●10175 Fortune Pkwy ● Unit 304● Jacksonville● FL 32256● Ph (904) 880-1889● www.FamilyAcupunctureClinic.com

Family Acupuncture & Herbal Clinic

Welcome to Family Acupuncture Clinic, please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. If you have anything you wish to bring to our attention which is not asked on this form, please note it in the *Comments* section. Thank You.

Name: _____ Date of Birth: _____ Age: _____

Address: _____ Height: _____ Weight: _____ Sex: _____

City: _____State: ____Zip code: _____ Employer: _____

Phone: (H) _____ (C) _____ (W) _____ Occupation: _____

Email: _____ Marital Status: _____ Spouse's Name: _____

Physician: _____ Phone _____ Referred to this clinic by: _____

In Emergency, Notify: _____ Relationship: _____ Phone: _____

Your main concerns: _____

_____

When did the problem begin (be specific): _____

Symptoms relieved by_____ Symptoms worsened by_____

Intensity: □ mild □ moderate □ severe □ other;

Duration: □ constant □ intermittent □ with certain motions _____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)? _____

_____

Have you been given a diagnosis for the problem? If so, what? _____

What kind of treatments have you tried? _____

Have you had acupuncture treatment in the past? Yes ☐ No ☐ When_____ with Who? _____

Other concurrent therapies: _____

Did the problem relate to any accident/ injury? Yes ☐ **No** ☐ Date of accident/ injury: _____

Past Medical History

	No	Yes		No	Yes		No	Yes		No	Yes
Cancer:	☐	☐	HIV/AIDS:	☐	☐	Diabetes:	☐	☐	High Blood Pressure	☐	☐
Hepatitis:	☐	☐	Pacemaker:	☐	☐	Thyroid Issue:	☐	☐	Seizures	☐	☐

Other conditions: _____

Surgeries (types & dates): _____

_____

Significant Traumas (Physical and Emotional): _____

Allergies (drugs, chemicals, foods, etc.) _____

Family Medical History

□ Cancer	□ Heart Disease	□ Asthma
□ Diabetes	□ Stroke	□ Allergies
□ High Blood Pressure	□ Seizures	□ Other _____

Medications, Herbs, Supplements (List those you are currently taking):

Name _____ Reason _____ How long and Dose _____

Name _____ Reason _____ How long and Dose _____

Name _____ Reason _____ How long and Dose _____

Others: _____

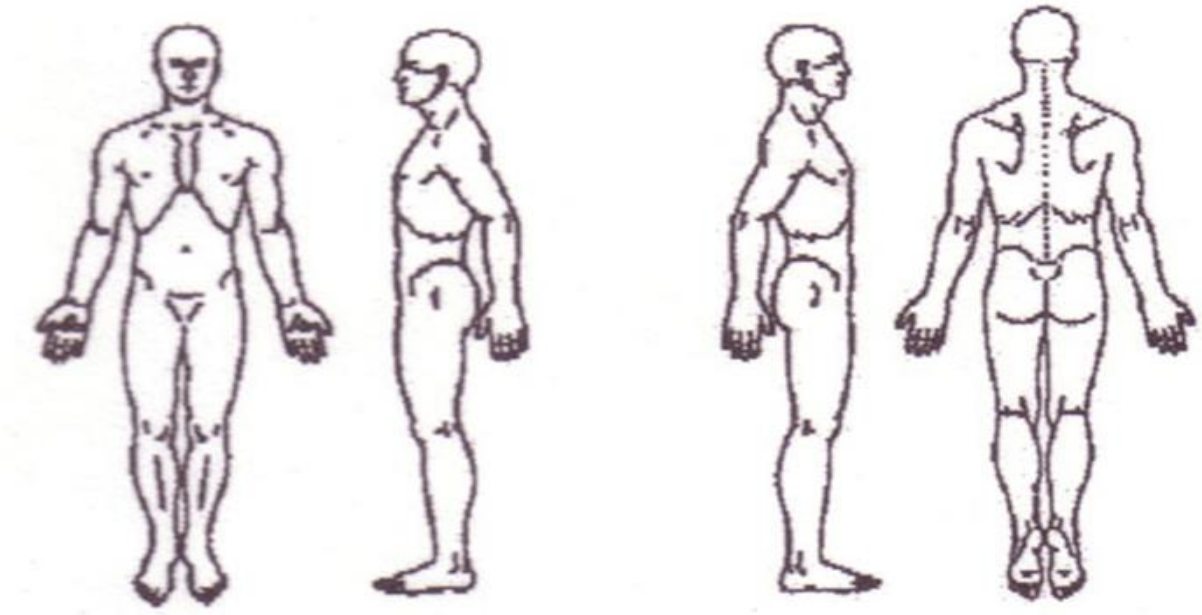
Please indicate usage per day or per week:

