CEDAR FOREST WELLNESS

ACUPUNCTURE
HERBAL APOTHECARY
MADISON WISCONSIN

Name:

Date of Birth:

Mailing Address:

Preferred Telephone Numbers (cell, work, or home):

E-mail address:

Emergency Contact:

Relationship:

Phone:

Current Physician:

Phone/contact for physician:

Have you had acupuncture before? ☐ YES ☐ NO

What are you questions/concerns, if any about treatment?

I have a minimum 48 hours cancellation policy. Please be aware that it is difficult to fill your appointment even with 48 hours notice. I appreciate as much notice as possible. I reserve your appointment time especially for you.

I do not double or triple book appointment times. This allows me to spend more time with each individual patient and manage my time effectively so as not to inconvenience you. Policies aside, I know that life often intervenes at the last moment and some situations cannot be avoided. I will work with you and appreciate your attentiveness to this matter.

I ask for payment to be made at the time of your visit. Our bank charges us a $15.00 fee for any bounced checks. Therefore, if you bounce a check, please be prepared to pay that fee.

Signature: _____ Date: _____
(or patient representative)

Print: _____ _____
(Indicate relationship if signing)

Matthew Brookman L.Ac • Cedar Forest Wellness
Madison • Wisconsin • 608-866-0064

HEALTH HISTORY

CONFIDENTIAL

Name (Last, First, Middle)	Date

Chief Compliant (Keep it simple - only list current complaints) What you are seeking care for?

1.

2.

3.

How long has this condition persisted?		
Is there anything that makes it better?		
Is there anything that makes it worse?		
Have you ever received treatment for this condition? ☑ YES ☐ NO	If yes when?	
Where?	By whom?	
What was the diagnosis?	What kinds of treatment?	
What were the results of treatment?		

List any substances you are allergic to:

List any medication/supplements you are currently taking (if more attach a separate list):	DOSE:	FOR WHAT CONDITION:	FOR HOW LONG:

List any major surgeries you have had:

DATE	PROBLEM/SURGERY

Significant trauma (auto accidents, falls, etc.)

DATE	

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Hypertension
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Other: _____

HEALTH HISTORY **CONFIDENTIAL**

NAME (LAST, FIRST, MIDDLE):	DATE:

Please check any symptoms you currently have or have had in the past year

General

- ☐ Chills
- ☐ Low energy
- ☐ Dizziness
- ☐ Allergies
- ☐ Fatigue
- ☐ Fevers
- ☐ Insomnia
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweat spontaneously
- ☐ Night sweating
- ☐ Lack of sweating
- ☐ Weight gain
- ☐ Weight loss
- ☐ Easy bruising
- ☐ Aversion to heat
- ☐ Aversion to cold

Vision

- ☐ Blurred vision
- ☐ Heaviness in the head
- ☐ Headache
- ☐ Cataract
- ☐ Double vision
- ☐ Red/inflamed eye
- ☐ Eye pain/strain
- ☐ Corrected vision
- ☐ See Floaters

Mouth/Thirst

- ☐ Sores on lips/tongue
- ☐ Taste change
- ☐ Mouth feels dry
- ☐ Crave Large amounts of liquid
- ☐ Crave small amounts of liquid
- ☐ Strange taste in mouth
- ☐ Teeth problems
- ☐ Friends/partner/you say you have bad breath

Ears

- ☐ Earache
- ☐ Ear discharge
- ☐ Ringing in ears
- ☐ Hearing loss

Sinus/Nasal

- ☐ Nasal obstruction
- ☐ Nasal discharge
- ☐ Loss of sense of smell
- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Recurrent sore throat
- ☐ Phlegm in throat

Cardiovascular

- ☐ Awareness of heartbeat/ palpitations
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

Respiratory

- ☐ Asthma
- ☐ Hay fever
- ☐ Persistent cough
- ☐ Coughing blood
- ☐ Shortness of breath
- ☐ Recurrent bronchitis
- ☐ Phlegm Production
- ☐ Difficulty inhaling
- ☐ Difficulty exhaling

Urination

- ☐ Dilute urine
- ☐ Dark urine
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Burning urination
- ☐ Scanty urine
- ☐ Profuse urine
- ☐ Frequent urine
- ☐ Frequent nighttime urine
- ☐ Poor bladder control
- ☐ Urgency to urinate

Weight

- ☐ Underweight
- ☐ Normal for height
- ☐ Overweight
- ☐ Very overweight

Bowels (check all that apply)

- ☐ Formed
- ☐ Unformed
- ☐ Sticky
- ☐ Foul odor Incomplete evacuation
- ☐ Wipe more than 3-4 times?
- ☐ Have to deep-breathe/ push to initiate a bowel movement
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Bloody stools
- ☐ Hemorrhoids

Gastrointestinal

- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Nausea
- ☐ Heartburn/reflux
- ☐ Indigestion
- ☐ Vomiting
- ☐ Vomiting blood

HEALTH HISTORY **CONFIDENTIAL**

NAME (LAST, FIRST, MIDDLE):	DATE:

Please check any symptoms you currently have or have had in the past year

Neurological

- ☐ Fainting
- ☐ Convulsions/Seizures
- ☐ Change in handwriting
- ☐ Paralysis
- ☐ Stroke
- ☐ Tremor
- ☐ Recent clumsiness
- ☐ Drowsiness
- ☐ Vertigo

Emotional

- ☐ Insomnia
- ☐ Irritability
- ☐ Often feel angry
- ☐ Frequent Sighing
- ☐ You have "11" lines between eyebrows (knitted brow)
- ☐ Troubling dreams
- ☐ Cry uncontrollably
- ☐ Feel sad a lot
- ☐ Forgetful
- ☐ Mind not clear
- ☐ Anxiety
- ☐ Much fear
- ☐ Mania/
- ☐ Terrors
- ☐ Difficultly expressing emotions
- ☐ You have unfulfilled desires and goals in your life.
- ☐ Your friends or partner would describe you as grumpy, irritable, impatient, frustrated
- ☐ Friends or partner would say you hold grudges.

Diet/Lifestyle

- ☐ Vegetarian
- ☐ Healthy diet
- ☐ Eat much fried foods
- ☐ Eat much meat
- ☐ Eat a lot of sweats
- ☐ Large appetite/always finish every meal/rapid hungering
- ☐ Drink Coffee
- ☐ Drink Alcohol
- ☐ Cannabis Use
- ☐ Exercise regularly
- ☐ Exercise excessively

Skin

- ☐ Thick skin
- ☐ Thin Skin
- ☐ Dry skin
- ☐ Acne
- ☐ Broken blood vessels
- ☐ Blood not clotting
- ☐ Bruise easily
- ☐ Discoloration
- ☐ Dark circles around eyes
- ☐ Bags under eyes
- ☐ Lumps in groin
- ☐ Lumps in underarm
- ☐ Brittle nails

Hair

- ☐ Premature gray hair
- ☐ Dry/brittle hair
- ☐ Hair falling out

Musculoskeletal:

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Feet
- ☐ Hands
- ☐ Joints
- ☐ Legs
- ☐ Knee(s)
- ☐ Hips
- ☐ Neck
- ☐ Shoulders
- ☐ Pain everywhere
- ☐ Cold limbs
- ☐ Low back
- ☐ Lack of strength
- ☐ Broken bones
- ☐ All over weakness
- ☐ Frequent muscle twitching
- ☐ Cramping of muscles - especially nighttime
- ☐ Joints frequently popping/cracking noise

Women Only

- ☐ May be pregnant
- ☐ Abnormal pap smear
- ☐ Contraceptives
- ☐ Low libido
- ☐ Vaginal discharges
- ☐ Uterine prolapse
- ☐ Endometriosis
- ☐ Facial hair
- ☐ Loss of head hair
- ☐ Menopausal

Menstruation

- ☐ Bleed between periods
- ☐ Irregular periods
- ☐ Heavy Periods (excessive volume of menstrual blood)
- ☐ Painful Periods
- ☐ PMS (Sore breasts, irritability, cramping, etc.)
- ☐ < 25 day cycle
- ☐ > 35 day cycle
- ☐ Menses > 5 days
- ☐ Menses < 3 days
- ☐ No Menses

Menopause/ Perimenopause

- ☐ Hot Flashes
- ☐ Dryness
- ☐ Irritability
- ☐ Insomnia
- ☐ Bone density

Men Only

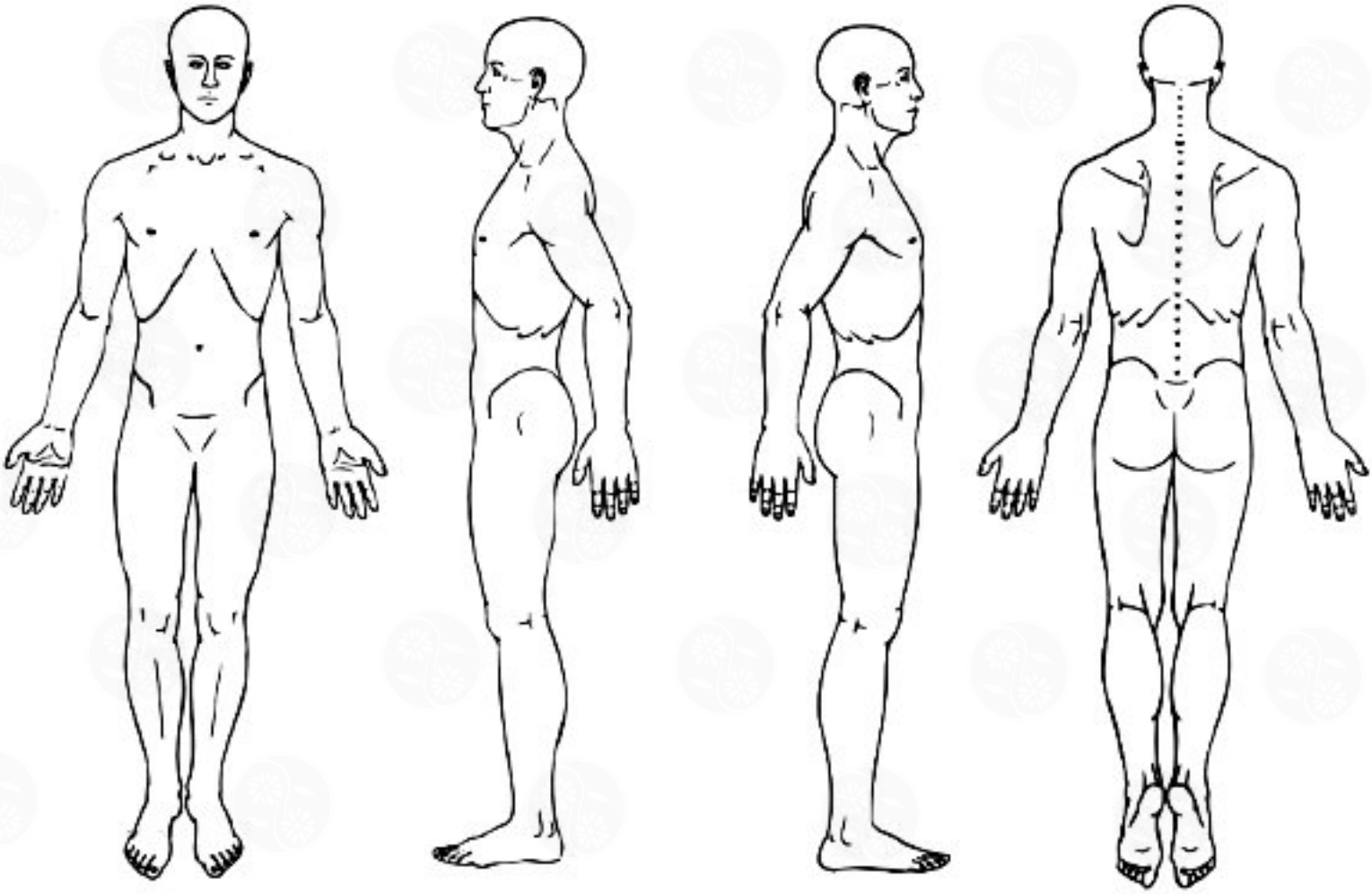
- ☐ Genital pain
- ☐ Impotence
- ☐ Genital sores
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Nocturnal emission
- ☐ Low libido

PAIN ASSESSMENT

NAME (LAST, FIRST, MIDDLE):	DATE:

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below



3. Next to each area marked above, please note the intensity of pain

No Pain	Minimal		Tolerable but hinders activities		High -50% of activities impaired		Extreme -most activities impaired		Unbearable	
0	1	2	3	4	5	6	7	8	9	10

Women's Fertility History

CONFIDENTIAL

Name (Last, First , Middle) Date

Age at which menses began? _____

Are you periods painful? ☐Yes ☐No

How many days does the pain last?_____

How many days do you normally bleed? _____

How heavy is the bleeding?_____

What color is the blood?
☐Light Red ☐Red ☐Purple ☐Brown ☐Black

Are there many clots larger then 1 cm? ☐Yes ☐No

Do you have any premenstrual tension symptoms? ☐Yes ☐No

Premenstrual back pain? ☐Yes ☐No

Premenstrual breast tension? ☐Yes ☐No

Facial break outs before or during your period? ☐Yes ☐No

Loose bowels at the beginning of your period? ☐Yes ☐No

Do you spot or bleed between periods? ☐Yes ☐No

Are you menstrual cycles spaced irregularly? ☐Yes ☐No

How many days are there from one period to the next?_____

Have your cycles changed since they began? ☐Yes ☐No

How?_____

Do you ovulate? ☐Yes ☐No

On what day of your cycle?_____

Do you have breast tenderness around ovulation? ☐Yes ☐No

Do you have excessive facial hair? ☐Yes ☐No

Do you have excessively oily skin? ☐Yes ☐No

Have you experienced loss of head hair? ☐Yes ☐No

Have you ever had a venereal disease? ☑Yes ☐No

Do you get yeast infections regularly? ☐Yes ☐No

Do you have chronic vaginal discharge? ☐Yes ☐No

Do you have any sores on your genitalia? ☐Yes ☐No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐Yes ☐No

Have you ever had an abnormal pap smear? ☐Yes ☐No

Date of last pap smear:_____

Have you been diagnosed with any pelvic abnormalities? ☐Yes ☐No

Have you been diagnosed with pelvic adhesions? ☐Yes ☐No

Have you ever been diagnosed with endometriosis? ☐Yes ☐No

Have you ever been diagnosed with uterine fibroids or polyps? ☐Yes ☐No

Have you ever had pelvic inflammatory disease? ☐Yes ☐No

Were you treated for it? ☐Yes ☐No

	Number of?	What year(s)?
How many pregnancies have you had?	_____	_____
How many children do you have?	_____	_____
How many miscarriages have you had?	_____	_____
Have you had any abortions?	_____	_____
How many times has a D&C been performed?	_____	_____

Women's Fertility History

CONFIDENTIAL

Name (Last, First , Middle) Date

Date of last menstrual period: _____

Have you had diagnosis relating to infertility? ☐Yes ☐No

If yes, what was it? _____

_____

_____

How you had fertility treatments? ☐Yes ☐No

If yes, when and where? _____

By whom? _____

What types? _____

Have you taken medication to help you ovulate? ☐Yes ☐No

If yes, when? _____

How Long? _____

Have your fallopian tubes been evaluated medically? ☐Yes ☐No

What were the results? _____

_____

_____

Have you had any tubal operations ? ☐Yes ☐No

Hav you had any hormone laboratory tests performed? ☐Yes ☐No

What were the results? _____

Have you taken oral contraceptives? ☐Yes ☐No

When? _____ How Long? _____

Have you ever had an IUD? ☐Yes ☐No

When? _____ How Long? _____

Have you ever taken DepoProvera? ☐Yes ☐No

When? _____ How Long? _____

How long have you been trying to conceive? _____

Do you have a single partner with whom you have been trying to conceive? ☐Yes ☐No

How long? _____

Is your partner supportive of your wish to conceive? ☐Yes ☐No

How long have you been married or living together? _____

Has your partner had a fertility work-up? ☐Yes ☐No

What were the results? _____

Low Libido: ☐Yes ☐No

Do you use vaginal lubricants? ☐Yes ☐No

Do you douche regularly? ☐Yes ☐No

If yes, with what?

