Open City Healing Arts –Laura Hawley, Lic Ac, MSW

1315 Walnut St, Ste 920 – Phila, Pa 19107 -215-545-7040

Patient Profile

Name: _____

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

Email address_____

Address: _____ Zip: _____

Today's Date: _____ Birth Date: _____ Height: _____ Weight: _____

Attending Physician: _____ Phone: ( ) _____ - _____

Your Occupation: _____

Referral Source: _____

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.

_____

_____

_____

_____

_____

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

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

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

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

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

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

Use of tobacco alcohol marijuana cocaine other street drugs

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

birth control pills

late periods early periods irregular periods premenstrual syndrome
breast tenderness low mood irritability cramping low energy
other: _____
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Men Only:
enlarged prostate nocturnal emission burning urination premature ejaculation
impotence urinary incontinence

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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):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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.			
5.			

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

	Name	Since (date)	For (condition)
1.			
2.			
3.			

Open City Healing Arts
The Philadelphia Building
1315 Walnut Street, Suite 920
Philadelphia, PA 19107

Informed Consent

Informed Consent For Acupuncture and Chinese Medicine Treatment

I hereby request and consent to the performance of acupuncture treatments and other Chinese Medicine procedures, including various modes of physiotherapy, on me by Laura Hawley, Lic Ac
I understand that methods or treatments may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), gua-sha, Chinese or Western herbal medicine, and nutritional counseling.
I have been informed that I have a right to refuse any form of treatment. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about the content of the consent, and by signing below I agree to receive the above-named treatments and procedures from Laura Hawley, Lic Ac.
I also understand there is always a possibility of an unexpected complication, and I understand that no guarantee can be made concerning the results of the treatments on me by Laura Hawley, Lic Ac. I intend this informed consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from Laura Hawley, Lic Ac.
I understand that it may be necessary for Laura Hawley, Lic Ac. to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives Laura Hawley, Lic Ac., permission to release any medical records for the reasons set forth in this paragraph.

_____
Patient's Name

_____
Patient's Signature

_____
Date of Signature