Cosmetic Acupuncture Patient History

Nu Yu Acupuncture
475 North Bridge Street Bridgewater, NJ 08807, 2nd Floor
Office: 908-429-9990 Fax: 908-393-6714 nuyuacup@aol.com http://wp.nuyuacu.com/

Patient Last Name	First Name	Gender M☐ F☐	Age	Occupation	Date of Birth

Patient Address	City	State	Zip	**Best Phone#** ( ) Leave Message: ☐ Yes ☐ No

Weight	Height	**Email**:	Emergency Contact Name: Phone# ( )

Primary Physician	**Referred by:**	**Reason for Coming:** ☐ Weight ☐ Smoke ☐ Facial

Medical History

Hepatitis A,C,B/HIV/AIDS: _____
Allergies: _____
Current Medications: _____
_____
Injuries: _____
Surgeries: _____
Circle if Apply: Hypertension / Heart Disease
Asthma /High Cholesterol / Stroke / Seizures
Kidney Disorder / Arthritis / Diabetes
Other: _____

Family History

Autoimmune: ☐
Arthritis: ☐
Cancer: ☐
Diabetes: ☐
Heart Disease: ☐
Kidney Disease: ☐
Mental Illness: ☐
Seizure: ☐
Obesity: ☐

Major Complain

Overweight: _____
Overeating: _____
Constipation: _____
Thyroid Disorder: _____
Stress: _____
Lack of Exercise: _____
Cravings: _____
Other Explain: _____
_____
_____

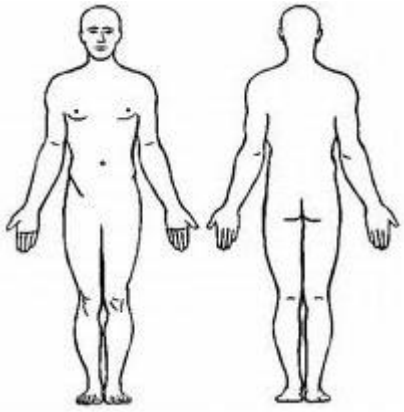
Overall Health

Do you use a Pacemaker? Yes No

Rate your overall health ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad
How often do you feel Stress/ Anxiety/ Depression? ☐ Never ☐ Occasionally ☐ Often ☐ All the time
How often do you exercise? ☐ Never ☐ Sporadically ☐ Regularly ☐ Daily
How is your Energy Level? ☐ Great ☐ Good ☐ Fair ☐ Poor ☐ Bad
Any Digestive Issues? ☐ Constipation ☐ Diarrhea ☐ Abdominal Pain ☐ Bloating
How often do you Smoke? ☐ Never ☐ Occasionally ☐ Often ☐ Daily ☐ Used to How many?_____
How often do you Drink Alcohol? ☐ Never ☐ Occasionally ☐ Often ☐ Daily ☐ Used to How many?_____
Do you sleep well? ☐ Yes ☐ No How many hours of sleep do you get? _____
How is your nutrition? ☐ Good ☐ Bad **(WOMAN) Are you currently pregnant? ☐ Yes ☐ No**

PLEASE MARK WHERE ARE YOUR CONCERNS:

Face: _____
Neck: _____
Arms: _____
Stomach: ___
Legs: _____
Hips: _____



How did the condition develop? _____
When did it start? _____
Have you ever received any treatment for this condition? **Yes No**
If yes, Where? _____ When?_____
What was the result of the treatment?
Has it gotten? ☐ Better ☐ Worse ☐ Stayed the same
(WOMAN) When was your last period: _____
Have you or Are you on Steroid: _____
If Yes, How long: _____
Have you or Are you on Hormone Therapy:_____
If Yes, How long: _____
Blood Thinner: **Yes No**
Name & Reason: _____

I certify that the above information is true and correct to the best of my knowledge.

Signature:_____ **Today's date:**_____

Nu Yu Acupuncture

475 North Bridge Street, 2nd Floor · Bridgewater, NJ 08807

Office: 908-429-9990 · Fax: 908-393-6714 · nuyuacup@aol.com

Patient Emergency Contact Information

The information will be strictly confidential, will remain in a secure, safe location, and will be used only in a true emergency when it is not possible to communicate with the patient directly. Thank you for helping us in our caring services.

