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 (FEVER-H) 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 _____

# INFORMED CONSENT FOR FACIAL ACUPUNCTURE TREATMENT

**INSTRUCTIONS** - This is an informed consent document that has been prepared to help your acupuncturist inform you concerning facial acupuncture treatments, the risks involved, and possible alternatives. Please be advised that this is not a surgical procedure. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for facial acupuncture treatments, as proposed by your acupuncturist.

I understand that my treatment may be modified to address: 1) Changes in my condition; 2) changes in my desired results; or 3) changes in the professional standards of acupuncture care. I understand, and agree to adjustments in my treatment as needed to optimally address my well-being, my objectives, and to take advantage of the full range of care options for me.

**INTRODUCTION** - An acupuncture facial treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Oriental medicine, the meridians or pathways of *Qi* (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely "cosmetic." An acupuncture facial involves the patient in an organic, gradual process that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift". A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures, including micro-current facial treatment.

**POTENTIAL BENEFITS** - Facial acupuncture can increase facial tone, decrease puffiness around the eyes, as well as bring more firmness to sagging skin, enhance the radiance of the complexion, and flesh out sunken areas. Customarily, fine wrinkles will disappear, and deeper ones be reduced. As this treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health. However, I understand that as with all acupuncture care, facial acupuncture treatment involves a gradual, healthful process that is customized for each individual, and that results may vary.

**ALTERNATIVE TREATMENT** - I understand that other alternatives exist for cosmetic care, including, but not limited to, surgery, such as a surgical facelift, chemical face peels, or liposuction. I realize that there are also risks and potential complications associated with these alternative forms of treatment.

**RISKS OF AN ACUPUNCTURE FACIAL TREATMENT** - Every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture facial. An individual's choice to undergo an acupuncture facial is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications, and consequences of an acupuncture facial.

- **BLEEDING AND BRUISING** – As with acupuncture in general, some minor bleeding may occur. This is normal and usually will not leave a bruise. Occasionally, a bruise or a hematoma may appear. With bruising, it is important that you wear sunscreen when going outside. Topical and internal remedies will be discussed to address bruising. If swelling persists, I understand, I should call my provider immediately.
- **INFECTION** – Infection at the probe site is very rare after treatment because the probe does not break the skin. If you suspect infection at the probe site (i.e. redness, swelling or warm to the touch), please call me. Additional treatment or referral to your M.D. may be necessary.
- **DAMAGE TO DEEPER STRUCTURES** - Deeper structures such as blood vessels, nerves, and muscles are rarely damaged during the course of a facial acupuncture treatment. If this does occur, the injury may be temporary or permanent.
- **ASYMMETRY** – All facial structures are naturally asymmetrical. Results may vary from side to side due to the natural asymmetry, previous injuries on one side of the body, or severity of symptoms from one side or the other.
- **NERVE INJURY** - Injuries to the motor or sensory nerves rarely result from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.
- **NEEDLE SHOCK** - Needle shock is a rare complication after an acupuncture facial.
- **UNSATISFACTORY RESULT** – There is the possibility of a poor result from a facial acupuncture treatment. You may be disappointed with the results. I understand that I am not having a surgical procedure. The alternatives, risks, and comparisons of surgical procedures versus facial acupuncture treatments have been discussed with me and outlined in this document. Should I have any further questions, I will discuss them with my provider before treatment begins.
- **ALLERGIC REACTIONS** – In rare cases, local allergies to topical preparations have been reported. Allergic reactions may require additional treatment or discontinuation of treatment.

- **DELAYED HEALING** – Delayed healing is a rare complication. Smoking and certain health conditions such as diabetes and chronic fatigue syndrome, to name a few, may delay the healing response of any of the aforementioned risks.
- **LONG-TERM EFFECTS** – Following facial acupuncture treatments, changes in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, stress, illness, or other circumstances not related to such treatment. It has been explained that following lifestyle and dietary instructions may enhance the longevity of the results, while non-compliance will adversely affect the longevity of the results from facial acupuncture treatments. Additional, future treatments may be necessary to maintain the results.
- **UNFORESEEABLE IMPACTS** – There are many variable conditions, in addition to the risks and potential complications enumerated, that may influence the long-term result from facial acupuncture treatments. While the complications cited are the ones particularly associated with facial acupuncture treatments, this is not an exact science, and other less common complications may arise. Should these or other complications occur, other treatments might be necessary.

***UNFORESEEN CONDITIONS*** – I understand that there are several styles or methods of facial, cosmetic, or rejuvenation acupuncture and have been informed that during the course of facial acupuncture treatments, unforeseen conditions may necessitate different procedures than those listed above.

**HEALTH INSURANCE/FINANCIAL RESPONSIBILITY** – I understand that most health insurance does not cover the cost of the facial acupuncture treatments or complications resulting from such treatments. Please contact your insurance if you have any questions about coverage. Depending on whether any or all of the cost of facial acupuncture treatments is covered by an insurance plan, I will be responsible for charges not so covered.

**DISCLAIMER** - Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

**AGREEMENT AND CONTINUOUS EFFECT**: I have read, or have had read to me, the above consent. It has been explained to me in a way that I understand: a) The risks involved with facial acupuncture treatments; b) That I have alternatives available to me for cosmetic improvements; and c) What protocols will be used in connection with treatment. I have also had an opportunity to ask questions regarding facial acupuncture treatment, and am satisfied that all my questions have been answered. I acknowledge that no guarantee has been given to me by anyone as to the results that may be obtained. I authorize the release of medical information, when required. Finally, by signing below I acknowledge that I have been fully informed about, and agree to, facial acupuncture treatments. 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** *(or Person Authorized to Sign for Patient)* | **Practitioner** |
| **Date** | **Date** |

**Photographic Consent** **Muscle Therapy & Acupuncture Center**

Patient name: _____

The purpose of before and after photos is to document the progress of the treatment. Such documentation will help you see changes that could be overlooked. They can also be helpful tools for teaching and demonstrating to prospective patients the potential results of Cosmetic Acupuncture. Please read and initial each statement to which you consent.

_____ I consent to have my pictures taken for comparison purpose but do not consent to have them used for teaching, advertising, or publication of any kind.

_____ I consent to have my pictures used in your advertising materials. I understand that my name will not be disclosed without written permission.

_____ I consent to have my pictures used on your website and the website of Cosmetic Acupuncture Seminars. I understand that my name will not be disclosed without written permission.

_____ _____

Patient signature Date