Please Note: We are a "fragrance free" Clinic. Patients may not wear any scented products

Patient Name (First, Middle Init., Last.)		**DOB**	**Gender**	**Height**	**Weight**
Patient Address			**Phone** (including area code)		
City	**State**	**Zip**	**How Did You Hear About Us?**		
Emergency Contact and Phone		**Email**			

Primary Complaint? _____

When did this begin? _____

What caused it? _____

How Severe is it now? ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

How Severe has it been? ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

What helps or makes it worse? _____

What treatment have you tried? _____

Secondary Complaint? _____

When did this begin? _____

What caused it? _____

How Severe is it now? ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

How Severe has it been? ☐ Mild ☐ Moderate ☐ Serious ☐ Severe

What helps or makes it worse? _____

What treatment have you tried? _____

Past Medical History (please write "Y" for You or "F" for Family. Use both initials if necessary)

Cancer _____	High Blood Pressure _____	Rheumatic Fever _____	Venereal Disease _____
Diabetes _____	Heart Disease _____	Seizures _____	Asthma _____
Hepatitis _____	Stroke _____	Thyroid Disease _____	Pacemaker _____

Other _____

Allergies (drugs, chemicals, foods, animals): _____

Medicines taken within the last 2 months? (prescriptions, vitamins, over-the-counter drugs, herbs)

_____

_____

_____

Patient Name: _____ Date: _____

Please Indicate the Symptoms You Are Currently Experiencing

General

- ☐ Chills
- ☐ Fevers
- ☐ Sweat easily
- ☐ Night sweats
- ☐ Localized weakness
- ☐ Bleed or bruise easily
- ☐ Peculiar tastes or smells
- ☐ Strong thirst (cold / hot)
- ☐ Thirst, no desire to drink
- ☐ Fatigue
- ☐ Sudden energy drop
  *Time of day:*_____
- ☐ Edema
  *Where:*_____
- ☐ Poor sleeping
- ☐ Tremors
- ☐ Poor balance
- ☐ Cravings
- ☐ Change in appetite
- ☐ Poor appetite
- ☐ Weight change
  Gain / Loss _____

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Change in hair or skin
- ☐ Ulcerations
- ☐ Eczema
- ☐ Oozing skin lesion
- ☐ Hives
- ☐ Pimples
- ☐ Loss of hair
- ☐ Dandruff

Other hair or skin problems

_____

_____

Head, Eyes, Ears Nose, and Throat

- ☐ Dizziness
- ☐ Migraines
- ☐ Headaches
  *When:*_____
  Where: _____
- ☐ Facial pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Spots in front of eyes
- ☐ Eye pain
- ☐ Eye strain
- ☐ Cataracts
- ☐ Eye Dryness
- ☐ Excessive tearing
- ☐ Discharge from eyes
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Discharge from ear
- ☐ Nose bleeds
- ☐ Sinus congestion
- ☐ Nasal drainage
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Concussions
- ☐ Recurrent sore throats
- ☐ Hoarseness
- ☐ Sores on lips/tongue

Other head / neck problems

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chest discomfort/pain
- ☐ Heart palpitations
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Fainting
- ☐ Difficulty in breathing

Other heart/blood vessel problems: _____

Respiratory

- ☐ Cough
- ☐ Asthma/wheezing
- ☐ Difficulty in breathing when lying down
- ☐ Phlegm *Color?*_____
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Bronchitis

*Other lung problems:*_____

_____

Gastrointestinal

- ☐ Bad breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Belching
- ☐ Indigestion
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chronic laxative use
- ☐ Blood in stools
- ☐ Black stools
- ☐ Abdominal pain/cramps
- ☐ Gas
- ☐ Rectal pain
- ☐ Hemorrhoids

*Other stomach or intestinal problems:*_____

_____

Genito-Urinary

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Decrease in flow
- ☐ Dribbling
- ☐ Kidney stones
- ☐ Impotency
- ☐ Change of sexual drive
- ☐ Sores on genitals

Do you wake to urinate?
☐ Yes ☐ No

How often? _____
What color is your urine?

_____

*Other genital or urinary system problems?*_____

_____

Pregnancy and Gynecology

of pregnancies: _____
# of births: _____
premature births: _____
of miscarriages: _____
# of abortions: _____
Age at first menses: _____
Length of full cycle: _____
Length of menses: _____
Last menses start date: ____

- ☐ Heavy periods
- ☐ Light periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation
- ☐ Clots
- ☐ Vaginal discharge:
- ☐ Menopause:
  Age: _____
  *Year:*_____
- ☐ Postcoital bleeding
- ☐ Vaginal sores
- ☐ Breast lumps
- ☐ Nipple discharge

Do you practice birth control?
☐ Yes ☐ No

What type and for how long?

_____

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Elbow pain
- ☐ Hand/wrist pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Foot/ankle pain
- ☐ Muscle pain
- ☐ Muscle weakness

Other pain? _____

_____

Neuropsychological

- ☐ Seizures
- ☐ Areas of numbness
- ☐ Weakness
- ☐ Sleep disorder
- ☐ Violence potential
- ☐ Vertigo
- ☐ Lack of coordination
- ☐ Bad temper
- ☐ Depression
- ☐ Easily stressed
- ☐ Loss of balance
- ☐ Poor memory
- ☐ Anxiety
- ☐ Substance abuse

Have you ever been treated for emotional problems?
☐ Yes ☐ No

Patient Name: _____ Date: _____

Acupuncture Informed Consent to Treat

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 legal responsible) by Steven Knobler, LAc (Lic# WA00000546), 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 Steven Knobler, including those working at North Seattle Community Acupuncture 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 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 thinks 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 conditions(s) for which I seek treatment.

PATIENT SIGNATURE _____
(or patient representative) (Indicate relationship if signing for patient)

Patient Name: _____ Date: _____

FINANCIAL AND CANCELLATION POLICY

North Seattle Community Acupuncture makes every attempt to provide acupuncture to as many people as possible by implementing a fair sliding scale policy.

For First Visits, our fee range is $35 to $60. For Return Visits, our fee range is $25 to $50. For our Extended Return Visits, including Orthopedic and General, our fee is $50-$70 per visit. In all cases, pay what you can afford within the fee range.

We recognize that life sometimes gets in the way of one's commitments. If you need to cancel or reschedule your appointment, we ask that you do so at least 12 hours before your original appointment.

All appointments that are cancelled or rescheduled with less than 12 hour advance notice, or appointments missed without notice, will be charged a $25 fee for that appointment. If appointments have been purchased in a package, the missed, cancelled or rescheduled appointment will be deducted from the number of remaining appointments in that package.

We thank you for your understanding.

The ***NorthSea*** Staff.

SIGNATURE _____DATE ___/___/_____

PRINTED NAME _____