PATIENT'S NAME _____ BIRTH DATE _____ SEX _____ S. M. W. D.

STREET _____ CITY _____ ZIP _____ TELEPHONE # _____

REFERRED BY _____ YOUR OCCUPATION _____ WORK TEL. # _____

MAIN COMPLAINT _____

## PERSONAL HISTORY

| HAVE YOU EVER HAD . . . | NO | YES | HAVE YOU EVER HAD . . . | NO | YES | HAVE YOU EVER HAD . . . | NO | YES |
|---|---|---|---|---|---|---|---|---|
| ☐ SCARLET FEVER ☐ SCARLETINA | | | ANEMIA | | | RECURRENT DISLOCATIONS | | |
| DIPHTHERIA | | | JAUNDICE | | | ☐ CONCUSSION ☐ HEAD INJURY | | |
| SMALLPOX | | | EPILEPSY | | | EVER BEEN KNOCKED UNCONSCIOUS | | |
| PNEUMONIA | | | MIGRAINE HEADACHES | | | ☐ FOOD ☐ CHEMICAL ☐ DRUG POISONING | | |
| PLEURISY | | | TUBERCULOSIS | | | EXPLAIN | | |
| UNDULANT FEVER | | | DIABETES | | | ☐ GONORRHEA ☐ SYPHILIS | | |
| ☐ RHEUMATIC FEVER ☐ HEART DISEASE | | | CANCER | | | ☐ HERPES ☐ AIDS | | |
| HEPATITIS | | | ☐ HIGH ☐ LOW BLOOD PRESSURE | | | ANY OTHER DISEASE | | |
| ☐ ARTHRITIS ☐ RHEUMATISM | | | NERVOUS BREAKDOWN | | | EXPLAIN | | |
| ANY ☐ BONE ☐ JOINT DISEASE | | | ☐ HAY FEVER ☐ ASTHMA | | | | | |
| ☐ NEURITIS ☐ NEURALGIA | | | ☐ HIVES ☐ ECZEMA | | | | | |
| ☐ BURSITIS ☐ SCIATICA ☐ LUMBAGO | | | FREQUENT ☐ COLDS ☐ SORE THROAT | | | WEIGHT: NOW ONE YR. AGO | | |
| ☐ POLIO ☐ MENINGITIS | | | FREQUENT ☐ INFECTIONS ☐ BOILS | | | MAXIMUM WHEN | | |
| BRIGHT'S DISEASE | | | ANY ☐ BROKEN ☐ CRACKED BONES | | | | | |

## HABITS

| DO YOU . . . | NO | YES | DO YOU USE . . . | NEVER | OCC.. | FREQ. | DAILY |
|---|---|---|---|---|---|---|---|
| EXERCISE ADEQUATELY | | | LAXATIVES | | | | |
| HOW? | | | VITAMINS | | | | |
| AWAKEN RESTED | | | SEDATIVES | | | | |
| SLEEP WELL | | | TRANQUILIZERS | | | | |
| AVERAGE 8 HOURS SLEEP (PER NIGHT) | | | SLEEPING PILLS, ETC. | | | | |
| HAVE REGULAR BOWEL MOVEMENTS | | | ASPIRINS, ETC. | | | | |
| | | | CORTISONE | | | | |
| LIKE YOUR WORK ( HOURS PER DAY) ☐ INDOORS ☐ OUTDOORS | | | ALCOHOLIC BEVERAGE | | | | |
| WATCH TELEVISION ( HOURS PER DAY) | | | COFFEE ( CUPS PER DAY) | | | | |
| READ ( HOURS PER DAY) | | | TOBACCO: ☐ CIGARETTES ( PKS PER DAY) | | | | |
| HAVE A VACATION ( WEEKS PER YEAR) | | | ☐ CIGARS ☐ PIPE ☐ CHEWING TOBACCO | | | | |
| HAVE YOU EVER BEEN TREATED FOR ALCOHOLISM | | | ☐ MARIJUANA ☐ OTHER DRUGS | | | | |
| HAVE YOU EVER BEEN TREATED FOR DRUG ABUSE | | | APPETITE DEPRESSANTS | | | | |
| RECREATION: DO YOU PARTICIPATE IN SPORTS OR HAVE HOBBIES WHICH GIVE YOU RELAXATION AT LEAST 3 HOURS A WEEK. | | | THYROID MEDICATION: ☐ NO ☐ YES, IN PAST ☐ NONE NOW NOW ON GR. DAILY | | | | |
| | | | HAVE YOU EVER TAKEN . . . ☐ INSULIN ☐ TABLETS FOR DIABETES ☐ HORMONE SHOTS ☐ TABLETS ☐ NO | | | | |

