Release Form

Name:_____ Age:_____ Sex:_____ Date:_____

Address:_____ City:_____ State & Zip:_____

Home Phone:(____)_____ Work Phone:(____)_____ Email:_____

How did you hear about us? _____

I understand that Chinese Medicine, like any other modality of healing, offers no guarantee or promise of immediate or long term changes in the patient's physiological or psychological condition.

I also understand the risks involved in Chinese Medicine could cause serious injury. These injuries include but are not limited to burns (scarring moxa or TDP lamp), numbness, bruising, possible infection, pneumothorax, miscarriage or premature labor.

I also understand and consent to the use of any viable form of medical technique used in the field of Chinese Medicine as allowed in the United States and the State of North Carolina. These techniques include acupuncture (insertion of needles in the body), moxibustion, cupping/gua sha, tui na (massage and body rotation), bleeding techniques and electrotherapy with needles.

I am aware that my practitioner may suggest the use of certain herbs and patent medicines to help me with my condition. These herbs and patent medicines may come in the form of powders, loose herbs, granules, pills and tablets. I also understand that research concerning the interaction between herbs and prescription drugs is limited and therefore release my practitioner from any liability thereof.

Having read through the information above I understand the risks and practices involved in Chinese Medicine and consent to treatment.

_____

Patient's Signature Legal Guardian (if under 18 yrs. Old)

_____

Date

Please inform your practitioner if you have ever been HIV or Hepatitis Positive. Please be considerate of your practitioner and other patients. It is very important to inform your practitioner of pacemaker or any other electrical devices in the body. If you suspect that you may be pregnant, please let your practitioner aware of this immediately.

Who is your primary care physician? _____

Phone: _____

In an Emergency please notify? Phone: _____

What is your *Main Complaint* you want to address? _____

How long ago did the problem begin? _____

Have you been given a diagnosis for the problem? _____
What kind of treatments have you tried for this condition? Have any of the treatments alleviated the condition? _____

Past Medical History:
Childhood Health:

Illnesses: _____

Surgeries: _____

Significant Injuries or Trauma: _____

Do you have or ever have had any significant infectious disease? _____

Have you taken any prescription drugs, over-the-counter drugs, herbs or vitamins recently or in the past 3 months? **Please list on last page**.

Average/Typical Blood Pressure: _____/_____ Average Pulse Rate: _____
Weight: _____ Height: _____

Social/Personal History:
Place of Upbringing? _____
Current Occupation? _____
Unusual Stresses or High Stress Levels? _____
Current Emotional Health? _____
Any Predominate Emotions? _____
Current Quality of Life? _____
Do you exercise regularly? _____
Have you traveled abroad in the past year? If so, where? _____
Drug Use-Cigarettes, Alcohol, Marijuana etc. Quantity of Use? _____

Family Medical History:
Please list if Mother/Father/Siblings are currently living. Any significant illnesses or deaths as a result of?

Personal Medical History: Please circle all that apply

Significant Illnesses:

Cancer	Seizures	Diabetes: Type I, Type II
Rheumatic Fever	Hepatitis A, B, C,	HIV/AIDS
Thyroid Disease: Hypo/Hyper	Tuberculosis	Heart Disease
STD	Mental Illness	Allergies
Asthma	High Blood Pressure	High Cholesterol
Stroke	Other:_____	

General Information:

Poor Appetite	Peculiar Tastes/Smells	Sweat Easily
Chills/Fever	Insomnia	Sudden Weight Loss/Gain
Bleeding	Night Sweats	Tremors
Poor Balance	Emotional Changes	Bruising Easily

Skin and Hair:

Rashes	Itching	Change in Skin Texture/Condition
Ulcers	Eczema/Psoriasis	Acne
Hair Loss/Early Graying	Dandruff	

Ear, Nose and Throat, Disorders of the Head:

Dizziness	Migraines	Eye Pain
Eye Strain	Glaucoma/Degeneration	Flowery Vision (Floaters, Blurry Vision etc.)
Eye/Ear Discharge	Ringing in the Ears	Sinus Problems/Nose Bleeds
Sores on Eyes/Ears/Mouth	Toothache	TMJ

Respiratory/Cardiovascular:

Cough	Phlegm	Shortness of Breath/Asthma
Easily Winded	Chest Pain	Cold Sweats
Irregular Heartbeat	Palpitations	Blood Clots
Poor Circulation	Cold Hands/Feet	Swelling of Hands/Feet

Gastrointestinal:

Nausea/Vomiting	Bloating	Belching
Constipation	Blood in Stools	Diarrhea
Gastric Ulcers	Intestinal Gas	Indigestion
Hemorrhoids		

Genito-Urinary:

Painful Urination	Urgent Urination	Scanty Urination
Night Urination	Frequent Urination	Incontinence of Urine (unable to hold)
Kidney Stones	Discolored Urine	Impotence/Premature Ejaculation

Gynecological and Pregnancy:

Irregular Periods	Spotting	Painful Menstruation
Continuous Heavy Flow	Discoloration (Prolonged Dark Red, Pale, Purple, etc.)	
Clots	PMS	Light Flow
Vaginal Discharge	Fertility Problems	
Number of Pregnancies_____	Number of Miscarriages/Abortions_____	
Number of Premature Births_____		Duration of Flow_____
Date of Last Menses_____		Date of Last Pap_____

Neuro/Psychological:

Poor Memory	Poor Concentration	Hyperactivity
Irritable/Easily Angered	Disorientation	Anxiety
Depression	Mood Swings	Lack of Coordination

Any other problems you would like your practitioner to be aware of?_____

Any other pain throughout the body (sprains, arthritis etc.?) Please list location.

Medication List: