



Wang's Acupuncture & Herbal Clinic

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Patient Name: _____ Age: _____ Birth Date: ___/___/___ Gender: M/F

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

Telephone: (H) _____ (W) _____ (C) _____

Email Address: _____ Occupation: _____

Welcome to Wang's Acupuncture & Herbal Clinic! We are glad you have chosen us to help serve your healthcare needs. For your information, we use disposable sterile acupuncture needles, which are disposed of following OSHA guidelines for biochemical waste. We are state licensed doctors of Oriental Medicine, licensed acupuncturists, and national board-certified Licensed Acupuncturists & Chinese Herbologists. Thank you again for choosing our clinic.

Consent for Treatment

I, the undersigned, freely consent to treatment at *Wang's Acupuncture & Herbal Clinic* by national certified and state licensed doctors of Oriental Medicine/acupuncturists. I understand that treatment may include the use of acupuncture needles, electrical acupuncture, TDP lamps, cupping, Chinese herb medicine (raw, granules and patent forms, etc.), acupressure, psychological advice, Chinese massage (Tui Na), Chinese food therapy, and Chinese fitness and nutritional counseling.

I fully understand that the risks of treatment, although very limited, could include the following: slight burns from a mineral heat lamp, slight bruising from cupping and needles, herbal side effects, or allergic reactions. (Some herbs and certain acupuncture points should not be used with pregnant females.) If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I accept that *Wang's Acupuncture & Herbal Clinic* cannot be held liable for any intentional misrepresentations by myself. I state that I have read the "*Consent for Treatment*" form in its entirety and understand and accept the risks involved in treatment.

Patient Signature: _____ Date: _____

Please complete the next two pages of this form.

New Patient Intake Form

Name: _____ Marital Status: M S W D Height: _____ Weight: _____

Your family Physician/health care provider: _____ Phone: _____

Insurance Co. _____ Policy # _____

Address: City, State, Zip _____

Phone: _____ Who referred you to us? _____

In an emergency notify: Name: _____

Phone: _____ Relationship to you _____

Main conditions you would like us to help you with? _____

How long have you had this problem? _____ Caused by _____

Have you been given a diagnosis for this problem? If so, what is it? _____

What kinds of treatment have you tried for the problem?: _____

_____ How long? _____

Effectiveness: _____

Past Medical History:

Illness: _____

Surgeries: _____

Significant Trauma (e.g. Motor Vehicle Accidents, Sports Injury, etc.): _____

Do you have or have you ever had any infectious diseases? Yes/No. If yes, please describe: _____

Medicines: (Include prescriptions, over-the-counter drugs, vitamins, herbs, etc. taken within the last 3 months) _____

Allergies: _____

Family Medical History (General Health):

Are there any hereditary diseases in your family? Yes/No. If yes, please describe: _____

Signature: _____ Date: _____

Personal Medical History

Significant Illnesses

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Weight Problem | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Addictive Disorders | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | |

Please check if you have experienced any of the following in the last 3 months.

General

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Sweat Easily |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Night Sweats |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Chills | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Emotional Changes |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Bruising Easily |

Skin & Hair

- | | | | |
|---------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Itching | <input type="checkbox"/> Change in Skin Texture | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Change in Hair Texture | <input type="checkbox"/> Hives | <input type="checkbox"/> Psoriasis |

ENT + Head & Eyes (HEENT)

- | | | | | |
|--|---|---------------------------------------|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Migraine | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Glasses | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Sores on Lips |
| <input type="checkbox"/> Gum Problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Teeth Grinding | <input type="checkbox"/> Sores on Lips |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Floaters | <input type="checkbox"/> Mouth Ulcers |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Concussion | <input type="checkbox"/> Spots in front of Eyes | |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Jaw Click | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Toothache |

Respiratory:

- | | | | | |
|-----------------------------------|---|---------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Painful Breathing |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily Winded | |

Cardiovascular

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Difficult Breathing |

Gastrointestinal

- | | | | |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Bloating | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Black Stools | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Gastric Ulcers |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Parasites | <input type="checkbox"/> Intestinal Gas | |

Genito/Urinary

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Scanty Urination | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Impotence | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Frequent Night Urination |
| <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Discolored Urine | |

Gynecology & Pregnancy (females only)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Irregular period | <input type="checkbox"/> Duration of Flow _____ | <input type="checkbox"/> # of Pregnancies _____ | <input type="checkbox"/> Difficult Births _____ |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> # of Births _____ | <input type="checkbox"/> Fertility Problems |
| <input type="checkbox"/> Light Flow | <input type="checkbox"/> Age of First Menses _____ | <input type="checkbox"/> # of Miscarriages _____ | <input type="checkbox"/> Breast Lumps |
| <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Date of Last Menses _____ | <input type="checkbox"/> # of Abortions _____ | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Last PAP _____ | <input type="checkbox"/> # of Premature Births _____ | <input type="checkbox"/> Vaginal Sores |

Personal Medical History

Significant Illnesses

Neuro-Psychological

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Concussion | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Depression | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Migraines | <input type="checkbox"/> Easily Angered | <input type="checkbox"/> Headache |

Have you ever received psychiatric treatments? _____

Have you ever considered or attempted suicide? _____

Any nervous habits? _____

Any other problems you would like us to be aware of? _____

Musculo-Skeletal

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Hand/Wrist Pain |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Muscle Cramping | |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Soreness | |
| <input type="checkbox"/> Recent Sprains | <input type="checkbox"/> Weak Joints | <input type="checkbox"/> Injuries | <input type="checkbox"/> Foot/Ankle Pain | |

Please Circle Any Areas of Pain or Injury
Please be prepared to describe the type and quality of pain

