

Goji Acupuncture & Wellness Clinic
(209) 597-3886

1770 N Tracy Blvd., Suite A
Tracy, CA 95376

Cindy Tsui, L.Ac

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Website: www.gojiacupuncture.com

Patient Form

This is a confidential questionnaire to help us determine the best treatment plan for you. Please fill it out as completely as possible. Thank you!

Contact Information

Today's Date: _ ____ / ____ / ____

Name: _____ Sex: F M DOB: ____ / ____ / ____ Age: _____

Street: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Martial Status: M S D W

Phone Number: _____ Alternative Phone Number: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

How did you find out about us? _____

Have you had acupuncture before? Y N Allow email/mail/phone/text contact by us? Y N

Chief complaint/ reason for your visit: _____

What diagnosis, if any, have you received for this problem? _____

How long have you had this condition? _____

What was the initial cause? _____

Have you ever experienced this before? ____N ____Y (If Y, When? _____)

What makes this problem worse? _____ Better? _____

Is there anybody in your family with the same problem? _____

What other treatments have you tried? _____ How long? _____

Were they effective? _____

Please list your other health concerns, if any, in order of importance

1. _____ 3. _____

2. _____ 4. _____

NOW: ___ Pregnant ___ Pacemaker ___ HIV Disease ___ Hepatitis A/B/C ___ Bleeding Disorder
 ___ Blood transfusion ___ Implants (metal, electronic, silicone, etc)

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P C	P C	P C	P C
<input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> <input type="checkbox"/> Digestive Disorder	<input type="checkbox"/> <input type="checkbox"/> Hypertension	<input type="checkbox"/> <input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Pneumonia
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> <input type="checkbox"/> Auto Immune	<input type="checkbox"/> <input type="checkbox"/> Heavy Bleeding/Hemorrhage	<input type="checkbox"/> <input type="checkbox"/> Mental Illness	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Migraines	<input type="checkbox"/> <input type="checkbox"/> Vein Condition
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Other: _____	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> HIV/Hepatitis		

Known allergies (food, medications, or other): _____

Significant trauma (car accident, sports injuries etc.): _____

Hospitalizations/Surgeries (procedures and dates): _____

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc): _____

Family Medical History (please specify family member)

<input type="checkbox"/> Alcoholism/Drug Abuse _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Asthma/Allergies _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Miscarriage _____
<input type="checkbox"/> Depression/Mental Illness _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Other _____	

Current Health & Lifestyle

Do you smoke? Y N If yes, how many per day? _____ For how long? _____

Do you exercise? Y N If yes, how many times per week? _____

Do you sit in traffic/commute as a daily routine? Y N

How many hours do you sleep in general? _____ What time do you usually go to bed? _____

What time do you usually get up? _____

Diet

Soft drinks per day _____ Cups of tea per day _____ Cups of coffee per day _____ Glasses of water per day _____

Alcoholic beverages per week _____ Are you a vegetarian? Y N

Please describe your average daily diet:

Foods you tend to crave: _____

Medications and Supplements: Please list all the prescriptions, over-the-counter medicines, vitamins and supplements you are currently using.

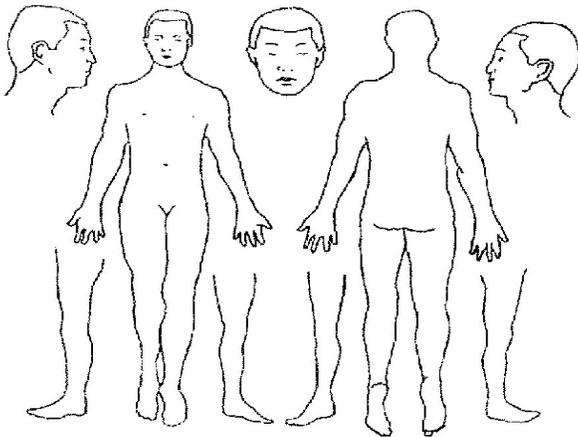
Name	Purpose	How Often	Dose	Start Date	Date of Last Dose

Please check any of the following symptoms that **currently** pertain to you.

