Pain & Clinic
Acupuncture & Herb
2415 S. Glendale · Wichita, KS 67218
(316) 293-8459

New Patient Form

Date (M/D/Y)_____ **Height:** _____ **Weight**_____ **Race**_____

Last Name (Mr. Mrs. Ms. Miss._____ **(First Name)**_____

Birthday: M ___/D___/Y___ **Occupation** _____ **Referred by**_____

Single Married Partnership Divorced Widowed Separated others

Address: _____ City_____ **Zip:**_____

Home phone: _____ **Cell:** _____ **Work**_____

E-mail:_____

Emergency Contact: _____ **Phone:**_____

Employer: _____

Have you had Acupuncture before? No, Yes **Herbal Medicine?** Yes, No

Reason for today's visit:_____

_____

How long have you had this condition?

_____

What makes is better or worse?_____

_____

Your Medical Doctor's Info:_____

Medications you're currently taking_____

_____

Allergies:_____

Are you pregnant (or any possibility you're)? Yes, No, N/A

General Past Medical History: _____

_____

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Lifestyle related questions: (Circle or underline the below questions)

Diet: Vegetarian, More veggie & fruit, More protein & meat, Heavy on cabs?

Exceedingly hungry, Poor appetite, Hunger w/no desire to eat, Specific

cravings_____

Drinks: coffee, tea, pop, beer, alcohol? How much or how often? _____

Excessive thirst, Thirst w / no desire to drink, No thirst, Prefer cold / hot drinks.

Tobacco Use: Yes, No, How long and how many per day?_____

Habits: _____

Exercise: what type of exercise and how often? _____

Head Neck & Shoulders:

Dizziness, Vertigo, Headache, Migraine, Stiff neck, Earache, Tinnitus, Reduced

hearing, Dry eyes, Blurred vision, Floaters, Eye pain, Poor night vision, Sore

throat, Bleeding gums, Bitter taste in mouth, Dry mouth, Tongue ulcers, Difficulty

swallow, Lump in throat, Sinus, Nasal congestion, Nose bleeding, Stiff Neck,

Heavy and Tensed shoulders

Respiratory:

Chronic Cough, With phlegm, Difficulty inhaling, Shortness Breath,

Wheezing/Asthma, Seasonal allergy, Panting, Frequent Colds, Bronchitis, Hay

Fever, Spontaneous sweats, Night sweats, Hot flashes

Genital/Urinary:

Pain/itching of genitalia, Genital lesions/discharge, Painful/burning urination, Urgent Urination, Frequent urination, Excessive or scant urination, Blood in urine,

Unable to hold urine, Nighttime urination (once, twice, more), Increased libido,

Decreased libido, Kidney Stone.

Cardiovascular: BP:_____/_____, HR:_____(per minutes)

Heart palpitations, Chest pain/tightness, Poor circulation, Varicose veins,

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Irregular heart beat, Swelling feet/ankles, Pace maker or any other surgeries?

Muscles & Joints:

Joint pain (where?_____) Body aches /stiffness , General weakness, Numbness/ tingling sensations, "Heaviness" of body/limbs, Joint swelling, Motion restriction, Arthritis,

Skin:

Hives/Rashes, Acne, Dry skin, Eczema/psoriasis, Bruise easily, Itchy skin, Brittle/weak nails, Changes in moles/lumps, Hair loss,

Gastrointestinal:

Nausea, Hiccups, Acid reflux/heartburn, Bad breath, Vomiting, Bloating, Gas, Rectal pain/itchiness, Constipation, Loose/soft stool, Anal fissures, Hemorrhoids, Intestinal cramping, Alternating diarrhea/constipation, How many BM _____ per day usually?

Sleep: Hours ____ of sleep in 24 hours

Sound/restful, Trouble falling asleep, Trouble staying asleep, Wake easily/early, Dream Disturbed sleeping, Nightmares often, Difficulty waking up,

Emotions:

Relaxed/calm, Sad/Grief/depressed, Fearful, Impatient, Angry/Frustrated, Forgetful/poor memory, Anxious, Stressed easily, Manic, Swing back and forth,

General:

Cold hands/feet, Always feel hot, Always feel cold, Fever& Chills, Recent unexplained weight changes, Fatigue

Menses:

First Menses at age of____, How many days in cycle_____? How many pregnancies _____? How many alive _____?

Amenorrhea, Dysmenorrheal, Excessive flow, Scanty flow, Mid-cycle spotting, Cramping

Oral Contraceptive use? Yes, No First day of last period: _____

Approx date/or age of menopause:_____

Anything else you would like to address at this time:_____

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Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of the acupuncturist Susan Sun on me (or on the patient named below, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, 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 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 needle 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 above licensed acupuncturist uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may

P 5 of 5

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 acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on her to practice the judgment during the course of treatment which she thinks at the time, based upon the facts she knows is in my best of interest. I understand that results are not guaranteed.

I understand that the acupuncturist may review my patient records and lab reports, but all my records will be kept confidential and will not be released 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 I seek treatment.

PATIENT SIGNATURE: _____ Date: _____

(Patient Representative, indicate relationship to patient): Date: _____