Jaime M. DeGuzman, L.Ac., Dipl. O.M., MSTCM
ACUPUNCTURE AND HERBAL MEDICINE

PERSONAL INFORMATION

PATIENT NAME: LAST	FIRST	MIDDLE
ADDRESS:		
TEL.: HOME ( ) -	MOBILE ( ) -	WORK ( ) -
FAX: ( ) -	EMAIL:	
DATE OF BIRTH:	AGE:	SOCIAL SECURITY NO.:
EMERGENCY CONTACT:	TEL.: ( ) -	RELATIONSHIP:
REFERRED BY:		
STATUS: [ ] MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED [ ] OTHER _____		

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: [ ] FULL TIME [ ] PART-TIME [ ] RETIRED [ ] UNEMPLOYED [ ] STUDENT		
EMPLOYER NAME:	EMPLOYER TEL: ( ) -	
EMPLOYER ADDRESS:		

PRIMARY HEALTHCARE PROVIDER

PRIMARY PHYSICIAN:	TEL.: ( ) -
PHYSICIAN ADDRESS:	
DATE OF LAST VISIT:	DATE OF INJURY/ONSET OF ILLNESS:

INSURANCE / SUPERBILL INFORMATION

INSURANCE COMPANY:	POLICY HOLDER'S NAME:
POLICY NAME (IF APPLICABLE):	EMPLOYER NAME (IF APPLICABLE):
POLICY NO.:	
INSURANCE COMPANY TEL.: ( ) -	INSURANCE COMPANY FAX.: ( ) -

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ILLNESS AND TREATMENT INFORMATION

HAVE YOU EVER HAD AN ACUPUNCTURE TREATMENT? WHEN AND FOR WHAT REASON?
[ ] NO [ ] YES

ARE YOU PRESENTLY BEING TREATED FOR A MEDICAL CONDITION? PLEASE DESCRIBE.
[ ] NO [ ] YES

PLEASE BRIEFLY DESCRIBE ANY CHRONIC PAIN?

WHAT HEALTH ISSUE DO YOU WANT TREATED? PLEASE DESCRIBE AS FULLY AS POSSIBLE.

HAVE YOU BEEN USING OTHER MEDICAL TREATMENTS FOR RELIEF OF THIS ISSUE? PLEASE DESCRIBE.
[ ] NO [ ] YES

DO YOU HAVE OTHER HEALTH CONCERNS? PLEASE DESCRIBE.
[ ] NO [ ] YES

FAMILY HISTORY INFORMATION: PLEASE COMPLETE FOR EACH FAMILY MEMBER, PLACING AN X IN THE APPROPRIATE BOX:

	SELF	MOTHER	FATHER	SISTER	BROTHER	SPOUSE	CHILD
ALLERGIES							
BLOOD DISORDER/ANEMIA							
DIABETES							
CANCER OR TUMORS							
SEIZURES							
HIGH BLOOD PRESSURE							
KIDNEY OR BLADDER DISORDER							
STOMACH OR INTESTINAL DISORDER							
DRUG ABUSE							
TUBERCULOSIS							
HEART DISEASE							
STROKE							
DEPRESSION/MENTAL ILLNESS							
HIV							
HEPATITIS							
OTHER							
AGE OF DEATH							

MAJOR HOSPITALIZATIONS: WRITE IN ANY RECENT HOSPITALIZATIONS FOR SERIOUS INJURY OR ILLNESS BELOW.

YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE
YEAR	OPERATION OR ILLNESS	NAME OF HOSPITAL	CITY AND STATE

PREVIOUS PREGNANCIES:

TOTAL PREGNANCIES	LIVING	ECTOPIC	MISCARRIAGES	INDUCED ABORTIONS

MEDICINES: MARK AN X IN THE BOX NEXT TO ANY OF THE FOLLOWING THAT YOU ARE NOW TAKING:

[ ] ASPIRIN	[ ] IBUPROFEN	[ ] ACETAMINOPHEN(TYLENOL)	[ ] OTHER: _____
[ ] ANTACIDS	[ ] LAXATIVES	[ ] COLD TABLETS	[ ] VITAMINS: _____
[ ] ORAL CONTRACEPTIVES	[ ] DIET PILLS	[ ] TRANQUILIZERS	[ ] HERBS: _____
[ ] FIBER SUPPLEMENTS	[ ] SLEEPING PILLS	[ ] HAY FEVER TABLETS	
[ ] BLOOD PRESSURE PILLS	[ ] BLOOD THINNING PILLS	[ ] INSULIN, DIABETIC PILLS	

DRUG ALLERGIES: PLEASE LIST.

