Herbal Medicine 4209 Santa Monica Blvd. Suite 100. LA, CA 90029 universalfamilyclinic.com p: 323.617.5027 f: 323.430.8791

Name:_____ **Appointment Date:**_____ **Time:**_____

Age:_____ **Date of Brith:** ____/____/____ **Gender:**_____ **Preferred Pronoun:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Telephone: _____ **Email Address:**_____

Referral Source:_____ **Occupation:**_____

Emergency Contact (if under 18 years old, name of legal guardian & relationship): _____ **Phone:**_____

Please briefly list your health concerns:

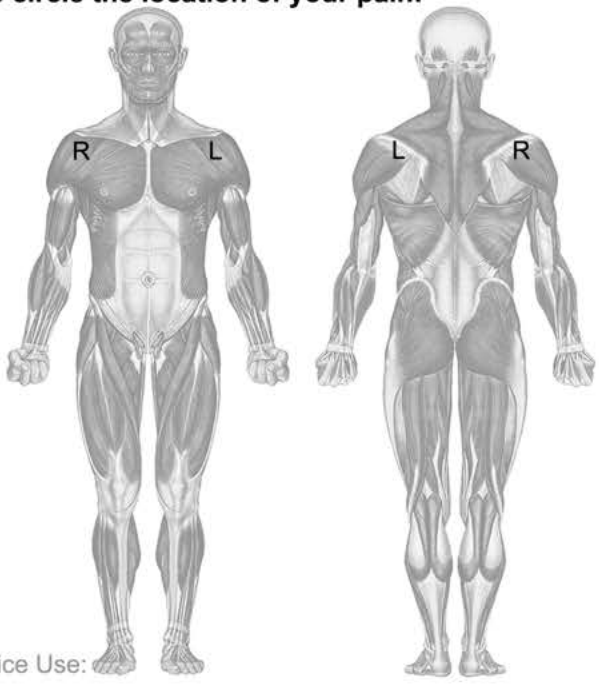
1._____

2._____

3._____

4._____

Please circle the location of your pain:



For Office Use:

Tongue: _____

Pluse: _____

TCM Dx: _____

Points: _____

_____

Diet & Lifestyle

How much water do you drink each day? ____ (oz)

If you drink coffee, how much? ____ (cups/ day)

If you drink alcohol, how much? ____ (drinks/ week)

Are there any foods you do not eat? If so please list them:

_____

Do you drink soda or energy drinks? yes:____ no:____

Do you eat fast food? yes:____ no:____

Do you smoke cigarettes? yes:____ no:____

Medical History & Medicines

Major illnesses:_____

Surgeries:_____

Significant Traumas:_____

List any infectious diseases:_____

Current prescriptions (& length of use):_____

_____

Current supplements:_____

Allergies/ sensitivities:_____

Have you traveled internationally in the past 6 months? yes:____ no:____ If yes, where? _____

Have you had a fever in the past 30 days? yes:____ no:____ Are you pregnant? yes:____ no:____

Family Medical History

Mother:_____

Father:_____

Siblings:_____

Grandparents:_____

Cousins:_____

Aunts/ Uncles:_____

Symptom Checklist

__ frequent or severe headaches
__ neck pain
__ neck lumps or swelling
__ loss of balance
__ dizzy spells
__ blackouts/fainting
__ blurry vision
__ eyesight worsening
__ see double
__ see halos or lights
__ eye pain or itching
__ watering eyes

__ hearing difficulties
__ earaches
__ discharge from ears
__ noises in ears

__ dental problems
__ sore or bleeding gums
__ sore tongue
__ tongue coating

__ wheezing or gasping
__ frequent coughing
__ cough up phlegm
__ cough up blood
__ chest colds
__ rhinitis, sinusitis, or sneezing
__ sore throat
__ swollen glands

__ rapid or skipped heartbeats
__ chest pains
__ shortness of breath
__ swollen feet or ankles
__ poor circulation

__ bad breath
__ stomach pain after eating
__ heartburn
__ antacids help
__ sugar cravings
__ fatigue after eating
__ increased thirst & appetite
__ salt cravings

__ recurring indigestion
__ frequent belching
__ nausea
__ vomiting
__ pain in abdomen
__ bloated abdomen
__ foul smelling gas
__ odorless gas
__ gas after eating

__ constipation
__ hard dry or small stool
__ loose bowels
__ diarrhea
__ not feeling empty after BM
__ undigested food in stool
__ alternating constipation diarrhea
__ pain relieved by gas or BM
__ black stools
__ grey or whitish stools
__ pain in rectum
__ itching rectum
__ blood in stool

__ frequent urination
__ involuntary escape of urine
__ burning on urination
__ brown black or bloody urine
__ weak urine stream
__ difficulty starting urine
__ constant urge to urinate

__ aching muscles or joints
__ swollen joints
__ back or shoulder pains
__ weakness in arms or legs
__ painful feet
__ trembling
__ numbness
__ leg cramps
__ joint pain worse w/weather
__ better w/heat
__ better w/cold

__ skin problems
__ scalp problems
__ itching or burning skin
__ bruise easily
__ acne

__ nervousness or anxiety
__ difficulty making decisions
__ lack of concentration
__ absentminded/loss of memory
__ lonely or depressed
__ frequent crying
__ hopeless outlook
__ difficulty relaxing
__ worrying a lot
__ frightening dreams or thoughts
__ feeling of desperation
__ angered easily
__ high stress at home
__ high stress at work
__ decrease in libido or sex function
__ considered suicide
__ sought psychiatric help

__ loss or gain in weight
__ feel warmer or colder than others
__ loss of appetite
__ always hungry
__ swelling in armpits or groin
__ unusual fatigue or weakness
__ difficulty sleeping
__ fever or chills
__ excessive sweating
__ night sweats
__ hot flashes
__ cannot stay asleep
__ insomnia
__ sweat easily

__ genital burning, discharge, or pain
__ lumps or swelling on testicles

__ age of first period
__ duration of period (days)
__ date of last period
__ # of pregnancies
__ # of births
__ missed period
__ menstrual problems
__ bleeding/spotting between periods
__ tension or pain before periods
__ heavy bleeding
__ clots
__ bearing down feeling
__ vaginal discharge
__ genital irritation
__ yeast infection
__ PMS
__ pain w/intercourse
__ swelling or lumps in breasts
__ painful breasts
__ scanty blood flow
__ alternating cycle lengths
__ facial hair growth
__ hair loss/thinning
__ menopause

Please use this section to further describe your health concerns.

1. _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

What other treatment have you tried? _____

Other important details: _____

_____

_____

_____

Notes (For Office Use): _____

_____

_____

_____

_____

2. _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

What other treatment have you tried? _____

Other important details: _____

_____

_____

_____

Notes (For Office Use): _____

_____

_____

_____

3._____

_____

_____

_____

4._____

_____

_____

_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 indicated below 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 named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese massage), Chinese 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 and 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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.

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 Chinese 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 clinical 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 had 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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)