TWIN ACUPUNCTURE

Kerri Kuhlsen, L.Ac., C.SMA
Licensed Acupuncturist, Certified in Sports Medicine Acupuncture®
917.826.0054

ALL INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL

(Please print clearly) Today's Date: _____

PERSONAL INFORMATION:

Name: Age: Date of Birth:

Address:

Primary Phone: Secondary Phone:

Email:

Emergency Contact Name: Phone Number:

Relationship to Patient:

Primary Care Physician (PCP): Phone #:

Date of last medical examination: Occupation:

Have you ever received acupuncture? YES NO

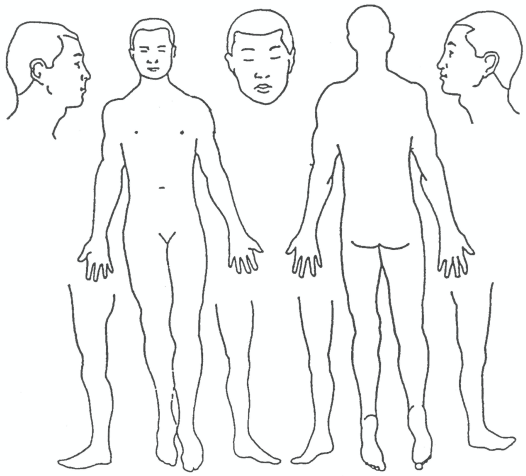
DESCRIPTION OF MAJOR COMPLAINT(S):

1. Primary Compliant: _____
2. Secondary (if any): _____

Diagnosis from medical Doctor (if applicable): _____

Briefly describe how your condition/injury occurred: _____

PLEASE "X" OR SHADE THE AREAS WHERE YOU FEEL SYMPTOMS ASSOCIATED WITH YOUR COMPLAINT.



For each questions, please indicate your level of pain by circling a number from 0-10

My current pain is……

No Pain: 0 1 3 4 5 6 7 8 9 10: Severe Pain

In the past week, the **best** my pain has been is……

No Pain: 0 1 3 4 5 6 7 8 9 10: Severe Pain

In the past week, the **worst** my pain has been is……

No Pain: 0 1 3 4 5 6 7 8 9 10: Severe Pain

How long have you been in pain? (Circle one)

Less Than < 6 months 6-12 Months 12-24 Months 24 Months +

Which treatments have you tried to manage your pain (Circle all that apply)?

Massage Chiropractic Physical Therapy

Prescription Medications Over the Counter Medications Surgery

Other: _____

MEDICATIONS/SUPPLEMENTS:

Please list all medications (prescription and over the counter) that you are currently taking and for what condition(s):

	Name	**Indication/for treatment of:**
1.		
2.		
3.		
4.		
5.		

ALLERGIES: List any food allergies, environmental allergies, etc.

PERSONAL MEDICAL HISTORY:

- Please list any injuries, accidents and/or surgeries

Year:_____ _____

Year:_____ _____

Year:_____ _____

Year:_____ _____

Year:_____ _____

MUSCULOSKELETAL:

Do you have *(circle all that apply):*

Joint Clicking	Limited movement	Stiffness	Spasms	Swelling
Muscle Weakness	Pain entire body	Facial/Jaw Pain	Neck Pain	Low Back Pain
Hip Pain	Knee Pain	Ankle Pain	Shoulder Pain	Elbow Pain
Hand Pain	Foot Pain			

OTHER: _____

CARDIOVASCULAR/EYES/EARS/HEAD/NEUROLOGICAL:

Blood Pressure: _____/_____ Have you ever been diagnosed with heart trouble? Yes No

Do you have *(circle all that apply):*

Chest Pain	Palpitations	Irregular Heart Beat	Mitral Valve Prolapse
Poor Circulation	Pacemaker	Other: _____	

Do you have *(circle all that apply):*

Frequent Colds	Headaches	Chronic Cough	Pain Inhaling	Pain Exhaling	Chest Pain
Numbness/Tingling	Wheezing	Nose Bleeds	Blurred Vision	Dizziness	
Dry mouth	Tinnitus	Vertigo/Meniere's	TMJ Pain	Swelling of Ankles or Feet	

