Integrated Health Center
7286 S Yosemite St #150
Centennial, CO 80112
(303) 220-7319

Acupuncture New Patient Forms

PATIENT PROFILE Date: _____

Last Name: _____ First Name: _____
Nickname: _____ Birthday: _____ Sex: _____
Address: _____ Town_____Zip Code_____
Phone Number: (home) _____ (work) _____
Email: _____

A note to our patients: Please complete this short questionnaire as thoroughly as possible in order to aid in diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance. Include any prior diagnosis of these problems.

1. 4.
2. 5.
3. 6.

What goals do you have for your visit at the clinic today? _____
_____

Have you ever consulted an Acupuncturist or other alternative health care provider before? If so, what kind of practitioner and when? _____
_____

Please list prescription medications that you are currently taking, with dosages:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6._____

List vitamins, minerals, herbs, and homeopathic remedies that you are currently taking, with dosages:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Do you have any severe or life threatening allergies to medications or anything else? □Yes □ No
If YES, please explain: _____

Personal Habits

Please circle any of the following substances that you use regularly:

Tobacco Coffee Black Tea Green Tea Cola Alcohol Recreational Drugs

Do you follow any particular diet regimens or restrictions? If yes, please describe: _____
_____

Do you exercise regularly? □Yes □ No
What type? _____
How long? _____ How often?_____

Past History

Hospitalizations: _____
_____

Serious Illnesses and Injuries:_____
_____

Date of last physical/annual exam _____
Date of last blood tests: _____

Social History:

Please circle those that apply: Single Married Significant Other

Do you have any children? Yes No
Please list their age(s) _____

Personal and Family History

Please check the "yes" box next to each condition that applies to you or one of your family members. Please note whether condition applied to family member in the past or currently by denoting a "P" for past or "C" for current. Indicate the relationship or the word "self" in the "Relationship" column.

	YES	RELATION	Past(P)/Current(C)		YES	RELATION	Past(P)/Current(C)
Alcoholism/Drug Addiction				Headaches			
Allergies				Heart Disease			
Arthritis				Hepatitis			
Asthma				High Blood Pressure			
Cancer				Kidney Disease			
Depression				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other			

Patient Signature: _____ Date: _____

Patient Informed Consent Form

I, the undersigned, hereby authorize Nicolas Song, Dip. L.Ac, MSOM, to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

- **Acupuncture:** The insertion of sterilized, disposable needles through the skin into the underlying tissues at specific points on the body.
- **Infrared Heat:** Applying heat generated from an infrared lamp over a specific area of the body.
- **Moxabustion:** The use of small amounts of dry herbs that a lit and applied to the skin either directly or indirectly.
- **Cupping:** Glass or plastic cups placed on the skin, using heat or a pump to create suction.
- **Gua Sha:** Scraping of the skin done with a smooth edged tool.
- **Acupressure/Tuina:** Chinese medical massage techniques.
- **Liniments, Oils, and Plasters:** Herbal formulas applied to the skin.
- **Dietary Advice**: suggestions for dietary changes and herbal supplements.
- **Massage Therapy**: including Swedish, deep tissue, manual ligament therapy, sports massage, myofascial release and prenatal massage.

I recognize the potential benefits and risks of these procedures as described below:

- **Potential Benefits (including but not limited to):** Relief of the presenting symptoms and improved balance of body energies that may lead to improvement and elimination of the presenting problem.
- **Potential Risks (including but not limited to):** Temporary discomfort, pain, bruising, blistering, bleeding, skin irritation, temporary discoloration of the skin, broken needle, temporary increases in symptoms before resolution.

Patients that are pregnant or may be pregnant and patients that have bleeding disorders or pacemakers must inform the practitioner of their condition prior to treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by my acupuncturist regarding cure or improvement of my condition. I hereby release the acupuncturist from any liability, which may occur in connection with the appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

_____	_____
Patient Name (print)	Guardian Name (print) and Relation
_____	_____
Patient Signature	Guardian Signature
Date: _____	Date: _____