Are you more than 20% over your ideal body weight? ☐Yes ☐No

Are you more than 20% below your ideal body weight? ☐Yes ☐No

Do you have a stressful occupation? ☐Yes ☐No

What is it?

Do you exercise regularly? ☐Yes ☐No

List any medications for taken for **gynecological** conditions other than contraception:

Medication	Reason

Any concerns, questions, or information you feel important for me to know about supporting your fertility?

Women's Fertility History TCM Questionnaire

Name (Last, First , Middle) Date

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent YES answers for more than one category.

KIDNEY YIN DEFICIENCY				/9
Do you have lower back weakness, soreness, or pain, or knee problems?	Yes	☐	No	☐
Do you have ringing in your ears or dizziness?	Yes	☐	No	☐
Does your hair prematurely gray?	Yes	☐	No	☐
Do you have vaginal dryness?	Yes	☐	No	☐
Is your midcycle fertile cervical mucus scanty or missing?	Yes	☐	No	☐
Do you have dark circles around or under your eyes?	Yes	☐	No	☐
Do you have night sweats?	Yes	☐	No	☐
Are you prone to hot flashes?	Yes	☐	No	☐
Would you describe yourself as afraid a lot?	Yes	☐	No	☐

KIDNEY YANG DEFICIENCY				/13
Do you have lower back premenstrually?	Yes	☐	No	☐
Is your low back sore or weak?	Yes	☐	No	☐
Are your feet cold, especially at night?	Yes	☐	No	☐
Are you typically colder than those around you?	Yes	☐	No	☐
Is your libido low?	Yes	☐	No	☐
Are you often fearful?	Yes	☐	No	☐
Do you wake up at night or early in the morning because you have to urinate?	Yes	☐	No	☐
Do you urinate frequently, and is the urine diluted and/or profuse?	Yes	☐	No	☐
Do you have early morning loose, urgent stools?	Yes	☐	No	☐
Do you have profuse vaginal discharge?	Yes	☐	No	☐
Does your menstrual blood tend to be dull in color?	Yes	☐	No	☐
Do you feel cold cramps during your period that respond to a heating pad?	Yes	☐	No	☐
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	Yes	☐	No	☐

SPLEEN QI DEFICIENCY				/27
Are you often fatigued?	Yes	☐	No	☐
Do you have poor appetite?	Yes	☐	No	☐
Is you energy lower after a meal?	Yes	☐	No	☐
Do you crave sweets?	Yes	☐	No	☐

Women's Fertility History TCM Questionnaire

Name (Last, First , Middle) Date

SPLEEN QI DEFICIENCY (continued)

Do you have loose stools, abdominal pain, or digestive problems?	Yes ☐	No ☐
Are you hands and feet cold?	Yes ☐	No ☐
Is your nose cold?	Yes ☐	No ☐
Are you prone to feeling heavy or sluggish?	Yes ☐	No ☐
Are you prone to feeling heaviness or grogginess in the head?	Yes ☐	No ☐
Do you bruise easily?	Yes ☐	No ☐
Do you have varicose veins?	Yes ☐	No ☐
Do you think you have poor circulation?	Yes ☐	No ☐
Are you lacking strength in your arms and legs?	Yes ☐	No ☐
Are you lacking in exercise?	Yes ☐	No ☐
Are you prone to worry?	Yes ☐	No ☐
Have you been diagnosed with low blood pressure?	Yes ☐	No ☐
Do you sweat a lot without exerting yourself?	Yes ☐	No ☐
Do you feel dizzy or light-headed, or have visual changes when you stand up fast?	Yes ☐	No ☐
Is your menstruation thin, watery, profuse or pinkish in color?	Yes ☐	No ☐
Are you more tired around ovulation or menstruation?	Yes ☐	No ☐
Do you ever spot a few days or more before your period comes?	Yes ☐	No ☐
Have you ever been diagnosed with uterine prolapse?	Yes ☐	No ☐
Are your menstrual cramps accompanied by a bearing-down sensation in your uterus?	Yes ☐	No ☐
Are you often sick, or do you have allergies?	Yes ☐	No ☐
Have you been diagnosed with hypothyroid or anemia?	Yes ☐	No ☐
Do you have hemorrhoids or polyps?	Yes ☐	No ☐
Do you have a pale, yellowish complexion?	Yes ☐	No ☐