## WOMEN ONLY

| MENSTRUAL HISTORY . . . | | NO | YES |
|---|---|---|---|
| AGE AT ONSET | ARE YOU REGULAR: ☐ HEAVY ☐ MEDIUM ☐ LIGHT | | |
| USUAL DURATION OF PERIOD DAYS | DO YOU HAVE ☐ TENSION ☐ DEPRESSION BEFORE PERIOD | | |
| CYCLE (START TO START) DAYS | DO YOU HAVE ☐ CRAMPS ☐ PAIN WITH PERIOD | | |
| DATE OF LAST PERIOD | DO YOU HAVE HOT FLASHES | | |

| PREGNANCIES | NO | YES | | | |
|---|---|---|---|---|---|
| CHILDREN BORN ALIVE (HOW MANY ) | | | STILL BORN (HOW MANY ) | | |
| CESAREAN SECTIONS (HOW MANY ) | | | MISCARRIAGES (HOW MANY ) | | |
| PREMATURES (HOW MANY ) | | | ANY COMPLICATIONS | | |

## SURGERY

| HAVE YOU HAD REMOVED . . . | NO | YES | | | | | | |
|---|---|---|---|---|---|---|---|---|
| TONSILS | | | ☐ OVARY ☐ OVARIES | | | HAD HERNIA REPAIRED | | |
| APPENDIX | | | HEMORRHOIDS | | | BEEN HOSPITALIZED FOR ANY ILLNESS | | |
| GALL BLADDER | | | EVER HAVE A TRANSFUSION | | | HAD ANY OTHER OPERATIONS | | |
| UTERUS | | | ☐ BLOOD ☐ PLASMA | | | LIST . . . | | |

LIST . . .

Place an "X" in the box if the answer is yes (within the last 3 months), leave blank if the answer is no. Read across.

## I & II (V & VI)

| | | | |
|---|---|---|---|
| HEART PALPITATION | | PROFUSE SWEATING | |
| INSOMNIA | | DREAM DISTURBED SLEEP | |
| MENTAL CONFUSION | | RESTLESSNESS | |
| PAIN IN CHEST | | PAIN IN SHOULDER | |
| LACK OF JOY IN LIFE | | UNCONTROLLABLE LAUGHTER | |
| CRAVING BITTER FOODS | | AVOIDING BITTER FOODS | |

## III & IV

IS YOUR URINATION . . .

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| FREQUENT | | URGENT | | DIFFICULT | | PAINFUL | |
| SCANTY | | CLEAR | | YELLOW | | REDDISH | |

DO YOU HAVE . . .

| | | | |
|---|---|---|---|
| DRIBBLING AFTER URINATION | | INCONTINENCE OF URINE | |
| BED WETTING | | NOCTURNAL EMISSION | |
| IMPOTENCE | | PREMATURE EJACULATION | |
| WEAKNESS OR PAIN IN LOWER BACK | | OR KNEES | |
| EDEMA IN THE LOWER LIMBS | | NIGHT SWEATS | |
| POOR MEMORY | | ASTHMATIC BREATHING | |
| DEAFNESS | | RINGING IN THE EARS | |
| HAVE YOU BEEN OVERLY SCARED OR FEARFUL | | | |
| CRAVING SALTY FOODS | | AVOIDING SALTY FOODS | |

## VII & VIII

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| PAIN OR DISTENSION IN SIDES | | | | BREASTS | | LOWER ABDOMEN | |
| ITCHING OR PAIN OF THE EXTERNAL GENITALIA | | | | SWELLING OR PAIN IN THE TESTIS | | | |
| MENTAL IRRITATION | | | | MOOD SWINGS | | | |
| EXCESSIVE ANGER | | | | FREQUENT HEADACHES | | | |
| FREQUENT MIGRAINES | | | | | | | |

DO YOU HAVE / ARE YOUR EYES . . .

