CHARLESTON COMMUNITY ACUPUNCTURE

HEALTH HISTORY AND REGISTRATION

Date: _____ / _____ / _____

Name:			Sex: M F	Age:
Street address:		City/State:	Zip:	DOB: / /
Primary phone: Cell Home Work	Secondary Phone: Cell / Home /Work	Email:		
Height:	Weight:	Relationship Status:	Occupation:	Employer:
Physician:	Physician Phone Number:	Ever had acupuncture before? Y N	How did you hear about us?	
Chief Complaint #1:			When did it start?	Scale of 1-10:
Chief Complaint #2:				
Chief Complaint #3:				

Check the box "SELF" if you have a history, or "FAM" if anyone in your immediate family has a history of the following conditions:

CONDITION	SELF	FAM	CONDITION	SELF	FAM
Cancer – type:			Herpes		
Diabetes I or II			AIDS/HIV		
Hepatitis - type:			Other STD's		
High blood pressure – numbers: /			Rheumatic fever		
Heart disease/pacemaker			Alcoholism or other addictions:		
Gallbladder			Allergies – to what:		
Stroke			Mental Illness		
Seizures			Kidney Disease		
Thyroid issues			Anemia		
Asthma			Osteoporosis		

Habits (please indicate how much):

Coffee/Tea: _____ Soda: _____ Tobacco: _____ Alcohol: _____ Drugs: _____

Diet (what type of foods do you eat daily): **Exercise**: Y N How often?

Medications (Rx, **Supplements,** Herbs etc):

Surgeries/Injuries:

Subjective Temp: Hot / Neutral / Cold	Thirst without exertion: Y N	Skin: Dry / Neutral / Oily Other skin issues:	
Stools: Diarrhea / Loose / Formed / Constipation	Digestions: Nausea / Vomiting / Bloating	Energy: Low / Neutral / High	Headaches: Y N
Heart palpitations: Y N	Shortness of breath: Y N	Bruise easy: Y N	Dizziness: Y N

Eyes, ears, nose, throat: phlegm / floaters / tinnitus
Other issues:

Sleep

Hours per night: Trouble falling asleep: Y N Trouble staying asleep: Y N Excessive dreaming / Nightmares Y N

Emotions: Anger / Irritability / Anxiety / Stress / Worry / Obsessive thinking / Sadness / Depression / Joy / Fear / Timid or Shy / Indecision

Women/GYN

Age of 1st menses: _____ Periods: Heavy / Light / Painful / Irregular

Cycle length (day 1 to day 1): _____ days Menses length: _____ days

# of pregnancies: _____ # of births: _____ Labor difficulties: Y N

PMS symptoms: Breast tenderness / Back pain / Moody / Fatigue

Cramps: Before bleeding / 1st day of bleeding / During period / After

Clots: Heavy / Light Mid cycle spotting: Y N

Digestive changes with menses: Y N Chronic yeast infections: Y N

Menopause:

Age of last menses: _____ Age changes began: _____

Hot flashes: _____ x per day Night sweats: _____ x per week

Vaginal Dryness: Y N Loss of sex drive: Y N

Men/Prostate Health/Urination

Fluid IN relatively equal to fluid OUT?: Y N

Urination: Decrease flow / Dribbling / Difficulty starting or stopping /

Incontinence / Stones / Urgent / Frequent / Pain / Burning / Cloudy / Bloody

Reproductive:

Sexually active: Y N Change in sex drive: Up / Down

Erectile dysfunction: Y N Premature ejaculation: Y N

Sores or rash on genitals: Y N Any diagnosis?: _____

Discharge: Y N Color: _____ Genital Pain: Y N

Jock Itch: Y N Vasectomy: Y N Hernia: Y N

Hemorrhoids: Y N Prostate disease: Y N Diagnosis: _____

Any other important info:

What are your expectations for the first treatment?(please circle one)

Total relief from chief complaint / Significant relief from chief complaint / Any relief is great / It may take more than 1 visit for any relief / No expectations

CHARLESTON COMMUNITY ACUPUNCTURE

Payment Policy

Our mission is to make integrative health care (acupuncture, herbs, nutrition, massage, nutraceuticals) affordable to everyone. With this in mind, we use a sliding scale fee - You decide what you can afford, no questions asked. Payment is expected at the time of your visit. We accept checks and cash only.