BLOOD DEFICIENCY /13

Are your menses scanty and/or late?	Yes ☐	No ☐
Do you have dry, flaky skin?	Yes ☐	No ☐
Are you prone to getting chapped lips?	Yes ☐	No ☐
Are you losing hair on your head (not in patches, but all over)?	Yes ☐	No ☐
Are your fingernails or toenails brittle?	Yes ☐	No ☐
Is your hair brittle or dry?	Yes ☐	No ☐

Women's Fertility History TCM Questionnaire

Name (Last, First , Middle) Date

BLOOD DEFICIENCY (continued)

Do you have diminished nighttime vision?	Yes	☐	No	☐
Do you get dizzy or light-headed around your period?	Yes	☐	No	☐
Do you have early morning loose, urgent stools?	Yes	☐	No	☐
Are you often timid?	Yes	☐	No	☐
Do you feel cold frequently?	Yes	☐	No	☐
Are your lips pale in color?	Yes	☐	No	☐
Do your joints creak and pop frequently?	Yes	☐	No	☐

BLOOD STASIS /15

Is your menstrual flow ever brown or black in color?	Yes	☐	No	☐
Do you feel mid-cycle pain around your ovaries?	Yes	☐	No	☐
Do you have painful, unmovable breast lumps?	Yes	☐	No	☐
Do you experience periodic numbness of your hands and feet (especially at night)?	Yes	☐	No	☐
Do you have varicose or spider veins?	Yes	☐	No	☐
Do you have red hemangiomas (cherry red spots) on your skin?	Yes	☐	No	☐
Does your complexion appear dark or have dark circles under your eyes?	Yes	☐	No	☐
Do you have chronic hemorrhoids?	Yes	☐	No	☐
Does your menstrual blood contain clots?	Yes	☐	No	☐
Have you been diagnosed with endometriosis or uterine fibroids?	Yes	☐	No	☐
Is your lower abdomen tender to palpation (resisting touch)?	Yes	☐	No	☐
Can you feel any abnormal lumps in your lower abdomen?	Yes	☐	No	☐
Do you have piercing or stabbing menstrual cramps?	Yes	☐	No	☐
Do you have dark spots in your eyes?	Yes	☐	No	☐
Have you been diagnosed with any vascular abnormality or blood clotting disorder?	Yes	☐	No	☐

LIVER QI STAGNATION /17

Are you prone to emotional depression?	Yes	☐	No	☐
Are you prone to anger and/or rage?	Yes	☐	No	☐
Do you become irritable premenstrually?	Yes	☐	No	☐
Do you feel bloated or irritable around ovulation?	Yes	☐	No	☐
Does it feel as if your ovulation lasts longer than it should?	Yes	☐	No	☐
Are your breasts sensitive/sore at ovulation?	Yes	☐	No	☐

Women's Fertility History TCM Questionnaire

Name (Last, First , Middle) Date

LIVER QI STAGNATION (continued)

Do you experience nipple pain or discharge from your nipples?	Yes	☐	No	☐
Do you have a lot of premenstrual breast distention or pain?	Yes	☐	No	☐
Have you been diagnosed with elevated prolactin levels?	Yes	☐	No	☐
Do you become bloated premenstrually?	Yes	☐	No	☐
Do you have difficulty falling asleep at night?	Yes	☐	No	☐
Do you experience heartburn or wake up with a bitter taste in your mouth?	Yes	☐	No	☐
Are your menses painful?	Yes	☐	No	☐
Do you feel your menstrual cramps in the external genital area?	Yes	☐	No	☐
Is your menstrual blood thick and dark, or purplish in color?	Yes	☐	No	☐
Are your fingertips and toes cold but your arms/legs warm?	Yes	☐	No	☐
Do you have difficulty twisting?	Yes	☐	No	☐

