In

ORTHOMED CLINIC AND SUPPLY

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ACUPUNCTURE & HOMEOPATHY
CLIENT INFORMATION PACKAGE

Date:_____
Title: [] Mr. [] Mrs. [] Miss. [] Ms. Gender: []M []F

Full Name_____ **Date of Birth**:_____
day / month /year

Address: _____City:_____

Postal Code_____ Phone: Home: (____)_____ Mobile: (____)_____
Are you taking medication? []Yes []No Describe:_____
Did you have any accidents, hospitalization, surgeries? Yes[] No[] When_____

PLEASE CHECK SYMPTOMS/DISEASES

[] Headaches	[] Loss of memory	[] Neck pain	[] Ears ringing	[] Neck stiffness
[] Face flushed	[] Mid back pain	[] Low back pain	[] Loss of balance	[] Nervousness
[] Fainting spells	[] Whiplash	[] Loss of smell	[] Disk problems	[] Chest Pain
[] Difficulty swallowing	[] Decreased ROM	[] Cold feet	[] Cold hands	[] Constipation
[] Pins & Needles in Legs	[] Upset stomach	[] Fatigue	[] Cold Sweats	[] Fever
[] Pins & Needles in Arms	[] Broken bones	[] Fibromyalgia	[] Arthritis	[] Breast augmentation
[] Pins & Needles in Toes	[] High blood pressure	[] HIV	[] Heart attack	[] Varicose veins
[] Allergies to oils or perfumes		[] Diabetes	[]Stroke	[]Cancer

Digestion

___ Extreme appetite	___ No appetite	___ Cravings	___ Dieting	___ Tired after eating
___ Bloating	___ Gas	___ Acid regurgitation	___ Bulimia	___ Heartburn/Ulcers
___ Nausea	___ Vomiting	___ Irritability or low energy between meals		

Intestinal

___ Diarrhea	___ Constipation	___ Hemorrhoids	___ Anal itching	___ Gallstones
___ Laxative use	___ Bloody stool	___ Mucous in stool	___ Anal fissures	___ Gout
___ Intestinal pain/cramping	___ IBS	___ Colitis	___ Other:_____	

Sleep

___ Fall asleep easily	___ Lie in bed with eyes open	___ Wake at specific times
___ Wake repeatedly	___ Wake frequently to urinate	___ Vivid or Lucid Dreams
___ Wake up not feeling rested	___ Nightmares or frightening dreams	___ Need drugs to fall asleep

Head, Eyes, Ears, Nose and Throat

___ Dry eyes	___ Blurred vision	___ Poor vision	___ Nosebleed
___ Night blindness	___ Cataracts	___ Macular degeneration	___ Bleeding gums
___ TMJ	___ Sores on tongue or mouth	___ Dry mouth	___ Excess saliva
___ Sinus problems	___ Sore throat	___ Headaches	___ Swollen glands
___ Difficulty swallowing	___ Earaches	___ Tinnitus / ringing	___ Deafness

Cardiovascular / respiratory

___ Heart palpitations	___ Chest pain	___ Difficulty breathing	___ High cholesterol
___ Varicose veins	___ Blood clots	___ Swollen ankles	___ Heart valve abnormality
___ Shortness of breath	___ Cold hands / feet	___ Dry cough	___ Wheezing
___ Chest tightness	___ Difficult inhalation	___ Difficult exhalation	___ Productive cough

Skin / hair

___ Dry skin	___ Rashes / hives	___ Eczema	___ Psoriasis	___ Dandruff
___ Pimples / acne	___ Fungal infections	___ Brittle nails	___ Hair loss	

Musculoskeletal

___ Vertebral disc degeneration	___ Joint pain	___ Tendonitis	___ Swelling	___ Arthritis
___ Limited range of motion	___ Osteoporosis	___ Carpal tunnel	___ Numbness	___ Spinal pain

Neuropsychological

___ Anxiety ___ Irritability ___ Insomnia ___ Depression
___ Easily stressed ___ Poor memory ___ Tics ___ Tremors
___ Seasonal mood disorder ___ Job stress ___ Recent divorce
___ Death of someone close ___ Currently in therapy ___ Financial setback