PATIENT INFORMATION

Patient: _____

Patient Line 1: _____ **Circle:** HOME WORK CELL

Patient Line 2: _____ HOME WORK CELL

Text: YES NO Email: _____

IN CASE OF EMERGENCY, NOTIFY:

Contact: _____ Relationship: _____

Contact Line 1: _____ **Circle:** HOME WORK CELL

Contact Line 2: _____ HOME WORK CELL

Text: YES NO Email: _____

Appointment Reminders

Would you like to receive reminders for upcoming appointments?

☐ **YES**, I would like to receive reminders for upcoming appointments via text.

☐ **NO**, I do **not** wish to receive reminders for upcoming appointments.

_____ _____

Signature Date

INFORMED CONSENT FOR ACUPUNCTURE AND ORIENTAL MEDICINE

I hereby voluntarily consent to receive Acupuncture and Oriental Medicine treatment for my present and future health condition. I understand that treatment will be administered by a Certified Acupuncturist CA. The treatments that will possibly be administered are described below.

Acupuncture and Oriental Medicine Treatments That May Be Administered

Acupuncture: This is a safe treatment involving the insertion of tiny sterile (and disposable) needles through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding, and will rarely leave a bruise (not painful). Other possible risks from acupuncture include dizziness and fainting. I will report to the CA any dizziness or light-headedness that occur during or after an acupuncture treatment. Extremely rare risks of acupuncture (these have an extremely low incidence, especially when acupuncture is administered properly) include nerve damage, organ puncture, and infection.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of herbs, I understand that I should stop the herbs and that I am responsible for informing the CA of any symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. I accept full responsibility to inform the Licensed Acupuncturist of a suspected or confirmed pregnancy, or if I am a nursing mother.

Heat Treatment with TDP Lamp: This is used to warm an area of the body. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction. Very rarely a slight bum or blister may appear due to the heat.

Gua Sha: Gua Sha is scraping on the skin in a small area using a smooth-edged instrument. This often results in bruising at the treated area. The bruising, which is not painful, usually resolves in 3-7 days.

Plum Blossom (or tapping): Multiple, mild needle pricks are applied in one area. Slight bleeding at the area is likely.

Electro-Acupuncture: A mild electric micro-current (similar to a TENS treatment) is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

By signing below, I show that:

I have read, or had read to me, the information on this consent form
I understand the possible risks and complications involved. I have had the opportunity to discuss this consent form with my Licensed Acupuncturist. I understand that I can request more information at any time if desired.
I consent to receiving treatment that involves that above procedures.
I understand that I have the right to refuse or discontinue any treatment at any time. I understand that this refusal may affect the expected results.

_____
Patient Name (please print)

_____ _____
Patient (or Guardian) Signature **Date**

If a Guardian has signed, please print your name: _____

NU YU ACUPUNCTURE
475 North Bridge Street, 2nd Floor · Bridgewater, NJ 08807
Office: 908-429-9990 · Fax: 908-393-6714 · nuyuacup@gmail.com

Authorization for Release of Patient Information

Name of Patient: _____ Date: _____

I, the undersigned, authorize the release of and/or request access to the information specified below from the medical record(s) of the above-named patient.

AUTHORIZATION FOR THE INFORMATION TO BE RELEASED TO:

Insurance company, doctors, hospitals, attorney, self, etc.,... Initial: _____

AUTHORIZATION FOR THE ACUPUNCTURIST TO OBTAIN:

A copy of your records. If a copy is requested, there will be a charge for completion of all forms and/or medical records copied. Copies of medical records are $10.00 for up to 10 pages; thereafter, $1.00 per page, up to a maximum of $200 for the entire record.

Initial: _____

PATIENT PRIVACY STATEMENT:

I have been provided with, read, and understand the Patient Privacy Statement. Initial: _____

_____ _____
Signature of Patient or Date
Legally Authorized Representative

_____ _____
Printed Name Relationship to Patient

Payment and Cancellation Policy

I, the undersigned, understand that payment for all care received is my responsibility. I also understand that a 24-hour cancellation notice, whenever possible, is necessary to avoid charges. ***Payment is due at the time of service.***

_____ _____
Signature of Patient or Date
Legally Authorized Representative

_____ _____
Printed Name Relationship to Patient