Open City Healing Arts

Patient Profile

Name _____Date_____

Phone H (_____) _____ - _____ W (_____) _____ - _____

Email address_____

Please sign me up for Open City Healing Arts periodic newsletter

Address _____ Zip _____

Birth Date _____ Height _____ Weight _____

Attending Physician _____ Phone (_____) _____ - _____

Your Occupation _____

How did you hear about Open City?_____

Emergency Contact _____

Phone: H (_____) _____ - _____ W (_____) _____ - _____

Relationship to Patient: _____

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Medical History:

Please describe what is leading you to seek treatment

_____

_____

_____

_____

What has been diagnosed by an MD?

_____
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Childhood illnesses, surgeries or accidents:

Age _____

Age _____

Age _____

Age _____

Adult illnesses, surgeries or accidents:

Age _____

Age _____

Age _____

Age _____

Please note location of any surgery or injury scars, even minor ones:

_____

_____

_____

Please note all major illnesses in your immediate biological family, like diabetes, heart disease, blood pressure, cancer, neurological or psychological disorders.

_____

_____

_____

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_____

Please any symptoms that you have now. Please underline symptoms that have affected you in the past.

hearing loss	lower back pain	edema	thyroid problems	perspire easily
ringing in ears	weak legs/knees	darkness under eyes	diabetes	fearfulness
dizziness	kidney stones	hair loss	up at night to urinate	
rapid weight loss	reduced sexual energy	dental problems	frequent urination	

headaches	poor eyesight	eczema	shingles	indecisiveness
migraines	dry eyes	tense shoulders or neck	herpes simplex	irritability
constipation		tension in jaw	hepatitis	

insomnia	palpitations	pain or tightness in chest	memory problems
nightmares	heart racing	anxiety	

indigestion	flatulence	gum disease	excessive hunger	worry
stomach ache	loose stools	mouth sores	poor appetite	rumination
heartburn	diarrhea	halitosis	gain weight easily	muscle ache
nausea	blood in stool		fatigue	joint pain

tendency to catch colds	chronic cough	lymphatic swelling	sinus infections
recurrent/ lingering bronchitis	shortness of breath	cysts	nasal congestion
environmental allergies	sore throat	tumors	dry skin
asthma			

Please describe past & present use of:

tobacco	alcohol	marijuana	cocaine	other:_____

Choose one or two emotions that seem predominant in your life (frequently experienced, difficult to express, or in some way influential):

____

____

Please indicate approximate dates and briefly describe the nature of any traumatic experiences (breakup of relationships, injury, death in family, loss of job, change of residence):

____

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____

____

Women Only: # of Pregnancies:______ # of Live Births:______

Birth Control Type:__________ # of Days in Cycle______ # of Days of Menses______

vaginal infection	urinary tract infection	ovarian cysts	genital herpes	breast lumps
yeast infection	urinary incontinence	uterine fibroids	pelvic inflammatory disease	

birth control pills	early periods	premenstrual syndrome	low mood	cramping
irregular periods	late periods	breast tenderness	irritability	low energy

Other:____

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Men Only:

enlarged prostate	nocturnal emission	burning urination
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impotence	premature ejaculation	urinary incontinence

Current Prescriptions:

Name Since (date) For (condition)

1.

2.

3.

4.

5.

6.

Any Over-the-Counter Medications that you regularly take:

Name Since (date) For (condition)

1.

2.

3.

4.

Current Herbal or Homeopathic Remedies, Vitamin Supplements, etc.:

Name Since (date) For (condition)

1.

2.

3.

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24 hour cancellation policy

I understand that I will be held responsible for rescheduling or cancelling my appointments 24 hours in advance. Open City Healing Arts will charge me the full fee for appointments cancelled or rescheduled without 24 hours advanced notice.
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Patient Signature:	Date:

Informed Consent For Acupuncture and Chinese Medicine Treatment

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 indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as backup 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 or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I will immediately notify a member of the clinic 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 clinic uses sterile disposable needles and maintains a clean and safe environment.

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, 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 hers 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 thinks at the time, based upon the facts then know 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 for to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Acupuncturist Name:	
Patient Name:	
Patient Signature/ Date:	