Ume Acupuncture and Integrative Medicine
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415.282.2806
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Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Cell Phone _____

E-mail Address _____

Birth date _____ Gender _____ Marital Status _____

Occupation_____ Employer _____

Referred by _____

Emergency Contact _____ Phone _____

Emergency Contact Relationship _____

Physician's Name _____ Phone _____

Insurance Carrier _____

Describe your principal complaint(s):

Have you been diagnosed by an MD?

What treatment have you received?

Name: _____

Any problems during your birth?

Please list any major illnesses, surgery, or accidents, and the age at which they occurred, from childhood to adulthood.

Please note all major illnesses in your immediate family, such as diabetes, heart disease, high blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, etc.

Please note all medication, herbs, vitamins and other supplements you take, even if only occasionally.

Do you have any scars? Please note the location of all operation or injury scars, even minor ones.

Please list all known allergies to foods and drugs.

Name: _____

Symptom List

Circle any problem, disease, or symptom you are currently experiencing.

Underline items that have affected you in the past.

Skin:

eczema
acne
dermatitis
fungal infections
psoriasis
skin rashes

Gastrointestinal:

Constipation
Diarrhea
No appetite
Stomach pain
Indigestion
Heartburn
Belching
Intestinal gas
Gastritis
Gastritis
Gastritis
Pancreatitis
Irritable bowel
Gall bladder disease

Respiratory:

Asthma
Bronchitis
Emphysema
Cough
Wheeze
Pneumonia

Female:

Cramping
Infertility
PMS
Low libido
Tubal ligation
Hysterectomy
Heavy/light/irregular periods
Menopause symptoms

Heart and vascular:

Palpitation
Irregular pulse
Chest pain
Dizziness
Migraine
Anemia
Raynaud's Disease
Rapid pulse (>100 beats/min)
Slow pulse (<60 beats/min)
High blood pressure
Low blood pressure
Cold hands/cold feet
Chest pressure or shortness of breath
Dizziness or faint when standing up quickly or standing for a long time

Hormonal imbalance:

Low thyroid
Diabetes
Hypoglycemia
Overactive thyroid

Male:

Impotence
Infertility
Vasectomy
Prostate condition

Name: _____

Autoimmune and inflammatory:

Hashimoto's rheumatism
colitis Crohn's disease
sinus allergies food allergies
arthritis fibromyalgia
tendinitis plantar fasciitis
staph infections swollen glands
pericarditis low immunity
rheumatic disease
constant low fever
systemic lupus erythematosus
alopecia (hair loss)

General:

insomnia exhaustion
depression anxiety
irritability
difficulty concentrating
easily carsick, seasick, airsick
no appetite for breakfast
unusual sweating (palm, sole, elsewhere)
never sweat

Ear, nose and throat:

deafness tinnitus
ear pain ear infections
stuffy nose sinus headaches
sore throat dry throat
itchy throat post-nasal drip
constant sinus congestion
strep throat infections

Oral disease:

bleeding gums periodontitis
mumps TMJ
toothaches without cavities
stomatitis (inflammation of the mouth)

Before noon time:

no energy brain fog
energetic all evening
difficulty waking early
dizzy or faint easily

Other: Liver disease Gall bladder disease Gout

Additional symptoms or comments:

_____

_____

_____

_____

_____

Name: _____

Women's Reproductive History

Age period began:_____ Frequency of period:_____

Duration of bleeding:_____

Cramps: mild, moderate or severe? _____

Before, during, or after period? _____

Non-menstrual bleeding/spotting? _____

Birth Control Methods (please list all, indicating past or present):

Vaginal/yeast infections: past _____ present _____

Treatment received:

Previous Pregnancies (#):

Total: Living: Ectopic: Miscarriage: Abortion:

Complications related to pregnancy or birth:

Have you gone through menopause? If so, when, and are you symptomatic now?

Other remarks regarding OB/Gyn history:

Acupuncture Informed Consent to Treat

I herby 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 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 have 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. While unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax), thorough training has been received to avoid these occurrences. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and 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 course of treatment which the clinical staff thins at the time, based upon the facts then known, is in my best interest. I understand that 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 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 (or patient representative) Date

_____

Relationship if signing for patient

Financial Agreement

I understand that I am financially responsible for all charges and services, including the balance after payment of possible insurance benefits or legal settlements, and charges for any missed appointments WITHOUT A MINIMUM OF 24-HOURS NOTICE.

I authorize payment of medical benefits to myself or the names provided for professional services rendered. I authorize release of any medical information necessary to process this claim.

_____ _____

Patient signature (or patient representative) Date

_____

Relationship if Signing for Patient

Name: _____

Fertility History

When did you start trying to conceive?

Have you had a diagnosis of fertility? If yes, what was it?

Please list any fertility treatments:

Date	Treatment	Doctor	Outcome

Male Fertility History:

Have you fathered any children? If yes, how many? Please list the years.

Have you experienced any symptoms such as difficulty initiating or maintaining an erection, difficulty ejaculating, penile discharge, or difficulty urinating?

Have you had any urological surgeries or a vasectomy?

Have you had a fertility workup that includes testosterone levels or a semen analysis?