the cancer wellness center

www.AustinCancerAcupuncture.com

Full Name:_____ Preferred Name:_____
Address:_____ Zip code:_____
E-mail:_____ Mobile #:_____ Phone #:_____
Birth date:_____ Age:_____ Occupation:_____
Have you been treated by acupuncture before? □ Y □ N Referred by: _____
Physician: _____Phone #:_____May we contact them? □ Y □ N
Emergency Contact:_____Phone #:_____Relationship:_____
Signature:_____ Date:_____

Main Concerns (include duration):

Have you been given a diagnosis? If so what?

What kind of treatments have you tried?

What alleviates your symptoms?

What aggravates your symptoms?

Is there anyone in your family with the same/similar problems?

Past Medical History:

Significant Illness: ☐ Cancer ☐ Diabetes ☐ Hepatitis ☐ Thyroid Disease ☐ Seizures
☐ Fibromyalgia ☐ Arthritis ☐ Tuberculosis ☐ Hypertension ☐ Depression/Anxiety
☐ Heart Disease ☐ Anemia ☐ Digestive Disorders ☐ Breathing Problems ☐ HIV/AIDS Positive
☐ STD ☐ Other: _____

Family Medical History (Please write in family member):

☐ Cancer_____ ☐ Diabetes_____ ☐ Hepatitis_____

☐ Hypertension_____ ☐ Heart Disease _____ ☐ Stroke _____

☐ Asthma _____ ☐ Alcoholism _____ ☐ Miscarriage_____

☐ Other: _____

Hospitalizations / Surgeries: _____

_____

_____

Significant trauma (auto accidents, sports injuries, etc): _____

_____

_____

Allergies (drugs, foods, chemicals): _____

_____

_____

Chemotherapy type and regimen (if applicable):

_____

_____

Radiation regimen (if applicable):

Other Medicines taken in the past 6 months (include vitamins, OTC drugs, herbs etc.) Use the back of this form if you need more space

Medicine:	Reason for taking:	Dose:

Occupational stress (chemical, physical, psychological, etc): _____

Personal: Height_____ Weight _____

Habits: Do you smoke? ☐ **Y** ☐ **N** What? _____ How much/day? _____ Since_____

Do you take recreational drugs? ☐ **Y** ☐ **N** What? _____

Do you exercise regularly? ☐ **Y** ☐ **N** Please describes: _____

How many hours do you sleep in general? _____ When do you go to bed? _____

Diet: How much caffeine do you drink/day? (Include: coffee, tea, colas etc…): _____

Kind of alcohol you usually drink, if any? _____ Avg. # of drinks/week_____

How much water do you drink per day? _____

Are you a vegetarian? ☐ **Y** ☐ **N** Do you eat a lot of spicy food? ☐ **Y** ☐ **N**

Please describe your average daily diet (be as specific as possible):

- Morning:
- Afternoon:
- Evening:
- Snacks:

Please check if you have or have had any of the following conditions within the past 6 months:

General:

☐ Poor sleeping ☐ Fatigue ☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily ☐ Tremors

☐ Cravings ☐ Poor appetite ☐ Change in appetite ☐ Poor balance

☐ Localized weakness ☐ Bleed or bruise easily ☐ Weight Loss ☐ Weight Gain

☐ Peculiar taste ☐ Desire hot food ☐ Desire cold food ☐ Strong thirst (cold or hot)

☐ Sudden energy drop - time of day _____

Skin & hair: ☐ Rashes ☐ Ulcerations ☐ Hives ☐ Itching ☐ Eczema ☐ Acne

☐ Dandruff ☐ Dry Skin ☐ Recent Moles ☐ Loss of hair ☐ Purpura ☐ Change in hair or skin texture

Other: _____

Musculoskeletal: ☐ Joint disorders ☐ Weakness in muscles ☐ Pain/Soreness in muscles ☐ Tremors

☐ Difficulty walking ☐ Cold hands/feet ☐ Swelling of hands/feet ☐ Back Pain ☐ Spinal Curvature

☐ Hernia ☐ Numbness ☐ Tingling ☐ Paralysis ☐ Neck Tightness ☐ Shoulder pain

☐ Neck pain ☐ Hand/wrist pain ☐ Hip pain ☐ Knee pain ☐ Sprain of joint

☐ Other: _____

Head, Eyes, Ears, Nose, and Throat: ☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses/lens

☐ Eye Strain ☐ Eye Pain ☐ Color Blindness ☐ Night Blindness ☐ Poor vision ☐ Cataracts

☐ Blurry vision ☐ Earaches ☐ Ringing in ears ☐ Poor hearing ☐ Spots in front of the eyes

