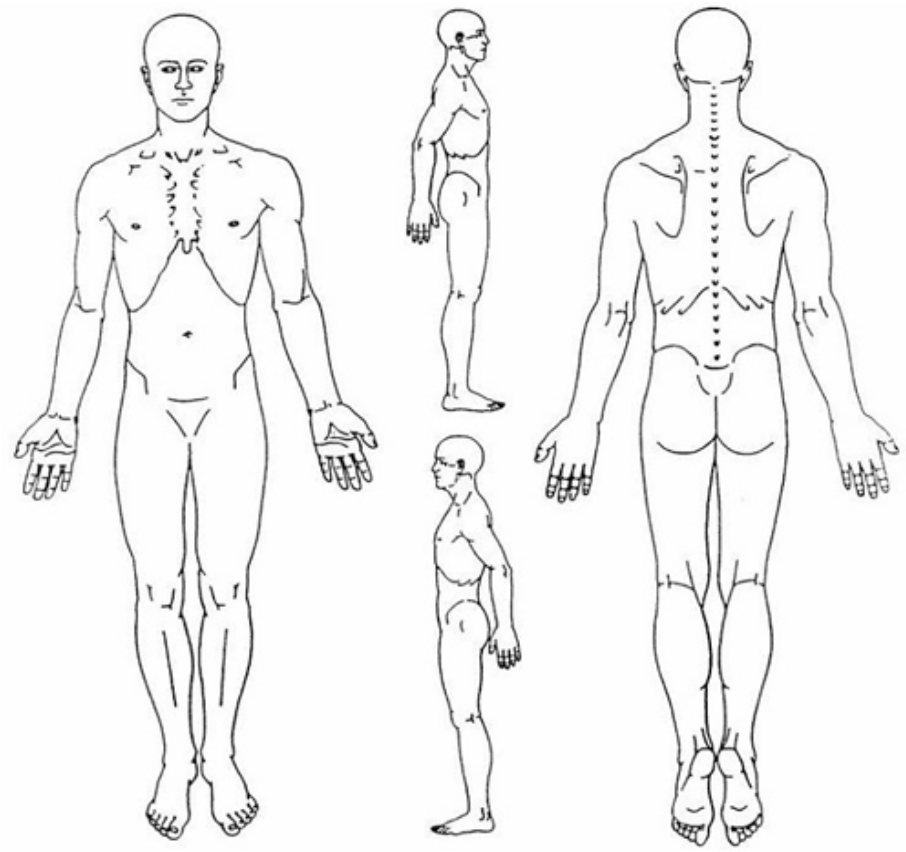
CENTERPOINT
wellness

NEW PATIENT FORM

First Name:	Last Name:
Address:	City:
State:	Zip Code:
Phone:	Email:
Gender:	Date of Birth/Age:
Height/Weight:	Place of Birth:
Occupation:	Marital Status:
Physician:	Referred by:
Emergency Contact:	Phone:
Have you been treated by acupuncture before?	
Main problem(s) you would like help with:	
Problem or Disease:	
How long ago did this begin?	
To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?	
Have you received a diagnosis for this problem?	
What type of treatment have you tried?	
List all medications you're currently taking:	
Past Medical History/Significant Illnesses (Cancer, Diabetes, Hepatitis, High Blood Pressure, Heart Disease, Rheumatic Fever, Thyroid Disease, Seizures, Venereal Disease):	

Surgeries:
Significant Trauma (Auto Accidents, Falls, Etc.):
Allergies (Drugs, Chemicals, Foods):
Birth History (Prolonged Labor, Forceps Delivery, Etc.):
Painful or Distressed Areas (Please Explain/Mark Below):



General

- ☐ Poor Appetite
- ☐ Fever
- ☐ Sweat Easily
- ☐ Localized Weakness
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Tastes or Smells
- ☐ Poor Sleeping
- ☐ Chills
- ☐ Tremors
- ☐ Poor Balance
- ☐ Weight Loss
- ☐ Strong Thirst (Cold or Hot Drinks?)
- ☐ Fatigue
- ☐ Night Sweats
- ☐ Cravings
- ☐ Change in Appetite
- ☐ Weight Gain
- ☐ Sudden Energy Drop Time of Day_____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Eczema
- ☐ Loss of Hair
- ☐ Change in Hair or Skin Texture?
- ☐ Hives
- ☐ Pimples
- ☐ Recent Moles
- ☐ Other hair or skin problems: _____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Glasses
- ☐ Poor Vision
- ☐ Cataracts
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Grinding Teeth
- ☐ Teeth Problems
- ☐ Jaw Clicks
- ☐ Concussions
- ☐ Eye Strain
- ☐ Night Blindness
- ☐ Blurry Vision
- ☐ Poor Hearing
- ☐ Nose Bleeds
- ☐ Facial Pain
- ☐ Migraines
- ☐ Headaches (When/Where?)
- ☐ Eye Pain
- ☐ Color Blindness
- ☐ Earaches
- ☐ Spots in Front of Eyes
- ☐ Recurrent Sore Throats
- ☐ Sores
- ☐ Other head or neck problems: _____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Cold Hands or Feet
- ☐ Blood Clots
- ☐ Low Blood Pressure
- ☐ Dizziness
- ☐ Swelling of the Hands
- ☐ Phlebitis
- ☐ Chest Pain
- ☐ Fainting
- ☐ Swelling of the Feet
- ☐ Difficulty Breathing
- ☐ Other Heart or Blood Vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Bronchitis
- ☐ Difficulty Breathing when Lying Down
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Chest Pain
- ☐ Pain with a Deep Breath
- ☐ Production of Phlegm Color:_____
- ☐ Other lung problems: _____