HABITS: PLEASE CHECK ANY OF THE HABITS LISTED BELOW WHICH APPLY TO YOU NOW OR IN THE PAST.

COFFEE:	[ ] NO [ ] YES	CUPS PER DAY/WEEK	AGE STARTED	AGE QUIT
TOBACCO:	[ ] NO [ ] YES	CIGARETTES PER DAY/WEEK	AGE STARTED	AGE QUIT
ALCOHOL:	[ ] NO [ ] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
MARIJUANA:	[ ] NO [ ] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
CRACK/COCAINE:	[ ] NO [ ] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
HEROINE:	[ ] NO [ ] YES	USE PER DAY/WEEK	AGE STARTED	AGE QUIT
OTHER: _____		USE PER DAY/WEEK	AGE STARTED	AGE QUIT
OTHER: _____		USE PER DAY/WEEK	AGE STARTED	AGE QUIT

HEALTH: CHECK ALL THAT APPLY:

GENERAL

PAST	CURRENT	CONDITION
[ ]	[ ]	POOR APPETITE
[ ]	[ ]	EXCESSIVE APPETITE
[ ]	[ ]	INSOMNIA
[ ]	[ ]	FATIGUE
[ ]	[ ]	FEVERS
[ ]	[ ]	NIGHT SWEATS
[ ]	[ ]	SWEAT EASILY
[ ]	[ ]	CHILLS
[ ]	[ ]	LOCALIZED WEAKNESS
[ ]	[ ]	POOR COORDINATION
[ ]	[ ]	CHANGE IN APPETITE
[ ]	[ ]	STRONG THIRST
[ ]	[ ]	OTHER: _____

SKIN & HAIR

PAST	CURRENT	CONDITION
[ ]	[ ]	RASHES
[ ]	[ ]	HIVES
[ ]	[ ]	ITCHING
[ ]	[ ]	ECZEMA
[ ]	[ ]	PIMPLES
[ ]	[ ]	DRYNESS
[ ]	[ ]	TUMORS, LUMPS

HEAD & NECK

PAST	CURRENT	CONDITION
[ ]	[ ]	DIZZINESS
[ ]	[ ]	FAINTING
[ ]	[ ]	NECK STIFFNESS
[ ]	[ ]	ENLARGED LYMPH GLANDS
[ ]	[ ]	HEADACHES
[ ]	[ ]	CONCUSSIONS
[ ]	[ ]	OTHER: _____

EARS

PAST	CURRENT	CONDITION
[ ]	[ ]	INFECTION
[ ]	[ ]	RINGING
[ ]	[ ]	DECREASED HEARING
[ ]	[ ]	OTHER: _____

EYES

PAST	CURRENT	CONDITION
[ ]	[ ]	BLURRED VISION
[ ]	[ ]	VISUAL CHANGES
[ ]	[ ]	POOR NIGHT VISION
[ ]	[ ]	SPOTS
[ ]	[ ]	CATARACTS
[ ]	[ ]	GLASSES / CONTACTS
[ ]	[ ]	EYE INFLAMMATION
[ ]	[ ]	OTHER: _____

NOSE, THROAT, MOUTH

PAST	CURRENT	CONDITION
[ ]	[ ]	NOSE BLEEDS
[ ]	[ ]	SINUS INFECTIONS
[ ]	[ ]	HAY FEVER OR ALLERGIES
[ ]	[ ]	RECURRING SORE THROATS
[ ]	[ ]	GRINDING TEETH
[ ]	[ ]	DIFFICULTY SWALLOWING

CARDIOVASCULAR

PAST	CURRENT	CONDITION
[ ]	[ ]	HIGH BLOOD PRESSURE
[ ]	[ ]	LOW BLOOD PRESSURE
[ ]	[ ]	BLOOD CLOTS
[ ]	[ ]	PALPITATIONS
[ ]	[ ]	FAINTING
[ ]	[ ]	PHLEBITIS
[ ]	[ ]	CHEST PAIN
[ ]	[ ]	IRREGULAR HEART BEAT
[ ]	[ ]	COLD HANDS / FEET
[ ]	[ ]	SWELLING OF HANDS / FEET
[ ]	[ ]	OTHER: _____

RESPIRATORY

PAST	CURRENT	CONDITION
[ ]	[ ]	ASTHMA
[ ]	[ ]	BRONCHITIS
[ ]	[ ]	FREQUENT COLDS
[ ]	[ ]	CHRONIC OBSTRUCTIVE PULMONARY DISEASE
[ ]	[ ]	PNEUMONIA
[ ]	[ ]	COUGH
[ ]	[ ]	COUGHING BLOOD
[ ]	[ ]	PRODUCTION OF PHLEGM
[ ]	[ ]	OTHER: _____