☐ Sinus problems ☐ Nose bleeding ☐ Sore throat ☐ Grinding teeth ☐ Teeth problems

☐ Facial pain ☐ Jaw clicks ☐ Sores on lips/tongue ☐ Difficulty swallowing

☐ Other: _____

Cardiovascular: ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest pain ☐ Palpitation

☐ Fainting ☐ Phlebitis ☐ Irregular heartbeat ☐ Rapid heartbeat ☐ Varicose Veins

☐ Other: _____

Respiratory: ☐ Cough ☐ Coughing blood ☐ Wheezing ☐ Difficulty in breathing ☐ Bronchitis

☐Pneumonia ☐ Chest pain ☐ Production of phlegm - What color? _____

☐ Other: _____

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Gas ☐ Belching

☐ Black Stools ☐ Blood in stools ☐ Indigestion ☐ Bad breath ☐ Rectal Pain ☐ Hemorrhoid

☐ Abdominal cramps/pain ☐ Gallbladder problem ☐ Parasites ☐ Chronic laxative use

Bowel movements: Frequency_____ Color_____ Odor_____ Texture/ Form_____

☐ Other: _____

Neuro-psychological: ☐ Loss of Balance ☐ Lack of Coordination ☐ Concussion ☐ Depression

☐ Anxiety ☐ Stress ☐ Bad temper ☐ Bi-polar ☐ Other: _____

Genito-urinary: ☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate

☐ Kidney Stones ☐ Unable to hold urine ☐ Dribbling ☐ Pause in flow ☐ Frequent urinary tract infection

☐ Pain in genital ☐ Itching of genital ☐ Other: _____

Female: ☐ Frequent vaginal infections ☐ Pelvic infection ☐ Endometriosis ☐ Vaginal discharge

☐ Fibroids ☐ Ovarian cysts ☐ Irregular periods ☐ Clots ☐ Pain/cramps prior/during periods

☐ Breast tenderness ☐ Breast lumps ☐ Fertility Problems ☐ Moodiness related to periods

☐ Low libido ☐ Hot Flashes ☐ Vaginal dryness ☐ Other: _____

_____#of pregnancies _____#of births _____Miscarriages _____Terminated _____Premature Births

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Male: ☐ Prostate problems ☐ Impotence ☐ Frequent seminal emission ☐ Painful/swollen testicles

☐ Fertility problems ☐ Discharge ☐ Ejaculation problems ☐ Other: _____

Are there any areas that you protect?

Any Pain or tenderness?

Any numbness or reduced sensation?

Ant areas that are warm or red?

Any swelling or tendency to swell?

Have you had any lymph nodes surgically removed?

If Yes, where were they removed from?

Do you have any SITES to be mindful of, due to (check boxes that apply):

☐ incision/wound ☐ radiation site ☐ neuropathy ☐ skin sensitivity/condition ☐ fracture history

☐ tumor site ☐ medical device ☐ area of infection

Please describe:

Are you experiencing any of the following (check boxes that apply):

☐ history or risk of lymphedema ☐ recent surgery ☐ infection or fever ☐ area of pain ☐ swelling

☐ risk of easy bruising ☐ pain medication ☐ fragile bones ☐ fatigue ☐ fragile/sensitive skin

☐ nausea ☐ other

Please describe:

Informed Consent:

I, _____, do hereby request and give permission to receive acupuncture, massage, and/or reiki therapy from The Cancer Wellness Center LLC, and any Licensed Acupuncturist, Licensed Massage Therapist, or Reiki Therapist working with them. Oriental Medical treatments include various modalities including but not limited to acupuncture and herbal supplements. I understand that I have the right to inquire about and refuse any part of the treatment.

I understand and am informed that, as in allopathic medicine, in the practice of Oriental Medicine there are some risks of treatment. I understand that although these risks are unlikely to occur, they are possible. These risks include but are not limited to: bleeding, bruising, nerve pain, punctured organ, aggravation of symptoms, appearance of new symptoms, fainting and fatigue. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment to be in my best interest based on the known facts at the time. Although I am aware that acupuncture and the other procedures used in Oriental Medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

Policies & Procedures:

Appointment Reminders and Follow Up Communication

We may use or disclose your health information to provide you with appointment reminders and follow up communication via phone, voicemail, email or letter.

Privacy Practices

I have reviewed The Cancer Wellness Center LLC's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

Payment

- Payment is due at the time of service. We accept cash, checks, and most major credit cards.
- Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 business hours notice you will be charged a $50 fee.
- A $30 fee will be charged for returned checks.
- We reserve the right to change our fee scale without notice.

I have completed this form to the best of my knowledge. I have read and understand the informed consent, privacy, and procedures information. By signing below I agree to a course of treatment in Oriental Medicine and intend this consent form to cover the entire course of treatment for my present condition as well as any future condition(s) for which I seek treatment with this practice.

_____

Patient's Name (please print)

_____

Patient's Signature Date