Oriental Health Therapies LLC

"Organic Medicine For A Better You."©

Patient Information

Name: _____ Date of Birth (mm/dd/yyyy): ____/____/_____

Gender: Female: [ ] Male: [ ]

Contact Information

Phone (check preferred): (Cell) :(____) _____-_____ [ ] (Home) :(____) _____-_____ [ ]

Email:_____@_____

Address: (Street):_____

(Apt or Suite Number):_____

(City):_____ (State):_____ (Zipcode):_____

Person to contact in an emergency: _____

Relationship: _____ Contact Phone: (____) _____-_____

Medical Information

Height: _____ft _____in Weight: _____lbs

Symptoms of your current health complaints or illness:

_____

_____

_____

_____

Have you had a history of Hypertension? No [ ] Yes [ ]

Medications and supplements that you currently take:

_____

_____

History of other illnesses:

Illness/Disease	Duration(Years)	Illness/Disease	Duration(Years)	Illness/Disease	Duration(Years)
Alcohol Abuse		Heart Disease		Stomach Ulcer	
Asthma		Lupus		Colon Disease	
Arthritis		Skin Rash		Stroke	
Cancer		Kidney Disease		HIV	
Diabetes		Tuberculosis		Jaundice	
Drug Abuse		Hepatitis		Uncontrolled Bleeding	
Depression		Mental Illness		Pregnancy issues	
Epilepsy		Rheumatic Fever		Other	
Glaucoma		Thyroid Disease			

Acupuncture Informed Consent to Treat

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, whether signatories to this form or not.

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 understand the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising. Numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontateous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if Iam or become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the staff believes at the time, based upon the facts the known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient 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, the above 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 may seek treatment.

ACUPUNCTURIST NAME:	Dr. Hongbo 'Lily' Liu, OMD, PhD, LAc

PATIENT NAME	DATE
Signature:	
Written:	
RELATIONSHIP if signing for patient):	

V11APR2014