epicenter wellness

Acupuncture and Oriental Medicine specializing in preventive wellness and pain relief

epicenterwellness.com

Personal Information

Today's Date: _____

Name _____ Date of Birth: _____/_____/_____

Street_____ Primary Phone: ( ) _____

City_____ State_____ Zip_____ Secondary Phone ( )_____

Email: _____

Occupation_____

Emergency Contact Name: _____ Relation to Emergency Contact: _____

Emergency Contact Phone: (____)_____-_____

Please circle your preferred method/s of contact for appointment reminders and other brief communications

Text Email Mobile Primary phone Secondary phone Other: _____

Who referred you? _____

History

What is/are the reason/s for your visit today? _____

_____

_____

How long have you had these conditions?_____

_____

_____

Briefly describe the history of above complaints: _____

_____

_____

Are you currently under the care of a health care practitioner for these conditions? Yes_____ No_____

If yes, specify purpose _____

List current medications _____

List any allergies _____

Previous History (Include year and treatment received)

Injuries/Accidents/Illnesses still affecting you _____

_____

Surgeries _____

_____

Family History: Please check boxes indicating illnesses of any family members

	Self	Father	Mother	Brother	Sister	Children
Allergies						
Blood Disorders/ Anemia						
Diabetes (indicate Type 1 or 2)						
Cancer or Tumors						
High Blood Pressure/ Heart Disorder						
Musculo-Skeletal Disorder						
Kidney or Bladder Disorder						
Seizures						
Stroke						
Tuberculosis						
Drug/ Alcohol Abuse						
Autoimmune disorder (specify)						
Thyroid disorder						
Other						
Age at Death	N/A					

Please mark any of the following that you have now or have had.**Use C for current or P for past**:

Musculoskeletal

___Bone or Joint Disease
___Tendonitis/ Bursitis
___ Muscle tension; location/s _____
___Jaw Pain (TMJ) ___Arthritis/Gout
___Spinal Problems
___Lupus
___ Metal implants
___ Other: _____

Circulatory

___Heart Condition
___Phlebitis/Varicose Veins
___Blood Clots
___High blood Pressure
___ Low blood pressure
___Lymphedema
___Thrombosis/Embolism
___ Palpitations
___ Irregular heartbeat/skipped beats
___ Heart attack
___ Stroke
___Other_____

Eyes/ears/nose/mouth

___ Blurry vision ___ Visual floaters
___ Other visual changes
___ Tinnitus/ringing in the ears
___ Dizziness/vertigo ___ Deafness
___ Decreased hearing ___ Bleeding gums
___ Decreased sense of smell ___ Mouth sores
___ Decreased sense of taste ___ Tooth/gum pain
___ Cracked/missing teeth ___ Jaw pain
___ Other: _____

Respiratory

___Breathing Difficulty
___Emphysema/COPD ___ Cough
___Allergies
___Sinus Problems
___ Tuberculosis ___ Asthma
___ Cold/flu ___ Chest pain
___ Other_____

Skin/Hair

___Allergies: _____
___Rashes
___ Fungal infections (e.g., Athletes Foot)
___Herpes/Cold Sores
___ Eczema
___ Psoriasis
___ Unexplained bald spots
___ Thinning hair ___ Other: _____

Neurological

___ Shingles
___ Numbness/Tingling; Location_____
___ Pinched Nerve
___ Restless leg syndrome
___ Paralysis
___ Guillain-Barre syndrome
___ Chiari malformation
___ Facial pain
___ Shooting pain into arms/hands
___ Shooting pain into legs/feet
___ Involuntary tremors
___ Concussion; if so, date: _____
___ Traumatic Brain Injury; if so, date: _____
___ Headaches ___ Other _____

Digestive System

___Irritable Bowel Syndrome
___Peptic ulcer
___ Acid reflux
___ Bloating/distention
___ Frequent gas
___ Constipation
___ Diarrhea
___ Crohn's Disease
___ Blood in stool
___ Other_____

Please mark any of the following that you have now or have had.**Use C for current or P for past**:

Genitourinary/Reproductive

Mind-Heart

___ Burning urination ___ Blood in urine
___ Disrupted urine stream
___ Kidney stones
___ Incontinence
___ Fibroids ___ Polycystic Ovaries
___ PMS/PMDD
___ Infertility
___ Menopause ___ Hot flashes ___ Night Sweats
___ Prostate disorder; if so, specify: _____
___ Erectile dysfunction
___ Decreased sexual appetite
___ Decreased sexual stamina
___Pregnant: if current, # of months: _____
___Ovarian/Menstrual Problems
___Prostate
___Other_____

___ Anxiety
___Depression ___ Bipolar disorder
___ ADD/ADHD ___ Trouble focusing
___ Relationship difficulties
___ Irritability/quick to anger
___ Easily excitable ___ Overly fearful
___ Tend to worry ___ Tend to overanalyze
___ Difficulty relaxing ___ Indecisive
___ Low energy ___ Fatigue
___ Daytime sleepiness
___ Insomnia ___ Sleeping difficulty

Additional Notes:

_____
_____
_____

Habits: Please check habits below which apply to you now or in the past

	Cannabis	Tobacco	Alcohol	Crack/Cocaine	Caffeine	Other:
Age Began						
Age Stopped						
Amount per day/week/month						

Major Hospitalizations: If you've ever been hospitalized for serious medical illnesses/ operations, write in most recent hospitalization. Do not include normal pregnancies. ___ Check here for more than three such hospitalizations.