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| RED | | DRY | | TIRED | | ITCHY | |
| BLURRED VISION | | MUSCLE SPASMS | | TIGHT JOINTS | | STIFF OR PAINFUL JOINT | |
| CRAVING SOUR FOODS | | | | AVOIDING SOUR FOODS | | | |

## IX & X

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| IS YOUR THROAT . . . | | | | | | | |
| ITCHY | | RED | | SWOLLEN | | PAINFUL | |
| DO YOU HAVE A COUGH | | | | IS IT DRY | | OR WITH SPUTUM | |
| FEVER | | | | AND / OR CHILLS | | | |
| NASAL DISCHARGE | | | | THIN AND WATERY | | OR THICK | |
| SHORTNESS OF BREATH | | EXCESSIVE PERSPIRATION | | LACK OF PERSPIRATION | | NIGHT SWEATS | |
| LACK OF STRENGTH | | | | HOT (FEVERISH) PALMS OF HANDS AND SOLES OF FEET | | | |
| LOWER ABDOMINAL PAIN | | | | DIARRHEA | | AND / OR CONSTIPATION | |
| SKIN RASHES | | | | DRY SKIN | | OILY SKIN | |
| AN EXCESS OF GRIEF OR MELANCHOLY | | | | | | | |
| CRAVING OF PUNGENT FOOD | | | | AVOIDING PUNGENT FOOD | | | |
| | | | | | | | |

## XI & XII

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| RETENTION OF FOOD IN STOMACH | | | | STOMACHACHE | | | |
| VOMITING | | | | BELCHING | | | |
| HICCOUGH | | | | FEELING HUNGER EASILY | | NO APPETITE | |
| GUM PAIN | | GUM SWELLING | | GUM BLEEDING | | BAD BREATH | |
| EDEMA | | COLD EXTREMITIES | | LOOSE WATERY STOOLS | | PROLAPSE OF RECTUM | |
| PROLAPSE OF UTERUS | | LASSITUDE | | BRUISE EASILY | | BLOOD IN STOOLS | |
| MUSCLES TIRED | | | | OR WEAK | | OR SORE | |
| BOTHERED BY TOO MUCH THINKING | | | | | | | |
| CRAVING SWEET FOODS | | | | AVOIDING SWEET FOODS | | | |

CURRENT MEDICATIONS AND DIETARY SUPPLEMENTS _____

# PATIENT INFORMED CONTENT/VOLUNTARY TREATMENT/MUTUAL ARBITRATION AGREEMENT

I, _____, hereby voluntarily consent to receive Acupuncture Therapy. I understand that Acupuncture is performed by the insertion of special, fine, sterile, disposable needles (with or without electrical stimulation) through the skin, to certain points on the body in an attempt to balance energy and thus improve body function and maintain good health. The techniques used will include, but are not limited to, one or more of the following: Acupuncture, Electro-Acupuncture, Cupping, Herbs and Guasha.

I acknowledge that I have read and understand the cover sheet entitled "Your Acupuncture Treatment Session" which defines the above procedures.

I acknowledge that although rare, certain side effects may result from Acupuncture. These can include bruising, mild pain, or aggravation of symptoms. These effects are unusual and of short duration. Other possible side effects are: burns, pneumothorax, and spontaneous miscarriage.

I understand that the evaluation given me and energetic assessment of the Acupuncture channel network, and in no way purports to be, or replaces the occidental or western medical examination and diagnosis. In the course of the evaluation, there may be reference to the state of various "organs" such as the heart, liver, spleen, etc., which actually refer to energetic channels of the same name.

I acknowledge that the Acupuncture Therapists is not and does not profess to be a medical doctor and does not advise on the use of medically prescribed pharmaceuticals or medical treatment, nor does the therapist give any substances by injection. I do not apply for or wish to receive a medical diagnosis and/or medical or surgical treatment.

I acknowledge that the Acupuncture Therapist has received training from an accredited Acupuncture school and has been certified by the school and by the National Commission for Certification of Acupuncturists. (NCCAOM).

It is agreed by all parties that any dispute, claim, allegation or lawsuit related to the treatment, care, or professional services rendered under this agreement will be determined and adjudicated by submission to arbitration as provided by the American Arbitration Association, in accordance with Michigan law. All parties to this contract, by entering into it, agree that they are freely and voluntarily consenting to waiving the right to have any such dispute decided in a court of law before a jury.

**PAYMENT IN FULL IS REQUIRED AT THE TIME OF APPOINTMENT.**
We accept payment by cash, checks, MasterCard, Visa or Discover. We will NOT bill your insurance company for this service, however, we will provide you with a receipt that you can send to your insurance company for possible reimbursement. Acupuncture may or may not be covered by (your) insurance company. It is your responsibility to check with your insurance company regarding coverage.

I agree to accept all responsibility for payment of services rendered.

Signature of patient (or legal guardian) _____

Date _____ Witnessed by _____

# YOUR ACUPUNCTURE TREATMENT SESSION

Welcome to the Muscle Therapy and Acupuncture Center. The following information is intended to help you better understand the ancient healing arts of Acupuncture and Oriental Medicine, so that you can relax and the most from your treatments. We want you to feel comfortable during your treatment and encourage your questions.

Traditional Oriental Medicine is hardly new. For over 3,000 years it has been used to help people heal from a wide variety of illnesses or "diseases". Your treatment may involve one or more of the following aspects of Oriental Medicine:

**Acupuncture:** The insertion of very fine needles into specific points on the body. These needles are so small that they will actually fit inside a regular hypodermic needle! These needles are sterile and used only once.

**Electro-Acupuncture**: The application of the minute pulses of energy to the needles after they have been inserted. This feels like a ticking or tapping of the needle.

**Nutritional Counseling**: Many illnesses are aggravated or helped by certain foods or beverages. We may encourage you to decrease or increase your intake of specific foods.

**Vitamin and Mineral Therapy**: If there is a nutrient that can help your specific condition, we may recommend it. The vitamins and minerals we have are of the highest quality, which means they are very effective. We may also recommend a supplement that we do not carry, but may be available in most health food stores.

**Lifestyle Counseling**: Our job is to help you regain and maintain good health. We will make every effort to share with you what activities will help or hinder your progress.

**COMMON QUESTIONS ASKED**:

**How long are the treatments?** Plan to be in the office for about an hour and a half for the first treatment. You will need to fill out forms and we will take time to go through your health history in detail. Subsequent treatments may last 45-60 minutes. If you are pressed for time, please tell me or the receptionist when you arrive. We like to give you plenty of time to relax, but we can adjust the length of the session if necessary.

**What happens during the treatment, and what does it feel like?** After the acupuncturist assesses your condition, she/he will insert a number of very fine needles into the skin. Insertion of the needle often feels like a mosquito bite or less! The acupuncturist then turns down the

lights and puts on soft music so you can relax while he/she is out of the room. The needles are usually left in for 20-25 minutes, and the acupuncturist will check on you once during this time.

**What do the needles do?** The needles cause the body to release it's own natural pain relievers and mood elevators, such as beta-endorphins and serotonin. This will help to relieve pain and relax you. Some people get so relaxed they actually fall asleep during treatment! The needles also increase the circulation (nerve and blood supply) to the area, which helps the area to heal. Other chemicals (such as ACTH) are released that help decrease inflammation, which helps in painful conditions such as arthritis. Lastly, the immune system of the body is boosted by acupuncture. The body has an incredible ability to heal itself, and the acupuncture just helps it along .

**Could I bruise from the treatment?** As with any needle procedure, bruising is a possibility. If you normally bruise easily your chances of bruising during a treatment are greater. If you have been using aspirin or other blood thinners the possibility is also greater.

**Will a treatment ever make me feel worse?** A very small percentage of patients (less than 5%) may notice an exacerbation (temporary flare up) of their condition after the first or second treatment. This is rare and is usually a good sign. After the exacerbation subsides the symptoms are much better and some cases, gone!

**How many treatments will it take?** This is our most frequently asked, and the most difficult – to- answer question. How soon the condition will improve depends on the number of factors: how long you have had the condition, your age, the strength of your immune system, which condition you have, how often you get treatments, what your diet and exercise programs are like, etc. Some problems take 3 treatments, some 30. Most people notice a difference within 4-6 treatments. They may need many more treatments than this, but there is a definite change in the condition within 4-6 treatments. It is not uncommon to notice an improvement after one treatment, but don't worry if you don't. As you have more treatments the change will be stronger and last longer. Be patient - you didn't get in the shape you are in overnight, and it won't change overnight either.

**Will insurance cover acupuncture?** In many cases insurance will not cover acupuncture. However, your receipt contains all the information your insurance company should need to process your claim. Attach your receipt to your insurance form and send to your agent/company.

**What is your payment policy and fee structure?** Payment is expected at time of treatment.

**Acupuncture – initial session.....$90.00**
**(Consultation fee is included in initial session fee)**

**Acupuncture session .....$70.00**

**Acupuncture session (0-12 years).....$55.00**