Maria Margate, L.Ac., LMT
Acupuncture & Massage for Wellness, Prosperity, & Longevity
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104 Valley Road
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Acupuncture Form

Patient Information

Name _____ Date: _____/_____/_____

Address _____ Phone: (_____)_____

City _____ State _____ Zip _____ Eve Phone: (_____)_____

Occupation _____ Date of Birth: _____/_____/_____

Emergency Contact Name: _____

Emergency Contact Phone: (_____)_____

Referred by _____ Email _____

Acupuncture History/Session Information

Have you ever received a professional acupuncture? Yes_____ No_____
Date of last acupuncture session: _____
What result do you want from your acupuncture session? _____
List any exercise activities. Include frequency _____
_____

Are you currently under the care of a health care practitioner? Yes_____ No_____
If Yes, specify purpose _____
List current Medications _____
List any Allergies _____

Previous History (Include ear and treatment received)

Injuries/Accidents/Illnesses still affecting you _____
_____
Surgeries _____
_____

Family History: Please check boxes indicating illnesses of any family members

	Father	Mother	Brother	Sister	Children
Allergies					
Blood Disorders / Anemia					
Diabetes					
Cancer or Tumors					
High Blood Pressure / Heart Disorder					
Musculoskeletal Disorder					

	Father	Mother	Brother	Sister	Children
Seizures					
Stroke					
Tuberculosis					
Drug / Alcohol Abuse					
Other					
Age of Death					

Please Mark any of the following that you have now or have had:

Musculoskeletal:

- ☐ Bone or Joint Disease
- ☐ Tendonitis / Bursitis
- ☐ Arthritis / Gout
- ☐ Jaw Pain (TMJ)
- ☐ Lupus
- ☐ Spinal Problems
- ☐ Other _____

Circulatory:

- ☐ Heart Condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/Low Blood Pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism
- ☐ Other _____

Please mark any of the following that you have now or have had:

Respiratory:

- ☐ Breathing Difficulty/Asthma
- ☐ Emphysema
- ☐ Allergies:_____
- ☐ Sinus Problems
- ☐ Other:_____

Nervous System:

- ☐ Shingles
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Other_____

Reproductive:

- ☐ Pregnant: Stage _____
- ☐ Ovarian/Menstrual Problems
- ☐ Prostate
- ☐ Other _____

Additional Patient Remarks

_____
_____
_____
_____

Skin:

- ☐ Allergies:_____
- ☐ Rashes
- ☐ Athletes' Foot
- ☐ Herpes/Cold Sores
- ☐ Other _____

Digestive System:

- ☐ Irritable Bowel Syndrome
- ☐ Ulcers
- ☐ Other _____

Other:

- ☐ Cancer/Tumors
- ☐ Bladder/Kidney Ailment
- ☐ Diabetes
- ☐ Drug/Alcohol/Caffeine/Tobacco
- ☐ Anxiety
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Sleep Disorders
- ☐ Chronic Pain
- ☐ Migraines/Headaches

What is the reason for your visit today?

_____
_____
_____

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Habits: Please check habits below which apply to you now or in the past

	Marijuana	Tobacco	Alcohol	Crack/Cocaine	Caffeine	Other
Age Began						
Age Stopped						
Amount per day						

Previous Pregnancies: Please fill in completely

1.

Year	Duration of Pregnancy	Labor Hours	Type of Delivery	Sex	Weight	Name
Comments:						

2.

Year	Duration of Pregnancy	Labor Hours	Type of Delivery	Sex	Weight	Name
Comments:						

3.

Year	Duration of Pregnancy	Labor Hours	Type of Delivery	Sex	Weight	Name
Comments:						

4.

Year	Duration of Pregnancy	Labor Hours	Type of Delivery	Sex	Weight	Name
Comments:						

_____# Total Pregnancies _____# Living _____# Ectopic _____# Miscarriages

_____# Induced Abortions _____# Induced _____# Multiple Pregnancies

Major Hospitalization: If you've ever been hospitalized for serious medical illnesses/operations, write in most recent hospitalization. Do not include normal pregnancies.
___ Check here for more than three such hospitalizations.

Hospitalizations	Year	Operations/Illnesses	Name of Hospital	City & State
First				
Second				
Third				

Physician Information:

Name of Physician: _____ Date of Last Visit: _____

Physician Address: _____
(Street) (City) (State) (Zip Code)

Physician Phone: (_____)_____-_____ Fax: (_____)_____-_____

_____ _____
Patient Signature Date

_____
Patient Name (Printed)

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

My signature below confirms that I request and consent to the performance of acupuncture and other Oriental Medical procedures on me by a licensed acupuncturist.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, Tui-Na (Chinese Massage). Chinese or Western herbal formulas and nutritional counseling may also be advised. I have had the opportunity to discuss with the acupuncturist or with other office or clinic personnel, the nature and purpose of my treatment and the procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain and to treat certain dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling or treatment sites that my may last for a few days. There have also been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax.

The herbs and nutritional supplements (form plant, animal and mineral sources) recommended are traditionally considered safe in the practice of Oriental Medicine. I will advise the acupuncturist if I am pregnant or become pregnant or if I experience gastro-intestinal upset or allergic reactions to the herbs.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgement during the course of the procedure which the acupuncturist feels, at the time and based upon the facts then known, is in my best interest.

I understand the clinical 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. As long as my identity remains confidential, I agree to permit my medical data to be used in reports or presentations.

I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content, and by signing below, I agree to the above-named procedures.

We, the undersigned, do affirm that _____
Print patient's name

has been advised by _____*Maria Margate, L.Ac./CA*_____
A Licensed Acupuncturist

to consult a physician regarding the condition/s for which such patients seeks acupuncture.

X_____ _____
Patient's signature Date

_____ _____
Licensed Acupuncturist's signature Date

_____
Location

Patient Name: **Date:**

Chief Compliant

Areas of concern:

Temperature	Thirst	Emotions	Sleep	Bowel Movement
Digestion	Appetite	Sweating	Energy	Urination

Tongue:

Body:

Fur:

Pulse

Overall Quality: BPM:

Right:

	Cun	Guan	Chi
Super			
Middle			
Deep			

Left:

	Cun	Guan	Chi
Super			
Middle			
Deep			

Physical: