VISTA ACUPUNCTURE

BY ASSOCIATED MEDICAL GROUP

550 W. Vista Way Suite #5, Vista CA 92083 • Office: (760) 941-1900

NAME_____ Date_____

Occupation_____Employer_____

Describe Duties:_____

What kind of Activities/Hobbies?_____

Referred By_____ Do you have HEALTH INSURANCE?_____

Is this a WORK INJURY?_____ Have you been in an AUTOMOBILE ACCIDENT?_____

☐ Past Year ☐ Past 5 years ☐ Over 5 years Describe Accident:_____

Other Personal Injuries or Accidents?_____ Please describe:_____

PURPOSE OF THIS APPOINTMENT (Major Complaint)_____

OTHER COMPLAINTS:_____

When did this start?_____ What did you do to hurt yourself?_____Describe the pain…Sharp, Dull, Burning, Throbbing, etc._____ Is the pain constant or does it come and go? If it comes and goes, how often does it hurt?_____ Have you ever had this problem before? When?_____ Do you have any pain in the shoulders, arms or legs or any tingling or numbness? Where?_____ Can you findacomfortable position which seems to relieve your symptoms? What is it?_____ Have you done anything for this? Heating Pad?_____Help?_____Ice?_____Help?_____ Aspirin, Advil, Tyle-nol? _____Help?_____ Ben Gay, Deep Heat, Icy Hot:_____Help? _____

Is this so bad you can't work? ☐ YES NO ☐ Does it slow you down at work? ☐ YES NO ☐

Does it keep you from sleeping? ☐ YES NO ☐

Which activities aggravate your condition? ☐ Walking ☐ Sitting ☐ Standing ☐ Sleeping Bending ☐ Other:_____ Does it keep you from doing anything that you want to do?_____

How does it affect you?_____ Is this condition getting progressively worse:_____

Is this condition interfering with your (☐)Daily Routine (☐) Other

Have you had previous CHIROPRACTIC CARE:_____ ACUPUNCTURE CARE:_____

Name of Previous Chiropractor or Acupuncturist:_____

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Have you seen a Medical Doctor or other Practitioner about this condition? ( )YES ( )NO
If so, what was the diagnosis? _____

What was the treatment? _____

Medications? _____

Date of Last Visit with Physician:_____Name of MD:_____

Address:_____

Phone:_____

SURGICAL HISTORY_____
_____

Please indicate if you have any of the following conditions; certain medications and health problem may be contraindicated for massage. If necessary, a physicians release may be required from your primary care provider.

	Yes	No	Additional Information
Arthritis	____	____	
Diabetes	____	____	Type I or Type II_____
Frequent Headaches	____	____	How Often?_____
High Blood Pressure	____	____	
Epilepsy or Seizures	____	____	
Joint Swelling	____	____	Where?_____
Varicose Veins	____	____	Where?_____
Contagious Disease	____	____	Explain_____
Osteoporosis	____	____	
Allergies	____	____	To What?_____
Back Pain	____	____	
Knee Pain	____	____	
Other Joint Pain	____	____	Where?_____
Surgery	____	____	For What?_____
Frequent Numbness or Tingling	____	____	Where?_____
Pregnant	____	____	How far along?_____
Recent Injury	____	____	Explain_____
Allergy to Lotion or Oils	____	____	What Type?_____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU MAY SUFFER FROM NOT LISTED ABOVE:
_____

