



Armonía Health LLC Medical History for Community Acupuncture

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Cell Phone: _____

Email: _____ Can we add you to our email list? YES NO Occupation: _____

Gender: _____ Age: _____ DOB: ____/____/____ Weight: _____ Referred to us by? _____

Name & contact number in case of emergency: _____

Who is your medical doctor? _____ Date of last visit: _____ Reason: _____

Have you received acupuncture/Chinese herbs in the past? _____ Date: _____ Reason: _____

Medications you are currently taking: _____

Supplements/Herbs you are currently taking: _____

Previous accidents, falls and/or surgery, with their dates: _____

Major Complaint

What is your primary reason for this visit? _____

Have you received treatment for this? If so, what? _____ Did it help? _____

CIRCLE any symptoms or illnesses you have currently, **CHECK** any you have had in the past:

AIDS/HIV

Allergies

Alcoholism

Arthritis

Asthma

Back problems

Blood pressure (high/low)

Cancer

Cholesterol high

Depression/Anxiety

Diabetes

Ear/Nose/Throat

Epilepsy

Fertility issues

Menstrual/Hormonal issues

Gastrointestinal issues

Headache/Migraine

Heart disease

Hepatitis B/C

Indigestion/Acid Reflux

Insomnia

Low energy

Poor memory/concentration

Tuberculosis

Vertigo

Venereal disease

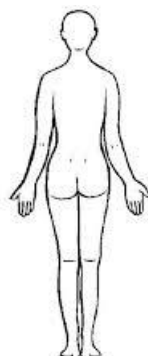
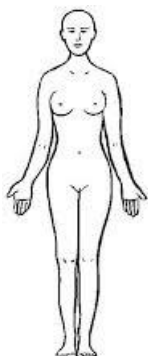
Smoke? _____

Drink alcohol? _____

Caffeine? _____

List any other conditions or comments you'd like for us to know: _____

Circle the areas that currently bother you



ARMONIA HEALTH LLC Community Acupuncture Policies and Consent to treat
Please initial after reading

_____ Our rates, payable in cash, check or credit card (we do accept Health Savings Accounts/Flex Accounts for acupuncture):

Initial Community Acupuncture session: \$55

Follow up Community Acupuncture session: \$40-60 (\$45 minimum for credit card)

_____ If you cannot make it to your session, please give us 24 hours advance notice. If you miss a session without 24 hour advance notice, you will be charged \$40.

_____ I, the undersigned, hereby consent to receive acupuncture treatment from a licensed acupuncturist. I understand that I am receiving acupuncture in a group setting (community acupuncture) and my initial consultation will be in private. Follow up sessions may be with a different acupuncturist depending on my treatment plan and appointment availability. I consent to Armonia Health LLC's acupuncturists communicating about my treatments with each other.

_____ I am fully aware that the acupuncture needles are sterile and disposable and that no needle used to treat me has ever been used on another person.

_____ I fully understand that there is no stated or implied guarantee of success or effectiveness of a specific treatment or series of treatments. My practitioner may refer me to other health care providers or another service at Armonia Health LLC to provide a more complete integrative care, my information will be shared with those Armonia Health LLC practitioners if I choose to see him/her.

_____ I understand that complications may result from acupuncture treatment. Among these possible complications are: bruising, fainting, numbness, weakness, nausea, hematoma, infection, burns, pain and discomfort, aggravation of present symptoms, and in very rare cases pneumothorax 24-48 hours after my session. I will communicate any concerns from my session with my acupuncturist or Armonia Health LLC's staff.

_____ I understand that acupuncture and Chinese medicine are not a substitute for standard Western medicine, that certain health disorders may require allopathic diagnosis and treatment, and that I am free to seek allopathic medical advice and treatment at any time, either in lieu of, or concurrently with acupuncture treatment.

_____ I understand I can communicate with the acupuncturist during my treatment if I experience discomforts.

_____ I understand I am to let the acupuncturist know if I am or think I may be pregnant.

_____ I fully realize that I may withdraw from my treatment at any time.

_____ I understand and agree to hold harmless, to indemnify and protect against court action the individual therapist as well as the management of this clinic, in the event of accidental injury on these premises.

Printed Name: _____ Signature: _____ Date: _____

Parent or Guardian Signature

I, the parent or guardian of the above named minor, hereby consent to all the above terms and conditions implied in the above document and hereby give permission for my minor child to undergo acupuncture treatments for the purposes and considerations above expressed.

Parent/Guardian Printed name and Signature: _____ Date: _____

Licensed Acupuncturist's Signature: _____ Date: _____



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Chinese Medicine Symptom Checklist

Name: _____ Date: _____

Please check any of the following symptoms you experience frequently or have a tendency towards.

**Spleen/Stomach
Energy System**

- Fatigue/Low Energy
- Bruise easily
- Tired after eating
- Low appetite
- Strong appetite
- Loose stools
- Constipation
- Abdominal bloating
- Heartburn/Reflux
- Post Nasal Drip
- Nausea/Vomiting
- Frequent hiccups or belching
- Flatulence
- Hemorrhoids
- Excessive vaginal discharge
- Bad breath
- Tendency to worry/obsess
- Stomach ulcers
- Mouth sores
- Bleeding gums

Lung/Large Intestine Energy System

- Recurrent colds/Infections
- Sinus problems
- Allergies
- Sweat easily
- Do not sweat
- Blood or mucus in stool
- Pain in the teeth or gums
- Skin problems
- Shortness of breath
- People often ask you to speak up
- Feel Sad

**Heart/Small Intestine
Energy System**

- Difficulty sleeping
 - Heart palpitations
 - Anxiety
 - Memory problems
 - Sores on the tongue
 - Startle easily
 - Laugh inappropriately
- Liver/Gallbladder Energy System**
- Frequent irritability/Frustration
 - Depression/Tendency to feel sad
 - Frequent sighing
 - Abdominal pain
 - Pain under the ribcage
 - Floaters
 - Can't see well at night
 - Red eyes
 - Wake between 1-3am
 - Trouble falling asleep
 - Dizziness
 - Tight muscles
 - Painful periods
 - Irregular periods
 - Inability to cry

Kidney/Bladder Energy System

- Low back pain
- Frequent urination
- Knee pain
- Low sex drive
- High sex drive
- Erectile dysfunction
- Night sweats
- Hot flashes
- Poor hearing
- Ringing in ear
- Wear socks to bed
- Vaginal dryness
- Congenital abnormalities

Other symptoms: