Goji Acupuncture & Herbs
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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:_____

City:_____State:_____Zip:_____ Martial Status: M ☐ S ☐ D ☐ W ☐

Phone Number:_____Email Address:_____

Occupation:_____

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?_____)

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

What other treatments have you tried?_____How long?_____
Were they effective? _____

How is the problem affecting your activities of daily living? What is this preventing you from doing?

_____

_____

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

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)

☐ Alcoholism/Drug Abuse_____
☐ Asthma/Allergies_____
☐ Cancer_____
☐ Depression/Mental Illness_____
☐ Diabetes_____
☐ Other_____
☐ Heart Disease_____
☐ Hypertension_____
☐ Miscarriage_____
☐ Osteoporosis_____
☐ Stroke_____

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.

General
___Insomnia
___Dreams/ nightmares
___Irritability
___Depression
___Mood swings
___Fatigue
___Poor memory
___Strongly like cold drinks
___Strongly like hot drinks
___Recent weight loss/gain
___Cold hands & feet
___Chills
___Fever

Head & Neck
___Headaches
___Migraines
___Stiff neck
___Dizziness
___Fainting
___Swollen glands

Ears
___Ringing
___Hearing loss
___Infections
___Earache
___Hearing aids
___Vertigo

Eyes
___Glasses/ contact lenses
___Blurred vision
___Poor night vision
___Spots or floaters
___Eye inflammation
___Double vision
___Glaucoma
___Cataracts

Skin
___Hives
___Rashes
___Eczema/ psoriasis
___Night sweating
___Excess sweating
___Dry skin
___Easy bruising
___Changes in moles, lumps
___Itching

Respiratory
___Difficulty breathing
___Difficulty breathing when lying down
___Wheezing
___Asthma
___Chronic cough
___Wet cough
___Dry cough
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Tight chest
___Pneumonia

Cardiovascular
___High blood pressure
___Low blood pressure
___Chest pain or tightness
___Palpitation
___Rapid heart beat
___Irregular heart beat
___Poor circulation
___Swollen ankles
___Phlebitis
___Anemia
___History of heart attack

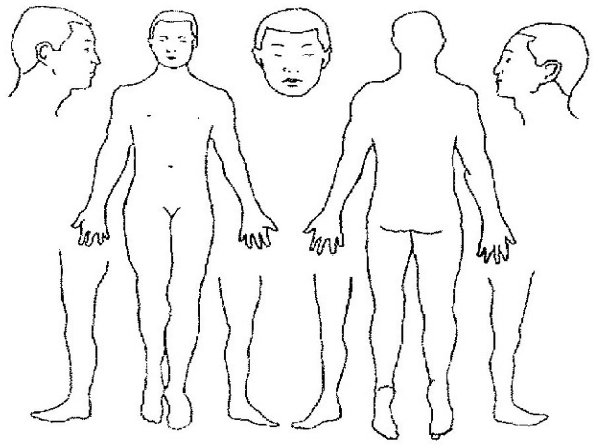
Musculoskeletal
___Joint pain/disorder
___Sore muscles
___Weak muscles
___Difficulty walking
___Neck/shoulder pain
___Upper back pain
___Lower back pain
___Rib pain
___Limited range of motion
___Other (describe)

Neurological
___Seizures
___Tremors
___Numbness or tingling
___Pain
___Paralysis
___Poor coordination
___Other (describe)

Genito-urinary
___Pain on urination
___Frequent urination
___Urgent urination
___Blood in urine
___Unable to hold urine
___Incomplete urination
___Bedwetting
___Wake to urinate
___Increased libido
___Decreased libido
___Kidney stones
___Impotence
___Premature ejaculation
___Nocturnal emission
___Pain/itching of genitalia
___Lumps in testicles

Nose, Throat & Mouth	**Gastrointestinal**	**Infection Screening**
___Sinus infection	___Nausea	___HIV risks: self or partner
___Hay fever/ allergies	___Indigestion	___TB: self or household
___Frequent sore throat	___Stomach pain	___Hepatitis risk: self or partner
___Difficulty swallowing	___Diarrhea	___History of sexually transmitted
___Mouth & tongue ulcers	___Constipation	disease: self or partner
___Frequent colds	___Poor appetite	___Gonorrhea
___Excessive phlegm	___Excessive hunger	___Chlamydia
___Dry nose ___Facial pain	___Vomiting	___Syphilis
___Nasal congestion	___Gas	___Genital warts
___Loss of voice	___Hiccups	___Herpes: oral/ genital
___Thirst ___Dry mouth	___Acid regurgitation	
___Nosebleed	___Bloating ___Mucus in stool	**Other:**_____
___TMJ ___Gum problems	___Bad breath ___Hemorrhoids	_____
	___Laxative use ___Gall Bladder	_____
	___Bloody stool disorder	

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**

Since the injury/occurrence, has your condition: ___Improved ___Deteriorated ____No Change
Please describe the type of pain: ____Sharp___stabbing____shooting__ throbbing__ tight____stiff___dull
____ aching ___other:_____
Paresthesia:__numbness__tingling___pins&neeedles___pricking___burning___loss of sensation
Paresthesia frequency: ___comes and go ___constant
Pain behavior: ___fixed ___moving___ comes and goes____ radiating
What makes the problem worse? ___walking___sitting___standing___laying down___stress
___changes of weather___exertion___rest ___heat ___
___cold ___heavy pressure___other:_____
What makes the problem better? ___walking__sitting___standing___laying down___ rest __heat __cold
___heavy pressure__sleep ___pain medications ___other:_____
What are the activities or movements that are painful/difficult to perform: __walking__ running __sitting
__ bending__ standing__ lying down__ lifting __other: _____

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

Goji Acupuncture & Herbs

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, auricular acupuncture, 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, tingling and burning sensation near the needling sites that last a few days to a few weeks or even longer, 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 and videos 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.

_____ X_____
Patient's name (PLEASE PRINT) Signature / Date

_____ X_____
Name of Legal Guardian (PLEASE PRINT) Signature / Date