HEART DEFICIENCY /9

Do you wake up early in the morning and have trouble getting back to sleep?	Yes	☐	No	☐
Do you have heart palpitations, especially when anxious?	Yes	☐	No	☐
Do you have nightmares?	Yes	☐	No	☐
Do you seem low in spirit or lacking in vitality?	Yes	☐	No	☐
Are you prone to agitation or extreme restlessness?	Yes	☐	No	☐
Do you fidget?	Yes	☐	No	☐
Is there a crack in the center of your tongue that extends to the tip?	Yes	☐	No	☐
Do you sweat excessively, especially on your chest?	Yes	☐	No	☐
Do you notice your heart beating?	Yes	☐	No	☐

EXCESS HEAT /8

Is your pulse rate rapid?	Yes	☐	No	☐
Is your mouth and throat usually dry?	Yes	☐	No	☐
Are you thirsty for cold drinks most of the time?	Yes	☐	No	☐
Do you often feel warmer than those around you?	Yes	☐	No	☐
Do you wake up sweating or have hot flashes?	Yes	☐	No	☐
Do you break out with red acne (especially premenstrually)?	Yes	☐	No	☐
Do you have a short menstrual cycle?	Yes	☐	No	☐
Do you have vaginal irritation or rashes?	Yes	☐	No	☐

Women's Fertility History TCM Questionnaire

Name (Last, First , Middle) Date

DAMPNESS				/10
Do you feel tired and sluggish after a meal?	Yes ☐	No ☐		
Do you have fibrocystic breasts?	Yes ☐	No ☐		
Do you have cystic or pustular acne?	Yes ☐	No ☐		
Do you have urgent, bright, or foul-smelling stools?	Yes ☐	No ☐		
Does it take more than 3 or 4 wipes to clean up after a bowel movement	Yes ☐	No ☐		
Does your menstrual blood contain stringy tissue or mucus?	Yes ☐	No ☐		
Are you prone to yeast infections and vaginal itching?	Yes ☐	No ☐		
Do your joints ache, especially with movement?	Yes ☐	No ☐		
Are you overweight?	Yes ☐	No ☐		
Do you have any chronic swelling?	Yes ☐	No ☐		

DAMP HEAT			/3
Do you have signs of heat and/or dampness as indicated above?	Yes ☐	No ☐	
Do you have foul-smelling, yellow, or greenish vaginal discharge?	Yes ☐	No ☐	
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual	Yes ☐	No ☐	

COLD UTERUS			/3
Do you fit the Kidney Yang deficiency category (50% or more)?	Yes ☐	No ☐	
Do you fall into the Blood stasis pattern?	Yes ☐	No ☐	
Does your lower abdomen feel cooler to the touch than the rest of your trunk?	Yes ☐	No ☐	

OFFICE USE ONLY:

GLOBAL PULSE (left): (width, length, depth, shape, wave):	Right: (width, length, depth, shape, wave):
Time/Rate:	Time/Rate:
State:	State:
UB/MB/LB	UB/MB/LB

Body Color:

Coat Color:

Coat Property:

Protrusions/ cracks/ movements:

SLV: 1 2 3

CHANNELS:

DX:

CONSENT TO SERVICES

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture and Chinese medicine on me (or on the patient named below, for whom I am legally responsible) by Matthew Brookman and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for

Matthew Brookman, including those working at the clinic or office listed or any other office clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, gua sha, cupping, electrical stimulation, tui-na (Chinese massage), Chinese herbs and nutritional counseling.

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 dew days, and rarely dizziness or fainting. Very rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable single-use needles and maintains a clean and safe environment.

Burns and/or scarring are a potential risk of heat treatments using Artemesia vulgaris (moxibustion, "moxa") or a conventional heat lamp. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.

Bruise-like marks are common side effect of cupping and gua sha. Cupping and a massage technique called "gua sha" leaves redness, or red/purple marks on the skin that can last for 1- 5 days, in rare cases cupping marks take more then 3 weeks to fade. Slight bruising and tenderness may persist after the treatment.

The herbs and/or nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic is large doses. I understand that the herbs and supplements may need to be prepared and the teas consumed according to the instructions unanticipated or unpleasant effects associated with the consumption of the herbs or nutritional supplements.

I understand that this document describes the major risks of treatment, other side effect and risks may occur. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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

Name: _____ Date: _____

Signature: _____
(or patient representative)

_____
(Indicate relationship if signing for patient)