No. _____

Patient Personal Record

Dear Patient: The following information will remain strictly confidential. We are concerned about all aspects of your health, and your attitude about your health is as important to us. Below are four prevalent health attitudes, please **mark the one that <u>closest</u> reflects your personal values**:

☐ **Treatment only:** I only consult a doctor when I have an ache or pain and discontinue treatment as soon as the issue has cleared up.

☐ **Prevention:** In addition to symptomatic treatment, I consult specialists to prevent problems from recurring.

☐ **Maintaining Health:** I am conscious about my health, diet, exercise, etc., and actively pursue these because I feel better, perform better, and it maximizes my potential.

☐ **Family Health:** I take an active part in assisting, informing and maintaining health, with my family. I am concerned with the long-term effects of good health.

Last Name: _____ First Name: _____

Nationality: _____ Sex: F ☐ M ☐

Marriage Status: _____ Birthdate: _____

Address: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Care Card #: _____

Email: _____ Family Doctor: _____

Referred By: _____

Have you ever received Chinese Medicine Care? Yes ☐ No ☐

Present Complaint:

Present Illnesses:

Past Illnesses:

Have you been in an accident? Yes ☐ No ☐

Other

Accident Date: _____ Claim Number: _____

Have you had any operations? Explain: _____

Do you have any allergies – Medicinal or otherwise? Explain: _____

Do you have any chronic diseases? _____

Do you smoke? Yes ☐ No ☐ Do you drink alcohol? Yes ☐ No ☐ Occasionally ☐

Family History:

Any family history of any of the following conditions? Place an **X** if yes.

	Heart Disease	Stroke	Cancer	Diabetes	Hypertension	Arthritis
Father's Side	☐	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐	☐

Office Use:

Diagnoses:

Treatment:

Dr. Jing requires a minimum 24 hours' notice to cancel or change an appointment; if there was not adequate time given I may be charged in full for the appointment. By signing this page I understand that I may be charged and will pay the missed appointment fee before I am able to have another treatment. _____ initial

Informed Consent to Chinese Medicine Treatment:

Acupuncture is generally a very safe procedure. In one study of outcomes in 101 consecutive patients, there were no complications or ill effects after 720 treatments. The most common minor effects of acupuncture, if they occur are:

- Mild Bruising or mild pain at one or two needle sites
- Aggravation of symptoms is usually temporary
- Occasionally a patient may feel a little faint, especially if he/she is given treatment in the upright position, mostly on the first treatment, and is likely related to apprehension and/or fear.
- A feeling of wooziness, or drowsiness (especially on the first one or two treatments) can occur, particularly when strong electrical stimulation is used.

I hereby request and consent to receiving Chinese medicine and acupuncture treatment including and not limited to diagnostic tests, various modes of physical therapy, and more. I understand that results are not guaranteed. I further understand and I am informed that, as in all health care, in the practice of Chinese medicine and acupuncture there are some very minimal risks to treatment including, but not limited to; joint infections, nerve damage, pneumothorax, and needle breakage. While such complications are very rare and in many cases not even directly attributable to acupuncture treatment, they are nonetheless occasionally associated with acupuncture treatment. I wish to rely on the doctor to exercise judgement during the course of any Chinese medical care, based upon all fact then known, and in my best interests.

I have read the above consent. I will also have an opportunity to ask questions about its content and by signing below I agree to accept Chinese Medicine Treatment.

Signature: _____ Date: _____