- Community Acupuncture: $20-$40 (plus additional $10 for the first visit). OR Monthly unlimited $175-$200
- Orthopedic Acupuncture: $40-$60
- Herbs: $15 + 5 for consultation if needed ($20 including consultation and herbs)
- Massage: $25 - $30 for 30 minutes, $40 - $60 for 1 hour, $70 - $90 for 1.5 hours

Cancellation policy:

All appointments missed without **24 HOUR** notice due to ANY reason other than medical emergency will be charged a **$10 fee** at the following appointment. If you are more than 15 minutes late to an appointment, the remainder of the time-slot may be given to another client.

TO AGREE, PLEASE INITIAL _____

South Carolina Mandatory Disclosure Form

This clinic complies with the rules and regulations promulgated by the South Carolina Department of Health, including the proper cleaning and sterilization of needles and sanitation of acupuncture offices. Only single-use, disposable, factory- sterilized needles are utilized.

Patient Rights

The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time with 24 hour notification. In a professional relationship, sexual intimacy is never appropriate and should be reported to the director of the Division of Registrations in the Department of Regulatory Agencies. The Practice of Acupuncture is regulated by the Director of Registrations, South Carolina of Regulatory Agencies. If you have any comments, questions or complaints, please contact the Department of Labor, Licensing and Regulation. The address and phone number is:

Department of Labor, Licensing and Regulation
P.O. Box 11289
Columbia, SC 29211
(803) 896-4500

Patient Informed Consent Agreement

I agree to receive acupuncture treatments and related therapies by Chad Houfek L.Ac and Nilsa Compton L.Ac. I understand that the practitioners at Charleston Community Acupuncture listed on this form are not Medical Doctors and therefore do not give western diagnosis. Treatment methods may include, but are not limited to: Acupuncture, Tui-Na massage and bodywork, Cupping therapy, Herbal medicine, Nutritional supplements, Heat and moxibustion therapy, Electrostimulation (leads attached to acupuncture needles), Physiotherapy exercises and Lifestyle and nutrition counseling.

I have been informed that acupuncture is very safe, but it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and in rare cases dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture. Infection is also a possible risk. I understand that Charleston Community Acupuncture clinic uses only sterile disposable single-use needles, and maintains a clean and safe environment. Tui-Na massage therapy is very safe but may lead to temporary muscle soreness, redness, or bruising. Burns and scarring are potential risks of heat or moxibustion therapy. Bruising is a common side effect of cupping.

The herbs and nutritional supplements used in Traditional Chinese Medicine are considered safe but may have potential side effects. I understand that some herbs may be toxic at large doses, and some herbs may be inappropriate to take during pregnancy. I will notify Chad Houfek L.Ac. or Nilsa Compton L.Ac., immediately if I notice any unanticipated or unpleasant side effects associated with the consumption of herbal medicine or nutritional supplements.

I do not expect Chad Houfek, L.Ac. or Nilsa Compton L.Ac., to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on them to exercise judgment during the course of treatment to make decisions that are in my best interest, based upon the facts then known. I understand that the clinical and medical staff may review my files but all my records will be kept confidential and can only be released under my personal written consent, or when required by law.

By voluntarily signing below, you are stating that you have read (or have had read to you) and understand Charleston Community Acupuncture's Payment Policy and Patient Informed Consent as well as your rights as a patient and South Carolina's Mandatory Disclosure. You acknowledge that you have been told about the risks and benefits of acupuncture and related therapies and have had an opportunity to ask questions. This form shall cover the entire course of treatment for your present condition and for any future conditions for which you seek treatment at Charleston Community Acupuncture:

Print Name: _____

Signature: _____ Date: _____