

## New Patient Registration Form

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
first middle last

Address: \_\_\_\_\_  
street city state zip

Telephone: \_\_\_\_\_  
home work cell

E-mail: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital status: S M D W

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Care Practitioners / Doctors: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Payment & Cancellation Policies

Payment is due at your appointment. We only accept cash or check right now

\$80 first visit, \$60 follow up visits, \$50 low-fee economic hardship follow up visits

Right now, our office is not ready to bill your insurance company. We may do it later. However, you can bill your insurance company by yourself. We can provide any paperwork they request within reason.

The office requires 24 hours notice to cancel an appointment.

By signing below, I do hereby voluntarily consent to comply with the Office Payment & Cancellation Policies at Zhang Oriental Medicine:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

## Acupuncture Intake & Consent Form

Name: \_\_\_\_\_ Have you had acupuncture before? \_\_\_\_\_

Please identify the health concerns that brought you to the Clinic in order of importance below:

	Condition	For how long?	Past treatment that helped this condition
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Are you allergic to any foods, herbs, supplements or medications? If so, please list:

\_\_\_\_\_

List any medications (prescribed and over-the-counter), herbs, vitamins, and supplements you are currently taking:

\_\_\_\_\_

Most recent blood pressure reading: \_\_\_\_\_ / \_\_\_\_\_ When was this reading taken? \_\_\_\_\_

Current weight: \_\_\_\_\_ Desired weight: \_\_\_\_\_ Any problems maintaining weight? \_\_\_\_\_

Your history of major illnesses, accidents, hospitalizations, surgeries:

Event	When	Event	When
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_

Note family history of major illnesses (including diabetes, heart disease, cancer, autoimmune disease, psychological disorders, etc):

### Lifestyle:

Exercise routine:

Relaxation practice:

How many hours per night do you sleep? \_\_\_\_\_ Do you wake rested? \_\_\_\_\_

Do you experience stress? \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_ Nicotine/alcohol/recreational drug \_\_\_\_\_

### Diet:

Restrictions:

Emphasis:

Caffeinated beverages: \_\_\_\_\_ How many per day? \_\_\_\_\_

Sweets (food & beverages, including artificially sweetened): \_\_\_\_\_

How much water or non-caffeinated beverages do you drink per day? \_\_\_\_\_

### Musculoskeletal:

Note any joint, muscle, tendon, or ligament pain or injury:

\_\_\_\_\_

Note any scars from accidents, surgeries, injuries:

### SYMPTOM LIST

(Please check any symptoms or conditions that currently apply to you):

**Emotional/Psychological**

Anxiety  Depression  Stress  Addictions Other: \_\_\_\_\_

**Immune & Inflammation**

Arthritis  Seasonal allergies Autoimmune: \_\_\_\_\_ Other: \_\_\_\_\_

**Eyes, Ears, Nose, Throat & Head**

Sinus congestion  Headaches  Migraines  TMJ/Jaw problems Other: \_\_\_\_\_

**Neurologic**

Seizures/Epilepsy  Vertigo/Dizziness  Numbness/Tingling Other: \_\_\_\_\_

**Cardiovascular & Blood Circulation**

Heart disease  High cholesterol  High blood pressure  Low blood pressure  Cold hands/feet  
Other: \_\_\_\_\_

**Gastrointestinal & Elimination**

Constipation  Loose stools/Diarrhea  Irritable bowel  Food allergies  Bloating after meals  
Other: \_\_\_\_\_

**Respiratory**

Frequent colds & flus  Bronchitis  Asthma Other: \_\_\_\_\_

**Kidneys & Urinary Tract**

Kidney stones  Frequent urinary tract infection Other: \_\_\_\_\_

**Skin**

Eczema  Acne Other: \_\_\_\_\_

**Endocrine**

Hypothyroid  Diabetes Other: \_\_\_\_\_

**Sleep & Energy**

Insomnia  Light sleeper  Fatigue Other: \_\_\_\_\_

**Blood Sugar Regulation**

Emotional eating  Hypoglycemic  Crave sweets Other: \_\_\_\_\_

**Men - Reproductive**

Difficulty conceiving  Decreased sexual energy  Prostate hypertrophy or cancer  
Other: \_\_\_\_\_

