I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, low level laser therapy, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping, and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner’s recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, the full fee will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions. In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred, or carried out at this practice.

Patient Signature          Date
This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have questions, please ask.

PERSONAL INFORMATION

Name_____________________________ Date______________
Home Address________________________
City_________________________ State_________ Zip Code________
Home Phone_________________________ Work Phone________________
Email address:________________________
Occupation_________________________ Person Responsible for your account________________
Who should we thank for referring you to this office?________________________

Sex: ___ Male    ___ Female    Height________  Weight________  Birthdate________  Age______
Marital Status: ___Married    ___Single    ___Divorced    ___Widowed  Number of children_____
Have you received acupuncture therapy before?     ___Yes     ___No
If yes, when? __________________________  With whom? __________________________

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

<table>
<thead>
<tr>
<th>Illness</th>
<th>You</th>
<th>Your Relative</th>
<th>Approx. Date</th>
<th>Illness</th>
<th>You</th>
<th>Your Relative</th>
<th>Approx. Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td></td>
<td></td>
<td>Seizures</td>
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<tr>
<td>Rheumatic Fever</td>
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<td></td>
<td></td>
<td>Emotional Disorders</td>
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<tr>
<td>Infectious Diseases</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
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</tr>
</tbody>
</table>

Sexually transmitted Diseases:     ___ Gonorrhea    ___ Syphilis    ___ AIDS    ___ HPV    ___ Chlamydia    ___ Herpes  Date_____

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dosage</th>
<th>Reason</th>
<th>How long?</th>
<th>Prescribed by</th>
<th>Date of last check-up</th>
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</thead>
<tbody>
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</tbody>
</table>

Please indicate the use and frequency of the following:

<table>
<thead>
<tr>
<th>Use</th>
<th>Yes</th>
<th>No</th>
<th>How much?</th>
<th>Reason</th>
<th>How long?</th>
<th>Prescribed by</th>
<th>Date of last check-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffee/black tea</td>
<td></td>
<td></td>
<td></td>
<td>Tobacco</td>
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<tr>
<td>Water Intake</td>
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<td>Soda</td>
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<tr>
<td>Non-medical Drugs</td>
<td></td>
<td></td>
<td></td>
<td>Alcohol</td>
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</tr>
</tbody>
</table>
What are the main health problems for which you are seeking treatment?

________________________________________________________________________________________________________

What forms of treatment have you sought?

________________________________________________________________________________________________________

List any other health problems you now have.

________________________________________________________________________________________________________

List any allergies, food sensitivities or food craving that you have.

________________________________________________________________________________________________________

List any accidents, surgeries, or hospitalizations (include date).

________________________________________________________________________________________________________

Lab results (please include copies).

________________________________________________________________________________________________________

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

<table>
<thead>
<tr>
<th></th>
<th>Great</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Bad</th>
<th>Your Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td></td>
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<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Family</td>
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<td>Diet</td>
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<tr>
<td>Sex</td>
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<tr>
<td>Self</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Work</td>
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<tr>
<td>Exercise</td>
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<tr>
<td>Spirituality</td>
<td>☐</td>
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<td></td>
</tr>
</tbody>
</table>
FOR WOMEN

Age of 1st period (menarche)______________________________
Age of last period (menopause)__________________________
Number of days between periods__________________________
Number of days of flow______________________________
Color of flow__________________________
Clots?  ☐ Yes  ☐ No
Color__________________________
Average number of pads you use per day: 1st day____ 2nd day____ 3rd day____ 4th day____ + days____
Have you been diagnosed with: ☐ Fibrocystic Breast  ☐ Endometriosis  ☐ Ovarian Cysts  ☐ PID  Other__________
Location of Pain (indicate before, during or after menses):
Cramping__________________ Stabbing__________________
Burning__________________ Aching__________________
Dull__________________ Bloating__________________
Consistent__________________ Intermittent__________________
Bearing down sensation__________________

FOR MEN

Date of last prostate check up__________________ PSA result__________________ Manual prostate exam result__________________
Lab results__________________
Frequency of urinations: daytime________ nighttime________
Color of urine:  ☐ clear  ☐ murky
Odor:__________________
Symptoms related to prostate
☐ prostate problems  ☐ delayed stream  ☐ dribbling  ☐ incontinence  ☐ Impotence
☐ rectal dysfunction  ☐ increased libido  ☐ decreased libido  ☐ premature ejaculation
☐ back pain  ☐ groin pain  ☐ testicular pain  ☐ retention of urine

SYMPTOM SURVEY (FOR EVERYONE)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

blank (□) = never experience  check mark (✓) = sometimes experience  plus sign (+) = frequently experience

☐ lack of appetite  ☐ excessive appetite  ☐ loose stool or diarrhea
☐ digestive problems, indigestion  ☐ vomiting
☐ belching, burping  ☐ heartburn/reflux  ☐ feeling of retention of food in the stomach
☐ tendency to become obsessive in work, relationships...
☐ insomnia, difficulty sleeping  ☐ heart palpitations  ☐ cold hands and feet
☐ nightmares  ☐ mentally restless  ☐ laughing for no apparent reason
☐ agina pains  ☐ abdominal pain  ☐ chest pain
☐ sciatic pain  ☐ headaches  ☐ pain or coldness in the genital area
☐ cough  ☐ shortness of breath  ☐ decreased sense of smell
☐ nasal problems  ☐ skin problems  ☐ feeling of claustrophobia
☐ bronchitis  ☐ colitis or diverticulitis  ☐ constipation
☐ hemorrhoids  ☐ recent use of antibiotics
☐ eye problems  ☐ jaundice (yellowish eyes or skin)  ☐ difficulty digesting oily foods
☐ gall stones  ☐ light colored stool  ☐ soft or brittle nails
☐ easily angered or agitated  ☐ difficulty in making plans or decisions
☐ spasms or twitching of muscles  ☐ asthma
☐ tendency to catch colds easily  ☐ intolerance to weather changes
☐ allergies  ☐ hay fever  ☐ dizziness
☐ tendency to faint easily  ☐ high cholesterol levels
☐ edema  ☐ blood in stool  ☐ black tarry stool
☐ easily bruised  ☐ difficult to stop bleeding
☐ low back pain  ☐ knee problems  ☐ hearing impairment
☐ ear ringing  ☐ kidney stones  ☐ decreased sex drive
☐ hair loss  ☐ urinary problems
☐ asthma  ☐ bronchitis  ☐ colitis or diverticulitis
☐ anemia  ☐ heart palpitations  ☐ cold hands and feet
☐ digestive problems, indigestion  ☐ vomiting
☐ fatigue  ☐ edema  ☐ blood in stool  ☐ black tarry stool
☐ easily bruised  ☐ difficult to stop bleeding
☐ lack of appetite  ☐ excessive appetite  ☐ loose stool or diarrhea