**Bamboo Wisdom Acupuncture**
**572 Washington Street, Suite 3, Wellesley, MA 02482**

# CONSENT FORM

I hereby voluntarily consent to be treated with acupuncture by a licensed acupuncturist at Bamboo Wisdom Acupuncture. I understand that acupuncture is a generally safe method of treatment, but that it occasionally may have side effects, including bruising, numbness, tingling or pain near the needling site that may last a few days, and in rare cases, dizziness or fainting. Treatment may include but is not limited to the following:

1. Heat treatments using conventional heat lamp or moxibustion (Artemesia Vulgaris). With any heat treatment exists the risk of burn.
2. Cupping treatments apply suction cups on the skin. These cups may produce a red or purple mark on the skin at the sight of the cup. Slight bruising or tenderness may persist after the treatment.
3. Electrical stimulation of the needles may be used producing a tapping sensation at the needle location.

I will notify my acupuncturist if I am, or become pregnant. I understand that if there is a worsening of my condition or if a new ailment or condition arises, or in the case of emergency, I should consult my personal physician or go to the local emergency room.

If applicable, I consent to Chinese herbal treatment. The herbal supplements that are 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. Possible side effects of taking herbs include nausea, and stomach ache. I understand that herbs must be consumed according to the instructions provided, and I will immediately notify my acupuncturist if any unanticipated or unpleasant side effects occur.

**Acupuncture treatment is not a replacement for diagnostic medical procedures. If you have any concerns about what may be causing your symptoms you must see a medical doctor.**

## PRIVACY NOTICE FOR GROUP TREATMENT

I understand that it is possible for others to overhear conversation with my acupuncturist in a group setting. I understand that the acupuncturist will do all they can to minimize any compromise of privacy, and that my written health records are strictly confidential.

## CANCELLATION POLICY

It is our intention to make acupuncture available to as many people as possible at the most affordable rates. In respect and support of that, **we ask for at least 24 hours notice to change or cancel an appointment. There is a $20 fee for appointments that are cancelled or changed with less than 24 yours notice.** If you are uncertain as to whether you can keep an appointment or give adequate notice, it may be better to call us on the day you'd like to come in, and we'll do our best to accommodate you. Thank you for your understanding.

_____ Date_____

Patient's name, printed

_____

Signature of patient or guardian

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# NEW PATIENT FORM

## CONTACT INFORMATION

| | | |
|---|---|---|
| First Name: | | Gender: F ☐ M☐ |
| Last Name | | DOB: / / Age: |
| Address: | | |
| City: | State | Zip |
| Occupation: | Employer | |
| Marital Status: M ☐ S ☐ D ☐ W ☐ | Primary Care Physician: | |
| Home Tel: | Cell # | Work # |
| Email: | | |
| Emergency Contact: Name, Relationship & Phone | | |
| How did you learn about our clinic (Please circle)?<br>Doctor's Referral Friend Web Event Business<br>Other: | | |
| Please let us know if someone referred you! We would like to thank them!<br>Referred by: | | |

## MAIN COMPLAINT(S)

| |
|---|
| 1st: |
| How long ago did this begin: |
| Have you been given a diagnosis, if so,what: |
| 2nd: |
| How long ago did this begin: |
| Have you been given a diagnosis, if so,what: |
| 3rd : |
| How long ago did this begin: |
| Have you been given a diagnosis, if so,what: |

## HEALTH HISTORY

| |
|---|
| Past Medical History - Please circle all applicable to you:<br>Cancer, Diabetes, Hepatitis, Heart Disease, High Blood Pressure, Stroke, Seizure, Thyroid, Asthma, Pacemaker, Osteoporosis, Herpes, Auto-immune Disease, AIDS/HIV, STD, Rheumatic Fever, Alcoholism, Mental Illness, Kidney Disease, Anemia, Glaucoma, Tuberculosis<br>Others: |
| Significant Trauma, auto accidents, injuries and Surgeries: |
| Medications:(include prescription, OTC, vitamins, herbs etc) |

**General**

| | | | |
|---|---|---|---|
| ☐Fever | ☐Strange Tastes or Smells | ☐Poor Sleep | ☐Chills |
| ☐Sweat Easily | ☐Cravings | ☐Fatigue | ☐Night Sweats |
| ☐Hair Loss | ☐Weight Loss/Gain | ☐Strong thirst | ☐Hot flashes |
| ☐Bruise easily | | | |

**Head/ENT**

| | | | |
|---|---|---|---|
| ☐Dizziness | ☐Vertigo | ☐Poor Concentration | ☐Sore Throat |
| ☐TMJ | ☐Teeth Grinding | ☐Sinus Congestion | ☐Running Nose |
| ☐Poor Vision | ☐Red/Itchy Eyes | ☐Poor Hearing | ☐Earache |
| ☐Floaters | ☐Bleeding Gums | ☐Toothache | ☐Bad breath |

**Respiratory**

| | | |
|---|---|---|
| ☐Persistent cough | ☐Chest congestion | ☐Chest tightness |
| ☐Nosebleeds | ☐Chronic allergies | ☐Sneezing |
| ☐Wheezing | ☐Shortness of breath | ☐Frequent colds/flu |

**Gastrointestinal**

| | | | |
|---|---|---|---|
| ☐Indigestion | ☐Gurgling in intestines | ☐Abdominal Fullness | ☐Gas |
| ☐Stomach ache | ☐Nausea | ☐Vomiting | ☐Acid reflux |
| ☐Belching | ☐Heartburn | ☐Hiccups | ☐Diarrhea |
| ☐Loose stools | ☐Constipation | ☐Mucous in stools | ☐Hemorrhoids |
| ☐Blood in stools | How many BM daily: | | |

**Female Health**

At what age did you get your first period: ___ First day of last menstrual period: ___
Are your menstrual cycles spaced regularly? Y ☐ N ☐ Cycle length: ___ Period length: ___
number of pregnancies: ___ number of live births: ___ miscarriages: ___
Are you currently using birth control? Y ☐ N ☐
If yes, what type and for how long? _____

**Please indicate areas of pain**