Other: _____

Do you smoke? Yes No How many **per day**? _____

How much liquor do you consume ***weekly***?_____ How many caffeine beverages do you consume ***daily***? _____

Medical Health History:

Circle anything current and <u>underline</u> anything that occurred in the past:

AIDS/HIV	Cancer	Depression	Glaucoma	High Cholesterol	Pneumonia
Alcoholism	Bulimia	Diabetes	Goiter	IBS	Prostrate Problems
Allergies	Bronchitis	Diarrhea	Gonorrhea	Kidney Disease	Rheumatoid Arthritis
Anemia	Breast Lump	Emphysema	Gout	Liver Disease	Stroke
Anorexia	Bleeding Disorders	Epilepsy	Heart Disease	Miscarriage	Thyroid Problems
Appendicitis	Cataracts	Fractures	Hepatitis A B C	Multiple Sclerosis	Trigeminal Neuralgia
Arthritis	Chicken Pox	Fibromyalgia	Herniated Disc	Osteoporosis	Tumors
Asthma	Constipation	Hernia	Herpes	Pinched Nerve	Ulcer

Other: _____

Women:

Are you **currently** pregnant? Yes No Are you **currently trying** to get pregnant? Yes No

Are you Nursing? Yes No Are you taking Birth Control Pills? Yes No

Number of Days between Cycles:_____ How long does your cycle last? _____

Number of pregnancies: _____ Deliveries: _____ Abortion/Miscarriages: _____

<u>PMS Symptoms</u>: Do you have *(circle all that apply):*

Painful Periods Irregular Periods Breast Tenderness Irritability

Spotting between Periods Migraines Cramping Heavy Flow

Other: _____

<u>Menopausal symptoms</u>: Do you have *(circle all that apply):*

Night Sweats Hot Flashes Insomnia Palpitations

Other: _____

Men:

Do you have *(circle all that apply):*

Prostate Problems Sexual Dysfunction Other: _____

Emotions and Sleep:

<u>Do you have</u> ***(circle all that apply):***

Panic attacks Depression Anxiety Bad Temper Mood Swings Nervousness

Fear Attacks Poor Memory PTSD Grief/Sadness

Other: _____

<u>Do you have difficulty</u> ***(circle all that apply):***

Falling asleep Staying asleep How many hours do you sleep per night? _____

Do you often wake in the middle of the night? If so, what time? _____

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CONSENT TO TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture by Kerri Kuhlsen, L.Ac. I understand that acupuncturists practicing in the state of New York are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Acupressure/ Massage: I understand that I may also be given acupressure/ massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a Licensed Physician.

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibilities to inform Kerri Kuhlsen, L.Ac. if I, or my minor child ever have a change in health.
I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I also give my permission and consent to be treated by Kerri Kuhlsen, L.Ac.

Patient Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Guardian/Parent Signature (**if under 18**): _____

Witness Signature: _____Date: _____
(Kerri Kuhlsen, L.Ac.)

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OFFICE POLICY

I value your time and don't want to keep you waiting. If there is a delay by an unexpected event with another patient, be assured that the quality of your time will not suffer. If you arrive more than 15 minutes late, there is a chance you may not be treated. If you do receive treatment, your treatment will end on its scheduled time in order not to keep the next person waiting.

No Shows/Cancellations

It is important to keep any appointments that have you scheduled or contact me if you cannot. This way I can schedule others who wish to be treated. **More than 1 cancellation** or **no show** during the course of your treatment may influence scheduling future appointments.

Kindly give **24 hours** notice if you have to cancel or reschedule your appointment to avoid the cancellation fee of $50.00. This charge will **NOT** be assessed to your insurance company and is **YOUR** responsibility.

All major credit cards, cash and personal checks are accepted as forms of payment. Returned checks are subject to a $30 fee.

I HAVE READ AND AGREE TO THE ABOVE.

_____	_____
PRINT NAME	DATE
_____	_____
Signature	Witness, Kerri Kuhlsen, L.Ac.