Genito-urinary

___ Frequent urination ___ Loss of urine when laughing or sneezing ___ Dribbling
___ Incomplete urination / retention ___ Burning urination ___ Blood in urine
___ Wake frequently to urinate ___ Kidney stones ___ Bedwetting
___ Decreased libido / sexual desire ___ Impotency ___ Infertility

Men only

___ Prostate problems ___ Erectile dysfunction ___ Herpes

Women only

Headaches ___ before menstrual cycle ___ during cycle ___ after cycle

___ Abortion(s) ___ Miscarriage ___ Live births ___ Birth control pills ___ Breast cancer
___ Ovarian cysts ___ Fibroids ___ Candida / yeast ___ Vaginal discharge ___ Herpes
___ Vaginal odor ___ Vaginal sores ___ Pain at ovulation ___ STD history
___ Human Papilloma Virus positive ___ Fibrocystic breast ___ Irregular cycle
___ Cramps / low back pain ___ Acne associated with period
___ Constipation or diarrhea associated with period ___ No period / skipped cycles
___ Emotional irritability or depression associated with period ___ Bleeding outside of regular menstrual cycle

WAIVER

I, the undersigned, have read, understand, and have answered the above survey/questions fully and truthfully. I am aware of my responsibilities to consult with my personal physician regarding my medical fitness to engage in exercise. I do herby intend to be legally bound for myself and waive release of any and all rights and claims for damages I may have against the treatment facility and the acupuncture professional administering the treatment program provided to me.

INFORMED CONSENT FORM

I understand that there will be one to ten treatment sessions. I know that I can request additional treatments, as needed, after that time. I understand that these treatments will include the stimulation of acupuncture points on the ear and body and that there is sometimes uncomfortable sensations when this procedure is done. I understand that my participation will involve completing several surveys of health distress and pain intensity. I understand that I am not required to fill in a response to any question that I do not feel comfortable answering.

Acupuncture is a technique utilizing fine sterile disposable stainless steel needles inserted at specific points in the body to cause a positive response in order to correct various ailments. The location of the application of the needles and the depth of their insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by some painful sensations and that there is a slight possibility that a minor swelling, bleeding, discoloration, hematoma, fainting, or bruise may occur at the site of insertion. A sensation of momentary euphoria or light-headedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. **Laser Acupuncture** involves using a infra-red laser and red light beam. The treatment is absolutely painless. **Moxibustion** is the application of indirect heat supplied by burning the herb Folium Artemisiae vulgaris, or commonly known as “Mugwort plant”, over a single or group of acupuncture points. The area of treatment may remain red and warm for several hours afterwards. In rare incidence a minor burn may occur at the site of moxibustion. I will immediately notify the acupuncturist if I experience any symptoms or problems. **Cupping** utilizes round suction cups over a large muscular area such as the back to enhance blood circulation to the designated area. This method may produce deep redness, discoloration, and on rare occasion a minor blister may form that may persist up to several days but will eventually disappear. **Herbal Nutrients** are utilized to facilitate the body’s own restorative process. These herbs are usually taken in tea form by boiling dried plants in their natural form. On rare occasions, temporary gastric upset may occur. If any discomfort persists, accompanied by hives or shortness of breath, I will advise my attending acupuncturist immediately.

There are risks involved in any procedure or treatment. I do not expect the acupuncturist to be able to anticipate all risks and complications related to my condition, and I understand that all medical conditions cannot be successfully treated by acupuncture or Chinese Medicine. I understand that an acupuncturist is not a medical doctor. I desire to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist deems appropriate and in my best interests, based upon facts then known. I also understand that, whenever necessary, I must continue to seek treatment with a medical doctor for any conditions which cannot be resolved by acupuncture or Chinese Medicine. The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release ORTHOMED CLINIC AND SUPPLY and a treating acupuncturist and/or specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. Note: All prices are subject to change without prior notice. **I confirm that all acupuncture needles are sterile and disposable and that they were taken out of the package by the practitioner in front of my eyes.**

CLIENT SIGNATURE_____ Date_____

Parent or Legal Guardian Signature_____ Date_____
(if client is under 18 years of age)