Hospitalizations	Year	Operation/Illness	Name of Hospital	City & State
First				
Second				
Third				

Notes:

_____

_____

_____

_____

Primary Care Provider Information:

Name of Provider: _____ Date of Last Visit: _____

Provider Address:

_____

(Street) (City) (State) (Zip Code)

Provider Phone: (_____)_____-_____ Fax: (_____)_____-_____

My signature below affirms that I have answered the above honestly and accurately to the best of my knowledge:

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

_____

Signature of Parent/Guardian (if patient is minor or unable to sign)

Informed Consent for Acupuncture Treatment and Care

My signature below confirms that I request and consent to the performance of acupuncture and other Oriental Medical procedures on me by a licensed acupuncturist.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, guasha, electrical stimulation, Tui- Na (Chinese therapeutic bodywork). Chinese or Western herbal formulas and nutritional counseling may also be advised. I have had the opportunity to discuss with the acupuncturist or with other office or clinic personnel, the nature and purpose of my treatment and the procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain and to treat certain dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling or treatment sites that may last for a few days. There have also been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and organ puncture, including pneumothorax (lung puncture).

The herbs and nutritional supplements (from plant, animal and mineral sources) recommended are traditionally considered safe in the practice of Oriental Medicine. I will advise the acupuncturist if I am pregnant or become pregnant or if I experience gastro-intestinal upset or allergic reactions to the herbs.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels, at the time and based upon the facts then known, is in my best interest.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent. As long as my identity remains confidential, I agree to permit my medical data to be used in reports or presentations.

I understand that as a consequence of the clinic layout, others may overhear conversations between myself and clinical/office staff, including discussions about private or otherwise sensitive personal information.

I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content, and by signing below, I agree to the above named procedures and policies.

We, the undersigned, do affirm that (print patient name)_____ has been advised by __**Justin Jaucian, L.Ac** _(licensed acupuncturist) to consult a physician regarding the condition or conditions for which such patient seeks acupuncture.

Patient Signature _____ Date: _____

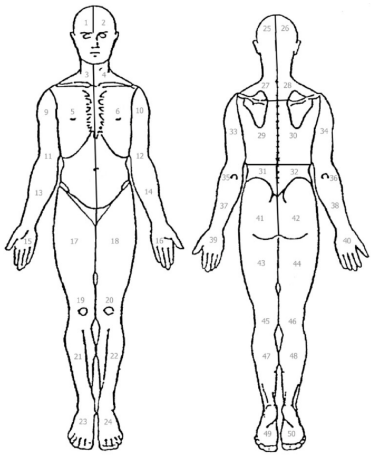
If the person signing is under the age of 18, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

Parent/ Guardian Signature_____

Date_____

Pain Assessment



Circle site/s of pain

When did it start? _____

What helps reduce pain? Circle all that apply

Medication Movement Rest Heat Ice Massage Other

Comments:_____

What factors increase pain? Circle all that apply

Movement Rest Heat Ice Pressure Stress Sleep Deprivation

Comments:_____

What is the quality of your pain? Circle all that apply

Sharp Dull Sore Tired Cramping Tight Swollen

Burning Electrical Numbness/Tingling Uncertain

Does the pain spread out, shoot, or refer to other places? Yes No

If yes, please describe: _____

Do you feel pain all the time, or does it come and go? _____

Is the pain worse during certain times of the day? If so, describe: _____

Is the pain less during certain times of the day? If so, describe: _____

During flare-ups, does pain last on the order of (circle which applies) seconds minutes hours days

Comments: _____

General Health Status

Please circle the term which best describes your overall levels of energy/vitality throughout the day:

Low Fair Good Very Good Excellent Variable

Notes: _____

* * *

Please circle which of the following best describes your overall subjective body temperature

I tend to feel cold and prefer warm environments.

I tend to feel warm and prefer cold environments.

I tend to feel more or less comfortable in both warm and cool environments.

I'm not sure.

Notes: _____

* * *

How many hours of sleep do you get a night, more or less? _____

For the following, circle which best applies to you.

Do you feel well-rested in the morning when you get up? Yes No Not sure

Is it difficult for you to fall asleep? Yes No

If yes: Do you feel that your mind keeps turning or remains agitated to some degree? Yes No

Does pain/discomfort in your body make falling asleep difficult? Yes No

Do you frequently wake up in the middle of the night? Yes No

If yes, explain: _____

If you do have difficulty falling &/or staying asleep, how long has this been going on? _____

Add'l notes: _____

* * *

Females: age of first menstrual period _____ Length of cycle (e.g., 28 days, 35 days) _____

days of bleeding: _____ Do you pass clots? _____ Current contraceptive use? Y/N Type: _____

Please list the practices which comprise your personal wellness program (e.g., meditation, gym workout, sports, yoga, taiji, dance, martial arts, etc.) Include frequency of practice:

_____

_____

_____

* * *

On a scale from 0 to 10, 0 being none at all and 10 being the worst possible,

How would you rate your stress/anxiety levels at home? _____

How would you rate your stress/anxiety levels with other family? _____

How would you rate your stress/anxiety levels at work? _____

How would you rate your stress/anxiety levels in your social circle? _____

How would you rate your stress/anxiety levels in your neighborhood? _____

Add'l notes: _____

_____

* * *

Marital status (circle which apply) Single Involved Married Separated Divorced Widowed Celibate

# of children: _____ Add'l notes: _____

* * *

24 R/D *for clinician use only*

1) B L D _____

_____

2) B L D _____

_____

3) B L D _____

_____

4) B L D _____
_____