Gastrointestinal

- ☐ Nausea
- ☐ Constipation
- ☐ Black Stools
- ☐ Bad Breath
- ☐ Abdominal Pain or Cramps
- ☐ Chronic Laxative Use
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in Stool
- ☐ Rectal Pain
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Other problems with your stomach or intestines? _____

Genito-Urinary		
☐ Painful Urination ☐ Urgency to Urinate ☐ Decrease in Flow ☐ Frequent Urination ☐ Unable to Hold Urine	☐ Blood in Urine ☐ Kidney Stones ☐ Impotence ☐ Sores on Genitals	☐ Do you wake up to urinate? ☐ Color of your urine? _____ ☐ Other problems with genital or urinary system? _____
Pregnancy and Gynecology		
_____ Number of Pregnancies _____ Number of Births _____ Miscarriages _____ Abortions _____ Premature Births	_____ Age of First Menses _____ Time between Menses _____ Duration _____ First Date of last Menses Changes to body/psyche prior to menstruation?	☐ Unusual Period (Heavy/Light) ☐ Painful Periods ☐ Vaginal Discharge ☐ Clots ☐ Vaginal Sores ☐ Breast Lumps ☐ Last PAP _____ ☐ Do you use birth control? ☐ What type/how long? _____
Musculoskeletal		
☐ Neck Pain ☐ Back Pain ☐ Hand/Wrist Pains	☐ Muscle Pains ☐ Muscle Weakness ☐ Shoulder Pain	☐ Knee Pain ☐ Foot/Ankle Pains ☐ Hip Pain ☐ Other Joint/Bone problems? _____
Neuropsychological		
☐ Seizures ☐ Areas of Numbness ☐ Concussion ☐ Bad Temper	☐ Dizziness ☐ Lack of Coordination ☐ Depression ☐ Easily Susceptible to Stress	☐ Loss of Balance ☐ Poor Memory ☐ Anxiety ☐ Treatment for Emotional Problems?
Have you ever considered or attempted suicide? Other neurological or psychological problems?		
Comments/Anything else you would like to discuss?		

CENTER POINT WELLNESS
INFORMED CONSENT FOR TREATMENT

TRADITIONAL ORIENTAL MEDICINE TREATMENT AND CARE

I understand a certified acupuncturist will perform methods or treatment that may include, but are not limited to: acupuncture, moxibustion or other heating modalities, cupping, gua sha, electrical stimulation, manual therapy (Tui-Na), the administration of any herb, homeopathic, or nutritional supplement and dietary, nutritional, or lifestyle counseling according to the principles of Oriental Medicine. I have had the opportunity to discuss with the acupuncturist named below, and/or with office personnel, the nature, purpose and possible side effects of acupuncture treatments and related Oriental Medical procedures. Acupuncture has the effect of normalizing physiological functions, to modify the perception of pain, and to treat certain dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling or treatment sites that may last up to a few days. There have been rare instances reported of fainting or dizziness and infection and/or scarring from the burning of moxa. There have also been extremely rare instances reported of spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional substances (which are derived traditionally from plant, animal and mineral sources) that have been recommended are traditionally considered safe, 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, stomach ache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify the acupuncturist of any adverse effects.

I will advise the acupuncturist if I am or become pregnant, because this will have a significant bearing on my treatment plan. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgement during the course of the procedure, which the acupuncturist feels, at the time and based upon the facts then known, is in my best interest. I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatment. I understand that the office staff may review my medical records and lab reports, but that all of my records will be kept confidential and not released to any third party without my written consent.

MASSAGE, REFLEXOLOGY, BODYWORK AND ENERGY HEALING

Bodywork techniques, including, but not limited to massage, can be defined as structured, professional touch. Massage techniques manually manipulate the muscles, tendons, and fascia of the body to promote health and wellness. Benefits of massage include stress reduction, circulation enhancement, increased relaxation, and relief from muscular tension, soreness, and pain. Massage therapists do not diagnose medical diseases or musculoskeletal conditions and massage is not a substitute for medical examination and treatment. Massage may lead to adverse reactions in certain situations or when used with certain conditions or medications. Please provide complete details of medical conditions and medications to your massage therapist during the health-intake interview. Failure to inform the massage therapist of all medical conditions and medications may place you at increased risk for adverse reactions.

I have read and understand the disclosures, policies, and procedures, and I would like to receive a massage session or request a session for my child or dependent. I understand the benefits and limits of massage therapy. If I experience any discomfort during the session, I will immediately inform my therapist. I understand massage therapists do not diagnose diseases or conditions, prescribe medications or treatments, or perform spinal adjustments. I recognize massage is not a substitute for medical treatment. I understand that it is my responsibility to keep the massage therapist informed of changes in my (or my child's or dependent's) health status. I release Center Point Wellness and its employees of any liability for these voluntary treatments.

By voluntarily signing below, I show that I have read or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to all contained within the above consent. I intend for 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.

Are you currently pregnant? _____ Do you have a pacemaker or bleeding disorder? _____

Patient Name: _____ Guardian Name/Relationship: _____

Patient/Guardian Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

CENTER POINT WELLNESS
PRIVACY PRACTICES ACKNOWLEDGEMENT

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

Name: _____ Birth Date: _____

Signature: _____ Date: _____