<p>General</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Dreams/ nightmares</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Mood swings</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> Strongly like cold drinks</p> <p><input type="checkbox"/> Strongly like hot drinks</p> <p><input type="checkbox"/> Recent weight loss/gain</p> <p><input type="checkbox"/> Cold hands & feet</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Fever</p> <p>Head & Neck</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Migraines</p> <p><input type="checkbox"/> Stiff neck</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Swollen glands</p> <p>Ears</p> <p><input type="checkbox"/> Ringing</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Infections</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Hearing aids</p> <p><input type="checkbox"/> Vertigo</p> <p>Eyes</p> <p><input type="checkbox"/> Glasses/ contact lenses</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Poor night vision</p> <p><input type="checkbox"/> Spots or floaters</p> <p><input type="checkbox"/> Eye inflammation</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Cataracts</p>	<p>Skin</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Rashes</p> <p><input type="checkbox"/> Eczema/ psoriasis</p> <p><input type="checkbox"/> Night sweating</p> <p><input type="checkbox"/> Excess sweating</p> <p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Changes in moles, lumps</p> <p><input type="checkbox"/> Itching</p> <p>Respiratory</p> <p><input type="checkbox"/> Difficulty breathing</p> <p><input type="checkbox"/> Difficulty breathing when lying down</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Wet cough</p> <p><input type="checkbox"/> Dry cough</p> <p><input type="checkbox"/> Coughing up phlegm</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Tight chest</p> <p><input type="checkbox"/> Pneumonia</p> <p>Cardiovascular</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Chest pain or tightness</p> <p><input type="checkbox"/> Palpitation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> Phlebitis</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> History of heart attack</p>	<p>Musculoskeletal</p> <p><input type="checkbox"/> Joint pain/disorder</p> <p><input type="checkbox"/> Sore muscles</p> <p><input type="checkbox"/> Weak muscles</p> <p><input type="checkbox"/> Difficulty walking</p> <p><input type="checkbox"/> Neck/shoulder pain</p> <p><input type="checkbox"/> Upper back pain</p> <p><input type="checkbox"/> Lower back pain</p> <p><input type="checkbox"/> Rib pain</p> <p><input type="checkbox"/> Limited range of motion</p> <p><input type="checkbox"/> Other (describe)</p> <p>Neurological</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Tremors</p> <p><input type="checkbox"/> Numbness or tingling</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Paralysis</p> <p><input type="checkbox"/> Poor coordination</p> <p><input type="checkbox"/> Other (describe)</p> <p>Genito-urinary</p> <p><input type="checkbox"/> Pain on urination</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Urgent urination</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Unable to hold urine</p> <p><input type="checkbox"/> Incomplete urination</p> <p><input type="checkbox"/> Bedwetting</p> <p><input type="checkbox"/> Wake to urinate</p> <p><input type="checkbox"/> Increased libido</p> <p><input type="checkbox"/> Decreased libido</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Impotence</p> <p><input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> Nocturnal emission</p> <p><input type="checkbox"/> Pain/itching of genitalia</p> <p><input type="checkbox"/> Lumps in testicles</p>
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Nose, Throat & Mouth <input type="checkbox"/> Sinus infection <input type="checkbox"/> Hay fever/ allergies <input type="checkbox"/> Frequent sore throat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Mouth & tongue ulcers <input type="checkbox"/> Frequent colds <input type="checkbox"/> Excessive phlegm <input type="checkbox"/> Dry nose <input type="checkbox"/> Facial pain <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Loss of voice <input type="checkbox"/> Thirst <input type="checkbox"/> Dry mouth <input type="checkbox"/> Nosebleed <input type="checkbox"/> TMJ <input type="checkbox"/> Gum problems	Gastrointestinal <input type="checkbox"/> Nausea <input type="checkbox"/> Indigestion <input type="checkbox"/> Stomach pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Poor appetite <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Vomiting <input type="checkbox"/> Gas <input type="checkbox"/> Hiccups <input type="checkbox"/> Acid regurgitation <input type="checkbox"/> Bloating <input type="checkbox"/> Mucus in stool <input type="checkbox"/> Bad breath <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Laxative use <input type="checkbox"/> Gall Bladder <input type="checkbox"/> Bloody stool <input type="checkbox"/> disorder	Infection Screening <input type="checkbox"/> HIV risks: self or partner <input type="checkbox"/> TB: self or household <input type="checkbox"/> Hepatitis risk: self or partner <input type="checkbox"/> History of sexually transmitted disease: self or partner <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Syphilis <input type="checkbox"/> Genital warts <input type="checkbox"/> Herpes: oral/ genital Other: _____ _____ _____
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Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:

XXX Sharp / Stabbing
PPP Pins and Needles
DDD Dull / Aching
NNN Numbness

Please circle your **current** level of pain: **Very mild** 1 2 3 4 5 6 7 8 9 10 **Very severe**

Thank you for taking the time to answer these questions, we appreciate your time and effort!

Goji Acupuncture & Wellness Clinic
Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible for and under my legal guardianship) by Cindy Tsui, who is a Licensed Acupuncturist in the state of California, and or other licensed acupuncturists who now or in the future treat me while employed by, working for, associated with, or serving as back-up for Cindy Tsui, 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, gua sha (scraping), electrical stimulation, Tui-Na (Chinese bodywork), acupressure, Chinese herbal medicine, application of liniments, oils and plasters, supplement recommendations, and nutritional counseling.

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some potential risks that may include, but are not limited to, discomfort, pain, bruising or tingling near the needling sites that last a few days to a few weeks, blistering, bleeding, infection at the site of the procedure, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the acupuncture treatment, dizziness, nausea, fainting, scarring, stuck or broken needle. There may be some bruising after cupping and gua sha (scraping). I understand that although it is rare, acupuncture during pregnancy can result in spontaneous miscarriage, induction of premature labor and pneumothorax.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the practitioner, Cindy Tsui, L.Ac.

Cindy Tsui, L.Ac. does not provide Western medical care, and asks that you see your medical doctor for routine check-ups. If you are pregnant, have a pacemaker, high blood pressure, have a bleeding disorder, local infection, or if you have been prescribed anticoagulant medications such as Coumadin, she can still treat you but needs to be informed of your condition. I have informed Cindy Tsui, L.Ac. of such conditions above and voluntarily consent to the above procedures.

With this knowledge, I voluntarily consent to the procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I hereby release the practitioner, Cindy Tsui, L.Ac., from any and all liability, which occur in connection with the above-mentioned treatments. I understand that I may choose to stop the treatment at any time at my discretion. I will immediately notify the practitioner of any unpleasant or unanticipated effects of my treatment. I understand the clinical 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 consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

To ensure patient privacy, please no photos may be taken by patients or visitors inside the clinic

By signing below, I agree to the above- named procedures. 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 (PLEASE PRINT)

X _____
Signature / Date

Name of Legal Guardian (PLEASE PRINT)

X _____
Signature / Date

**Patient Advisory and Acknowledgement
Receiving Treatment During COVID-19**

Dear Patient,

You have presented to the office today out of your own willingness to be treated in-person. Please be advised of the following:

While our office complies with State Health Department and the U.S. Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, and have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

By signing below, you acknowledge that you understand the risk of possible viral exposure by entering our office and release our office and employees of any liability associated with that exposure.

Patient Name: _____

Signature: _____

Date: _____