GASTRO-INTESTINAL

PAST	CURRENT	CONDITION
[ ]	[ ]	NAUSEA
[ ]	[ ]	VOMITING
[ ]	[ ]	DIARRHEA
[ ]	[ ]	BELCHING
[ ]	[ ]	BLOOD IN STOOLS/BLACK STOOLS
[ ]	[ ]	BAD BREATH
[ ]	[ ]	RECTAL PAIN
[ ]	[ ]	HEMORRHOIDS
[ ]	[ ]	CONSTIPATION
[ ]	[ ]	PAIN OR CRAMPS
[ ]	[ ]	INDIGESTION
[ ]	[ ]	GALL BLADDER DISORDER
[ ]	[ ]	GAS
[ ]	[ ]	OTHER: _____

GENITO-URINARY

PAST	CURRENT	CONDITION
[ ]	[ ]	KIDNEY STONES
[ ]	[ ]	PAIN OR URINATION
[ ]	[ ]	FREQUENT URINATION
[ ]	[ ]	BLOOD IN URINE
[ ]	[ ]	URGENCY TO URINATE
[ ]	[ ]	UNABLE TO HOLD URINE
[ ]	[ ]	OTHER: _____

MALE

PAST	CURRENT	CONDITION
[ ]	[ ]	PAIN / ITCHING GENITALIA
[ ]	[ ]	GENITAL LESIONS / DISCHARGE
[ ]	[ ]	IMPOTENCE
[ ]	[ ]	WEAK URINARY STREAM
[ ]	[ ]	LUMPS IN TESTICLES
[ ]	[ ]	OTHER: _____

FEMALE

PAST	CURRENT	CONDITION
[ ]	[ ]	FREQUENT URINARY TRACT INFECTIONS
[ ]	[ ]	FREQUENT VAGINAL INFECTIONS
[ ]	[ ]	PAIN / ITCHING OF GENITALIA
[ ]	[ ]	GENITAL LESIONS / DISCHARGE
[ ]	[ ]	PELVIC INFLAMMATORY DISEASE
[ ]	[ ]	ABNORMAL PAP SMEAR
[ ]	[ ]	IRREGULAR MENSTRUAL PERIODS
[ ]	[ ]	PAINFUL MENSTRUAL PERIODS
[ ]	[ ]	PREMENSTRUAL SYNDROME
[ ]	[ ]	ABNORMAL BLEEDING
[ ]	[ ]	MENOPAUSAL SYNDROME
[ ]	[ ]	BREAST LUMPS
[ ]	[ ]	OTHER

NEUROLOGICAL

PAST	CURRENT	CONDITION
[ ]	[ ]	SEIZURES
[ ]	[ ]	TREMORS
[ ]	[ ]	NUMBNESS/TINGLING OF LIMBS
[ ]	[ ]	CONCUSSION
[ ]	[ ]	PAIN
[ ]	[ ]	PARALYSIS
[ ]	[ ]	OTHER: _____

PSYCHOLOGICAL

PAST	CURRENT	CONDITION
[ ]	[ ]	DEPRESSION
[ ]	[ ]	ANXIETY / STRESS
[ ]	[ ]	IRRITABILITY
[ ]	[ ]	TREATED FOR EMOTIONAL OR PSYCHOLOGICAL PROBLEMS
[ ]	[ ]	OTHER: _____

INFECTION SCREENING

PAST	CURRENT	CONDITION
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	HEPATITIS
[ ]	[ ]	GONORRHEA
[ ]	[ ]	CHLAMYDIA
[ ]	[ ]	SYPHILIS
[ ]	[ ]	GENITAL WARTS
[ ]	[ ]	HERPES: ORAL
[ ]	[ ]	HERPES: GENITAL

INFORMED CONSENT TO TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Jaime M. DeGuzman, L.Ac., Dipl. O.M., MSTCM have discussed the nature and purpose of my treatment with the above named practitioner.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this clinic uses sterile disposable single-use needles, and maintains a clean and safe environment. Burns and /or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Jaime M.DeGuzman, L.Ac., Dipl. O.M., MSTCM, of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Jaime M. DeGuzman, L.Ac., Dipl. O.M., MSTCM, if I am or become pregnant.

I do not expect Jaime M. DeGuzman, L.Ac., Dipl. O.M., MSTCM, to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the above named practitioner to exercise judgment during the course of treatment which he thinks at the time, based upon facts then known, is in my best interests.

I understand the clinical medical 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.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____	_____
Print Name of Patient (or representative)	**Print name of Practitioner**
X_____	_____
Signature of Patient (or representative)	**Jaime M.DeGuzman, L.Ac., Dipl. O.M., MSTCM**