SIGNATURE OF PATIENT (OR GUARDIAN)_____DATE_____

Emergency Contact _____Phone_____

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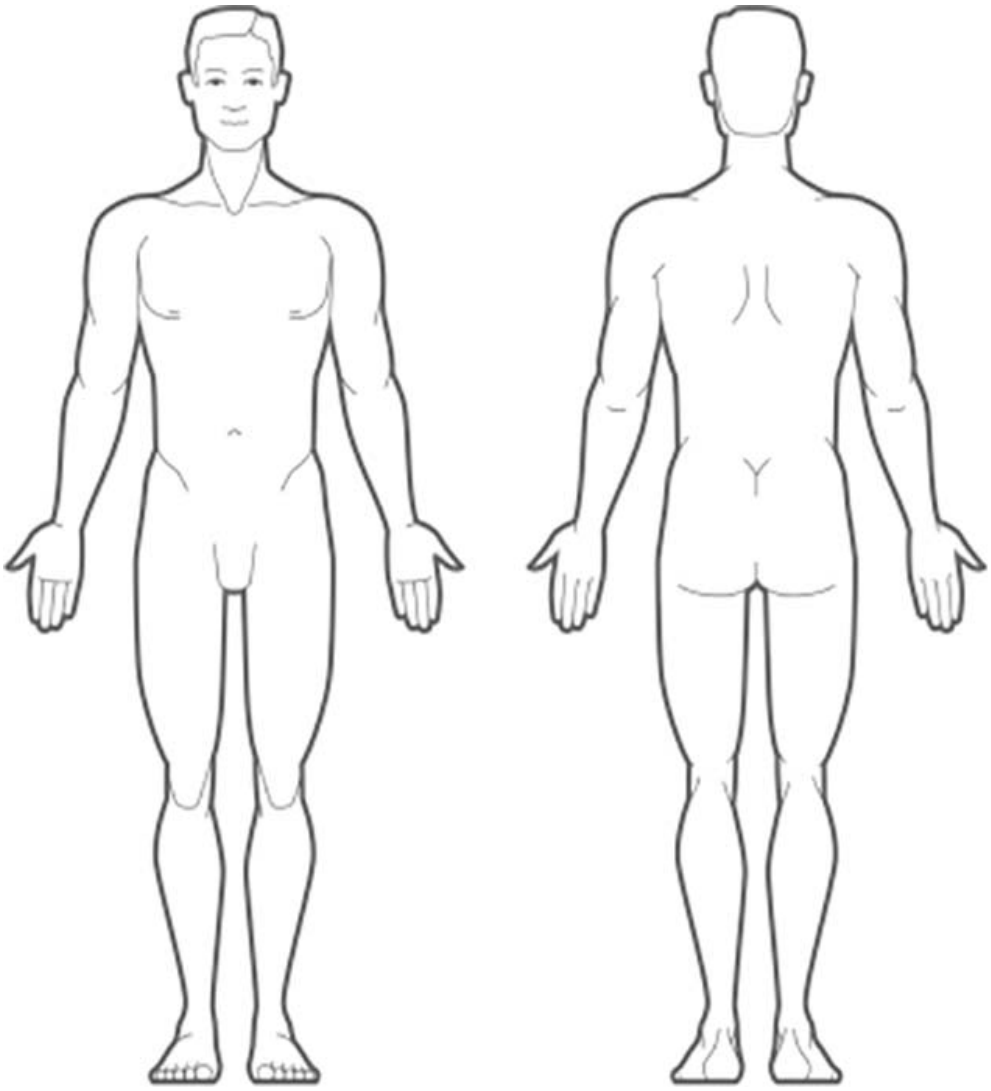
Patient Profile:

Please draw a circle on the diagram below indicating the areas where you feel pain, also please write the type of pain you feel (ex. Pain, Spasm, Numbness, or Tingling).



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Informed Consent For Acupuncture Treatment & Care

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 the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at this office or any other office or clinic, whether signatories to this form or not.

I understand the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting.

I understand that I should not move while the needles are being inserted, retained, or removed. 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 acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. 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, mineral, and animal sources) that have been recommended are traditionally considered save 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 immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist 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 risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the office medical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

ASSIGNMENT AND RELEASE: I authorize payment of benefits be made directly to this healthcare provider and I understand I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

By voluntarily signing below I show that I have read, or have had read to me, this 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's Name _____

Patient's Signature _____

Date Signed _____