HENDERSONVILLE
ACUPUNCTURE
PATIENT INFORMATION

Name: _____ Today's Date: _____

Age: _____ ❑ Male ❑ Female Marital Status: _____

Date of Birth: _____ / _____ / _____

Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email address: _____

Referred by: _____

Are you under the care of a physician now? ❑ Yes ❑ No

If yes, what for: _____

Physician's Name: _____ Phone: _____

I have been presented with and read the patient Notice of Privacy Policies form and agree to the terms stated: ❑ Yes ❑ No

Reason for today's visit: _____

How long have you had this condition: _____

Are you receiving other treatments for this condition? (please specify): _____

_____

Have you had Acupuncture? ❑ Yes ❑ No

Have you used Chinese Herbs before? ❑ Yes ❑ No

Is your condition getting: ❑ Worse ❑ Better

What seemed to be the initial cause: _____

Please list current medications you are taking, including vitamins, herbs, etc: _____

_____

_____

_____

Family Medical History:

❑ Heart Disease ❑ Strokes ❑ Diabetes ❑ Asthma
❑ Seizure ❑ Alcoholism ❑ High blood pressure
❑ Cancer ❑ Other: _____

Your Past Medical History:

❑ HIV/AIDS ❑ Alcoholism ❑ Allergy ❑ Appendicitis
❑ Athsma ❑ Cancer ❑ Chicken Pox ❑ Diabetes
❑ Emphysema ❑ Epilepsy ❑ Goiter ❑ Heart Disease
❑ Hepatitis ❑ Hypertension ❑ Multiple Sclerosis ❑ Mumps
❑ Pacemaker ❑ Pneumonia ❑ Seizure ❑ Stroke
❑ Thryroid ❑ TB ❑ Typhoid Fever ❑ Ulcers
❑ Other: _____

List any hospitalizations you've had during the past 5 years:

_____

_____

Surgeries (list): _____

_____

Your Lifestyle:

❑ Alcohol ❑ Marijuana ❑ Stress ❑ Tobacco
❑ Drugs ❑ Occupational Hazards

Regular Exercise: ❑ Yes ❑ No If so, what type: _____
How often: _____

General Symptoms:

❑ Poor appetite ❑ Dream disturbed sleep ❑ Shortness of breath
❑ Excess appetite ❑ Fatigue ❑ Fever
❑ Strongly like cold drinks ❑ Lack of strength ❑ Chills
❑ Strongly like hot drinks ❑ Peculiar taste in mouth ❑ Night sweats
❑ Recent weight loss/gain ❑ Body feels heavy ❑ Sweat easily
❑ Bleed or bruise easily ❑ Cold hands/feet ❑ Muscle cramps
❑ Poor sleep ❑ Poor circulation ❑ Verigo or dizziness
❑ Sleep too much

Head, Eyes, Ears, Nose, Throat:

❑ Glasses ❑ Headaches ❑ Red eyes ❑ Itchy eyes
❑ Spots in eyes ❑ Poor vision ❑ Blurred vision ❑ Dry eyes
❑ Night blindness ❑ Glaucoma ❑ Cataracts ❑ Teeth problems
❑ Grinding teeth ❑ TMJ ❑ Facial pain ❑ Gum

Problems:

❑ Dry mouth ❑ Excess saliva ❑ Sinus problems ❑ Swollen glands
❑ Lumps in throat ❑ Enlarged thyroid ❑ Nose bleeds ❑ Poor hearing
❑ Ringing in ears ❑ Sores on lips/tongue ❑ Recurrent sore throat ❑ Excessive phlegm
color of phlegm: _____

Respiratory:

❑ Difficulty breathing lying down ❑ Shortness of breath ❑ Tight chest
❑ Asthma / Wheezing ❑ Pneumonia ❑ Cough
❑ Strongly like cold drinks ❑ Lack of strength ❑ Chills
❑ Cough up blood

Cardiovascular:

❑ High blood pressure ❑ Irregular heart beat ❑ Phlebitis
❑ Low blood pressure ❑ Blood clots ❑ Palpitations
❑ Difficult breathing ❑ Chest pain ❑ Fainting
Are you taking blood thinners / aspirin? ❑ Yes ❑ No

Gastrointestinal:

❑ Nausea ❑ Vomiting ❑ Gas
❑ Acid regurgitation ❑ Hiccups ❑ Bloating
❑ Bad breath ❑ Diarrhea ❑ Constipation
❑ Use laxatives ❑ Black stools ❑ Bloody stools
❑ Mucus in stools ❑ Itchy anus ❑ Burning anus
❑ Rectal pain ❑ Hemorrhoids ❑ Anal fissures
❑ Intestinal pain or cramping

Bowel Movements:

Frequency: _____ Color: _____
Formed or Loose: _____ Strong Odor: ❑ Yes ❑ No

Musculoskeletal:

❑ Neck shoulder pain ❑ Upper back pain ❑ Joint pain ❑ Muscle pain
❑ Low back pain ❑ Rib pain ❑ Limited range of motion ❑ Sciatica
❑ Paralysis ❑ Numbness

Skin and Hair:

❑ Rashes ❑ Eczema ❑ Dandruff ❑ Hives
❑ Ulcerations ❑ Psoriasis ❑ Itching ❑ Acne
❑ Hair loss ❑ Fungal infections ❑ Change in hair/skin texture
❑ Other: _____

Neuropsychological:

❑ Seizures ❑ Poor memory ❑ Irritability ❑ Depression
❑ Easily stressed ❑ Anxiety ❑ Tics ❑ Abuse survivor
❑ Seeing a therapist ❑ Considered or attempted suicide

Genitourinary:

❑ Pain on urination ❑ Blood in urine ❑ Venereal disease ❑ Increased libido
❑ Frequent urination ❑ Incontinence ❑ Bedwetting ❑ Decreased libido
❑ Urgent urination ❑ Kidney stone ❑ Wake to urinate ❑ Impotence
❑ Incomplete urination ❑ Other: _____

Gynecology:

❑ Irregular periods ❑ Vaginal sores ❑ Breast lumps ❑ Painful periods
❑ Vaginal odors ❑ Pregnancies #____ ❑ Clots ❑ Vaginal discharge
❑ Live births #_____ ❑ PMS color _____ #_____ ❑ Breast self exam
❑ Premature births #_____ ❑ Other:_____

Hendersonville Acupuncture, LLC

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 legally responsible) by the licensed acupuncturist Amanda Stierwalt.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, electrical stimulation, cupping, tui-na (Chinese massage),Chinese herbal medicine and nutritional counseling.

I have been informed that acupuncture and the adjunct therapies are generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needle site, dizziness or fainting. Possible side effects of taking herbs are nausea, indigestion or loose stools. If I have any questions about the herbs I have been prescribed, those questions will be answered by Amanda Stierwalt, L.Ac.

I understand the Acupuncturist may review my patient records, but all my records will be kept confidential and will not be released without my written consent.

I will notify Amanda Stierwalt if I am or become pregnant.

I understand that no promises have been made to me as to the results of treatment.

By signing below, I show that I have read, or have had read to me, the above consent to treatment, have been informed about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend for 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's Name (please print)_____

Patient/Patient Representative Signature_____

HENDERSONVILLE ACUPUNCTURE

312 8th Ave. West, Hendersonville, NC 28791

PRIVACY PRACTICES ACKNOWLEDGEMENT

Hendersonville Acupuncture
312 8TH Avenue West
Hendersonville, NC 28791
828-698-7888

I have reviewed the posted Notice of Privacy Practices located in the office lobby.

Name_____

Signature_____

Birthdate_____

Date_____