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HEALTH HISTORY

Check symptoms you now have or have had in the last year.

- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/irritability
- Overwhelmed by life

MUSCLE/JOINT/BONES

- Tremors Cramps
- Swollen joints

Pain, weakness, numbness in

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

Other _____

GASTROINTESTINAL

- Belching, gas or bloating
- Colon trouble
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids (piles)
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

CARDIOVASCULAR

- Chest pain
- Hardening of arteries
- High or low blood pressure
- Pain over heart
- Poor circulation
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles

EENT/RESPIRATORY

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever
- Hoarseness
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems

SKIN

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sore won't heal
- Sweats

GENITO/URINARY

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

FOR MEN ONLY

- Erection difficulties
- Penis discharge
- Prostate trouble

FOR WOMEN ONLY

- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow

Could you be pregnant? _____

Check conditions you have or have had in the past.

- AIDS
- Allergies
- Anemia
- Arthritis
- Bleeding disorders
- Breast lump
- Cancer
- Diabetes

- Eczema
- Emphysema
- Heart disease
- Hepatitis
- Herpes
- HIV positive
- Kidney disease
- Liver disease

- Pneumonia
- Rheumatic fever
- Scarlet fever
- Seizures
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

How long has it been since you have had a complete medical exam?

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LIFESTYLE

Check which substances you use and describe how much you use.

- Caffeine _____
- Drugs _____
- Alcohol _____
- Tobacco _____
- Sugar _____

Check if your work or lifestyle exposes you to these.

- Stress
- Insufficient sleep
- Very long working hours
- Long commuting times
- Heavy lifting or hazardous substances
- Other _____

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SIGNATURE

The information on this form is correct to the best of my knowledge. I understand that my protected health information will be used and disclosed consistent with the policies in this office's Notice of Privacy Practices.

Signature _____ Date _____

AcupunctureWorks Inc.

Informed Consent for Acupuncture Treatment and Care

1. CONSENT

I hereby voluntarily consent to be treated by acupuncture administered by Edna M. Brandt, L.Ac., or Clayton Spivey, L.Ac., who is licensed in the State of Maryland, and/or another licensed acupuncturist who is serving as a back-up for Edna Brandt or Clayton Spivey.

2. ACUPUNCTURE

I understand that acupuncture is performed by the insertion of needles through the skin, or by application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat body dysfunction or disease, to modify the perception of pain, and to normalize the body's physiological functions. The procedures have been fully explained to me. I understand that no guarantees concerning the use and effects of acupuncture are given to me, and that I am free to stop acupuncture treatment at any time.

3. PHYSICIANS

I am aware that if there is a worsening of my ailment or condition, or if a new ailment or condition appears, that I should consult my personal physician or any other licensed physician. None of the foregoing preclude the administration to me of conventional medical therapy by a licensed physician when in his or her discretion such therapy is deemed appropriate.

4. SIDE EFFECTS

While acupuncture is a safe treatment, I am aware that certain adverse effects may result. These could include, but are not limited to, some local bruising, bleeding, tingling, brief pain or discomfort. Very rare instances have been reported of fainting or pneumothorax. Occasionally there may be temporary aggravation of symptoms existing prior to acupuncture treatment.

5. PAYMENT

Payment will be at the time of service, unless otherwise prearranged. I am responsible to send my own claims for reimbursement to my insurance company. If I am a member of an HMO, PPO or health insurance company that does not reimburse for acupuncture, I have freely sought acupuncture services at my own expense and do not hold my HMO, PPO or health insurance company liable for payment.

6. MISSED APPOINTMENTS/LATE CANCELLATIONS

I understand that there will be a charge for missed appointments and appointments cancelled with less than 24 hours notice unless the cancellation results from an emergency (a sudden, unexpected situation or set of circumstances). I understand that insurance does not pay for missed appointments or late cancellations and that I will be personally responsible for the charges.

7. NOTICE OF PRIVACY PRACTICES

I have received a copy of the *Notice of Privacy Practices* for AcupunctureWorks Inc. I understand that my protected health information will be used and disclosed consistent with the policies in that document. I understand that if I have questions about the policies, I may ask questions for clarification.

8. UNDERSTANDING/QUESTIONS

I have carefully read (or have had read to me) this consent and understand all the foregoing and so am fully aware of what I am signing. I intend this consent form to cover the entire course of my treatment. I have felt free to ask any questions I have.

Patient Signature _____ Date _____

Acupuncturist Signature _____ Date _____