平福和 Acupuncture & Homeopathy of Hingham
195 Whiting Street, Hingham, MA 02043 | 781.749.8088
Megan Stewart, MEd, MAc | Licensed Acupuncturist & Homeopath

INFORMED CONSENT

I, the undersigned, hereby give consent for the administration of treatment by the method of acupuncture/magnet therapy.

I understand that acupuncture is performed by the insertion of needles, with or without the addition of an electric current, through the skin or the application of heat to the skin, or both, at certain points on the body in an attempt to improve body function and/or relieve pain.

I have been make aware that certain side effects may result. These may include, but are not limited to, some local bruising, bleeding, fainting, temporary pain or discomfort and the possible aggravation of symptoms existing prior to acupuncture treatment.

I am aware that although acupuncture is a common practice, there are no guarantees about its effects.

I understand that the results obtained from this treatment may be published, but that my identity will not be revealed.

I understand that none of the foregoing provisions shall prevent adminstration to me of more conventional medical therapy by a licensed physician.

I hereby certify that I have read the above and that I understand the provisions described therein.

Patient Signature Date

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PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ Employed by: _____

_____ Occupation: _____

Residential Phone Number: _____ Business Phone Number: _____

Cell Phone Number: _____ Age: _____ Weight: _____ Height: _____

Email Address: _____ Your Family Doctor: _____

Date of Birth: _____ Referred by: _____

Place of Birth: _____ Marital Status: _____ Number of Children: _____

Chief Health Concern: _____

How long ago did this problem begin? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)? _____

_____

If you've been given a diagnosis for this problem, what is it? _____

Names of all drugs, medicines or supplements that you are now taking: _____

Therapies that you have tried in the past for this problem: _____

If you are currently involved in any other therapies for this problem, what are they? _____

Is this your first experience with acupuncture? ❑ Yes ❑ No

HABITS AND LIFESTYLES

Exercise: ❑ Yes ❑ No What type? _____ How often? _____

Cigarettes? ❑ Yes ❑ No Amount per day: _____ Recreational Drugs: _____

Alcohol? ❑ Yes ❑ No Amount per week: _____

Caffeinated tea, coffee, cola: ❑ Yes ❑ No Amount per day: _____

Sweets? ❑ Yes ❑ No Amount per day: _____

How do you unwind stress? _____

Exposure to chemicals? ❑ Yes ❑ No Exposure to cigarette smoke? ❑ Yes ❑ No

Describe your average diet (morning, afternoon evening, snacks, list what time for each): _____

_____

Time you go to bed: _____ Time you get up: _____ Amount of sleep: _____

Do you sleep through the night? ❑ Yes ❑ No

FAMILY MEDICAL HISTORY

❑ Cancer ❑ Heart Disease ❑ High Blood Pressure ❑ Diabetes

❑ Allergies ❑ Arthritis ❑ Alcoholism ❑ Cigarette Smoking

Anything else not listed above? _____

MEDICAL HISTORY

❑ Heart Murmur ❑ Rheumatic Fever ❑ Heart Attack ❑ High Blood Pressure ❑ Jaundice

❑ Blood Transfusion ❑ Emphysema ❑ Anemia ❑ Bleeding Disorder ❑ Diabetes

❑ Hepatitis ❑ Ulcer ❑ Arthritis ❑ Thyroid Disorder ❑ Surgery

❑ Cancer ❑ Glaucoma ❑ Kidney Stones ❑ Tumor

❑ Epilepsy ❑ Tuberculosis ❑ Kidney/Bladder Trouble ❑ Pneumonia

❑ Sexually Transmitted Disease(s): _____

❑ Allergic Reactions (foods, medicines, chemicals): _____

❑ Significant Trauma (date, description): _____

❑ Any other disorders that were not listed above: _____

PERSONAL MEDICAL HISTORY

Place and X beside the symptoms that you have had in the last three months.

GENERAL

❑ Poor Appetite
❑ Night Sweats
❑ Poor Balance
❑ Peculiar Tastes or Smells

❑ Poor Sleeping
❑ Sudden Energy Drop (what time of day?)_____
❑ Sweat Easily
❑ Change in Appetite

❑ Fatigue
❑ Tremors
❑ Bleed of Bruise Easily
❑ Strong Thirst (cold or hot drinks?)
❑ Fevers

❑ Food Cravings
❑ Weight Loss
❑ Constipation
❑ Bloating
❑ Diarrhea

❑ Chills
❑ Localized Weakness
❑ Weight Gain

SKIN AND HAIR

❑ Rashes
❑ Pimples
❑ Ulcerations
❑ Dandruff
❑ Hives
❑ Change in hair or skin texture
❑ Itching
❑ Recent Moles
❑ Excema
❑ Hair Loss

Any other hair or skin problems?_____

HEAD, EYES, EARS, NOSE AND THROAT

❑ Dizziness
❑ Eye Pain
❑ Blurry Vision
❑ Sinus Problems
❑ Jaw Clicks
❑ Concussions
❑ Poor Vision
❑ Earaches
❑ Nosebleeds
❑ Teeth Problems
❑ Migraines
❑ Night Blindness
❑ Ringing in the ears
❑ Recurrent Sore Throats
❑ Sores on Lips or Tongue
❑ Glasses
❑ Color Blindness
❑ Poor Hearing
❑ Grinding Teeth
❑ Eyestrain
❑ Cataracts
❑ Spots in front of eyes
❑ Facial Pain

Headaches (where and when?)_____

MUSCULOSKELETAL

❑ Neck Pain
❑ Foot or Ankle Pain
❑ Muscle Pain
❑ Hand or Wrist Pain
❑ Knee Pain
❑ Shoulder Pain
❑ Back Pain
❑ Hip Pain
❑ Muscle Weakness

Any other joint or bone problems?_____

MEN

❑ Weak Urine Stream ❑ Prostate Trouble ❑ Impotency ❑ Discharge from Penis ❑ Painful or Swollen Testes

WOMEN

❑ Trouble with Menstruation:_____ Date of Last PAP smear:_____

❑ Painful Period ❑ Clots ❑ Breast Lumps or Discharge ❑ Vaginal Discharge
❑ Vaginal Sores ❑ Hot Flashes ❑ Changes in body or psyche prior to menstruation

Time between periods:_____ Duration of periods:_____
Usual characteristics (heavy, light, etc.):_____
Age at time of First Period: _____ Date of Last Period: _____ # of Pregnancies:_____ Abortions: _____ Miscarriages: _____
Are you pregnant now? ❑ Yes ❑ No
Are you trying to become pregnant now? ❑ Yes ❑ No
Do you practice birth control? ❑ Yes ❑ No If yes, what type?_____

NEUROPSYCHOLOGICAL

❑ Seizures ❑ Bad Temper ❑ Concussion ❑ Depression ❑ Anxiety ❑ Palpitations
❑ Poor Memory ❑ Dizziness ❑ Loss of Balance ❑ Areas of Numbness ❑ Lack of Coordination ❑ Easily Susceptible to Stress

Have you ever been treated for emotional problems? ❑ Yes ❑ No
Have you ever considered or attempted suicide? ❑ Yes ❑ No
Any other neurological or psychological problems? ❑ Yes ❑ No
Any other problems not covered above you would like to discuss?_____