**Women - Reproductive**

Frequent Vaginal infections  Breast/Uterine fibroids  Endometriosis  Ovarian Cyst  
 Decreased sexual energy  Difficulty conceiving  Hormone Replacement Therapy  
Other: \_\_\_\_\_

Do you have menstrual cycles? \_\_\_\_\_ Describe (regular or not, heavy or light, PMS, painful periods, clots in blood, etc.): \_\_\_\_\_

Are you pregnant now? \_\_\_\_\_ Current method of birth control: \_\_\_\_\_

# of Pregnancies \_\_\_\_\_ # of Births \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Abortions \_\_\_\_\_

Any complications during pregnancies, births, postpartum? \_\_\_\_\_

Monthly breast exam? Y N Last Pap Smear: \_\_\_\_\_ Last mammogram: \_\_\_\_\_

Any reproductive surgeries (for cancer, hysterectomy, C-section, etc): \_\_\_\_\_

**Additional**

Is there anything else that is not included in this form? Use extra page if necessary.  
\_\_\_\_\_  
\_\_\_\_\_

## Consent to Acupuncture Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or herbs and supplements by licensed acupuncturist Dr. Zhenguo Zhang.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are generally safe and free of side effects; however I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Cupping and skinscraping:** I understand that the acupuncturist may perform cupping and skinscraping as parts of treatment. Cupping and skinscraping involve the use of suction cups placed on the body or scraping the skin to modify or prevent pain perception by improving circulation. I understand that the use of this therapy may result in temporary redness or bruising, which normally disappears within a few hours, or a few days. I understand that I may refuse this therapy.

**Chinese Herbs, Western Herbs, and Nutritional Supplements:** I understand that Chinese Herbs, Western Herbs, and/or Nutritional Supplements may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems which I associate with these substances, I should suspend taking them and call Dr. Zhenguo Zhang as soon as possible.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

**Ear point pressure therapy:** I understand that the acupuncturist may place some plant seeds or glass beads on certain points of my ear in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that the use of this therapy may result in temporary pain or redness of the ears, which normally disappears within a few hours, or a few days. I understand that I may refuse this therapy.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Parent or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

## Prepare for Acupuncture Treatment

**Please wear loose comfortable clothes that allow easy access to your skin.**

Acupuncture needles may remain inserted in your body for 30 minutes or more, so it's important that you wear an outfit you're able to relax in. Jeans, tight clothing like yoga clothing, and dresses are too restrictive. Loose shorts/boxers, wide-legged pants or capris, and a tank top or bra work well. If we need to "needle" an area that is not reachable because of clothing restraints (examples are thighs, chest, abdomen, upper arms) then you have the option of putting on a gown or wearing undergarments. You will be covered up and kept warm.

**Please eat at least a snack before your appointment, and avoid caffeine.** It's important to not let your blood sugar drop during acupuncture or you may feel faint. Don't drink so much water that you cannot rest comfortably for 15-30 minutes; however be aware that acupuncture works better if you are not dehydrated.

**Please inform us if you are under the influence of any recreational drugs, alcohol, or prescription pain medicine.**

**Please thoroughly complete your new patient forms before or at your appointment.** Fill out and sign all downloadable forms before your appointment. An original Arbitration Form and Informed Consent Form will be given to you to sign at the time of your appointment. These forms also include important information about our fees.

**Please allow approximately an hour and a half for your first visit and one hour for subsequent visits.**

**We require 24 hours to cancel an appointment.** The fee for missed appointments or late cancellations will be charged.

**Allow time after your appointment to have a snack, water, and to move slowly to your next activity.** Many people feel deeply relaxed after acupuncture and want to go home and rest. Some people feel light headed and need to sit for a while before driving. Other people feel very energized after acupuncture and want to be active. All these responses are fine. If possible, listen to what your body tells you to do after the session.

**We will discuss your treatment plan at your visit.** Visits will include advice about diet, lifestyle, herbs and supplements, if applicable.