Cigarettes _____ per _____ Duration _____
Alcohol _____ per _____ Duration _____
Drugs _____ per _____ Duration _____
Coffee _____ per _____ Duration _____
Tea _____ per _____
Soft Drinks _____ per _____
Sugar _____ per _____
Other _____ per _____

Muscles, Joints & Bones:
Do you have pain or tightness? □ No □ Yes Where?_____
The pain is (check all that apply): □ Sharp □ Dull □ Aching □ Numb □ Tingling □ Shooting □ Superficial Pain □ Deep Pain □ Burning Pain □ worse/□ better with heat Pain □ worse/□ better with cold Pain □ worse/ □ better with pressure □ Pain worse in □ am/□ pm
What number best describes your pain now? □0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10 Worst pain
I have (check all that applies): □ Swollen joints □ Arthritis/joint pain □ Tendonitis □ Bone pain □ Muscle cramping □ Muscle pain □ Repetitive Strain Injury □ Fractured Bone(s) Where? _____ Other_____

Head: □ Headaches/Migraines: how do you describe the pain: _____Frequency: _____
Location: _____How long it last: _____ Other Symptoms accompanied with it _____

Please indicate areas of pain or distress:



Exercise & Energy:
How is your energy? _____ Do you fatigue easily? _____
What kind of exercise do you do?_____ How often do you exercise? _____

Emotions & Sleep:
How do you feel emotionally? _____
Do you have (check all that apply): □ Panic attacks □ Depression □ Anxiety □ Bad temper □ Nervousness □ Fear attacks □ Poor memory □ Difficult concentration
How long do you normally sleep? _____hours per night _____
I have difficulties with (check all that apply): □ Falling asleep □ Staying asleep □ Dream-disturbed sleep
Waking up at about _____am/pm and not being able to fall asleep again

Cardiovascular:
I have (check all that apply): □ Chest pain □ Palpitation □ Varicose veins □ Phlebitis □ Cold hands and feet
□ Irregular heart beat □ Poor circulation □ Other: _____

Respiratory:
I have (check all that apply): □ Frequent colds □ Chronic runny nose □ Frequent sore throat □ Chronic cough □ Coughing blood □ Cough up mucous □ Pain inhaling □ Shortness of breath on exertion/at rest □ Asthma

Gastrointestinal:
How is your appetite? _____ I have craving for _____
I have (check all that apply): □ Belching □ Nausea □ Vomiting □ Vomiting of blood □ Ulcers □ Bloating □ Acid regurgitation □ Heartburn □ Hernia □ Indigestion □ Severe stomach pain
Bowel movements: How often? _____time(s)/day _____days/week
I have (check all that apply): □ Irregular □ Constipation □ Diarrhea □ Gas □ Burning sensation □ Hemorrhoids □ Undigested food in stool □ Loose stool □ Hard stool □ Blood in stool □ Itchiness □ Painful bowel movements

Urinary:
Urination: How often? _____ Times per day Color: □ Pale □ yellow □ Dark yellow/orange □ Other _____
I have or had (check all that apply): □ Trouble starting stream □ frequent urination □ Incontinence □ Pain □ Burning □ Dribbling when sneezing □ Blood in urine □ Kidney stones □ Urinary tract infections □ other

Eyes, Ears, Nose, &Throat:
I have (check all that apply): □ Nose bleeds □ Stuffy nose □ Postnasal drip □ Painful/red eyes □ Poor vision □ See spots/floaters □ Dizziness □ Cold sores □ Bleeding gums □ Dry mouth □ Ear pain □ Ringing in ears □ Clogged/popping in ears

Skin & Hair:
I have or often have (check all that apply): □ Dry skin □ Skin rashes □ Itching □ Acne □ Eczema □ Hives □ Hair loss □ Premature graying □ Other:_____

Women:
Are you pregnant? □ Yes □ No □ Possible At what age did you start menstruating? _____ Day of Last Menses: _____ Number of days between cycles: _____ Number of days of flow:_____ Color: _____
I have or had (check all that apply): □ Irregular menstruation □ Heavy flow □ Light flow □ No flow □ Clots □ vaginal itching/burning □ Spotting between periods □ Discomfort/pain before period □ Discomfort/pain during period □ other _____Any vaginal discharge? □ No □ Yes Color _____

Men:
I have (check all that apply): □ Prostatitis □ Impotence □ Penis blood/mucous discharge □ Other _____

Comments: _____
_____
_____
_____

The above information is true to the best of my knowledge!

_____ _____ _____
Your Name (Please Print Name) Signature Date

Parent / Guardian (if applicable) _____ Date _____

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ACUPUNTURE 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 Dr. Xiaolu Luo, AP., DOM, and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for Dr. Xiaolu Luo, AP., DOM, 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, Tui-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. 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. Burns and/or scarring are potential risk of moxibustion and cupping. 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 occurs of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand the treatment 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 release 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 l seek treatment.

_____ _____ _____

Your Name (Please Print Name) Signature Date

Parent / Guardian (if applicable) _____ Date _____