Sun & Moon Acupuncture Clinic
Nancy Goodwin, LAc
61 Greywolf Rd
Sequim, WA 98382
360-355-5989
www.sunandmoonacupuncture.com

Name _____ Phone: Home _____ Cell/Work _____

Address _____ City _____ State ____ Zip _____ Email_____

Date of Birth _____ Age _____ Height ____'____" Weight _____ Occupation _____

Marital Status _____ Number of Children _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you find me?
Phonebook ___ Newspaper Ad ___ Friend / Relative ___ Who? _____ Physician ___

What are your primary concerns, conditions, injuries, or illnesses? List date each began.
1. _____ 3. _____
2. _____ 4. _____

Describe what caused it or how it started.
1. _____ 3. _____
2. _____ 4. _____

Personal Medical History including dates
Major Surgeries _____
Illnesses _____
Diseases _____
Accidents _____

Please list all prescriptions, over the counter medications, vitamins, and other supplements you are taking.
1. _____ 4. _____
2. _____ 5, _____
3. _____ 6._____

Are you hypersensitive or allergic to Any drugs? _____
Any foods? _____

Age Parents Died and Cause of Death Mother _____
Father _____

Contagious Diseases Check if you have ever had any of the following:
___ Hepatitis A, B, C ___ Herpes ___ HIV ___ AIDS ___ Other _____

Lifestyle
Please mark box with "P" for past use and "C" for current use. If "C" then state quantity.
___ Cigarettes _____ packs ___ Soft Drink _____ ___ Energy Drinks _____
___ Coffee _____8 oz. cups ___ Alcohol _____ ___ *Plain* Water _____ ___Tea_____

Exercise ___ None ___ Some ___ Moderate *Type*? _____

Patient Name _____ DOB_____ Date _____

Emotions Check all that apply.

___ Happy ___ Easily Irritable ___ Restless
___ Angry ___ Cry Easily ___ Hurry to do things
___ Depression ___ Stressed ___ Anxiety / Anxious
___ Difficulty making decisions ___ Other _____

Do you have a history of: ___ Physical Abuse ___ Emotional Abuse

Have you experienced any major traumas? Yes No

More than 2 in 1 year? Yes No
(ex. Divorce, change of residence, injury, loss of job, death in family, bankruptcy, etc.)

Do you enjoy your work? Yes No
Do you have a supportive relationship? Yes No

Diet
List your typical breakfast: _____

List your typical lunch: _____

List your typical dinner: _____

List your typical snacks: _____

List your cravings: _____

Energy
___ Low ___ Normal ___ Excess ___ Low after Eating

Spiritual
Do you have a religious or spiritual practice? Yes No If yes, what? _____

Body Temperature

___ Warm Natured ___ Flushed Face ___ Feel Warmer Late Afternoon / Night
___ Cold Natured ___ Aversion to Heat ___ Aversion to Cold
___ Cold Hands & Feet ___ Aversion to Wind ___ Normal

Perspiration
___ Night Sweats ___ Palms / Feet ___ Normal

Digestion

___ Indigestion ___ Nervous Stomach ___ Bloating
___ Heartburn ___ Nausea ___ Vomit
___ Excessive Gas ___ Bitter Taste ___ Abdominal Pain
___ Gall Stones ___ Difficulty Digesting Fatty Food ___ Normal

Patient Name _____ DOB_____ Date _____

Bowels

___ Loose Stool
___ Constipation
___ Blood in Stool
___ Hemorrhoids
___ Undigested Food in Stool
___ Hard Stool
___ Mucous in Stool
___ IBS
___ Diarrhea
___ Laxatives Used
___ Stool with Bad Smell
___ Normal

Urination

___ Frequent
___ Urgent
___ Incontinence
___ Kidney Stones / Infections
___ Burning
___ Night Time
___ Profuse
___ Painful
___ Bladder Infections
___ Blood
___ Strong Smell
___ Normal

Thirst

___ Not Thirsty
___ Prefer Hot Drinks
___ Excessive Thirst
___ Prefer Cold Drinks
___ Thirsty but do not Drink
___ Normal

Sleep

___ Difficulty Falling Asleep
___ Difficulty Going Back to Sleep
___ Sleep too Much
___ Awaken Easily
___ Restless
___ Tired on Rising in Morning
___ Lots of Dreams
___ Vivid Dreams
___ Normal

Headaches / Dizziness

___ Headaches
___ Migraines
___ Poor Memory
___ Vertigo
___ Poor Balance
___ Faint Easily
___ Dizzy on Standing
___ Dizziness
___ Normal

Skin

___ Dry
___ Oily
___ Shingles
___ Eczema
___ Hives
___ Itching
___ Psoriasis
___ Bruise Easily
___ Normal

Hair

___ Dry ___ Hair Loss ___ Early Grey ___ Normal

Eyes

___ Sensitive to Light
___ Cataracts
___ Poor Night Vision
___ Dark Under the Eyes
___ Glaucoma
___ Blurry Vision
___ Eyelids Swollen
___ Macular Degeneration
___ Normal

Nose

___ Stuffy Nose
___ Loss of Smell
___ Hayfever
___ Sneeze a Lot
___ Bleeding
___ Sinusitis
___ Normal

Mouth & Throat

___ Dry
___ Difficulty Swallowing
___ Thyroid Problems
___ Bitter Taste in Mouth
___ Frequent Sore Throats
___ Dry Cracked Lips
___ Feel Lumps in Throat
___ Teeth Problems
___ Frequent Colds
___ TMJ Syndrome
___ Grind Teeth
___ Normal

Patient Name _____ DOB_____ Date _____

Ears

___ Hearing Loss ___ Sensitive to Cold ___ Sensitive to Noise
___ Ringing in Ears – High Pitch ___ Ringing in Ears – Low Pitch ___ Normal

Respiratory

___ Asthma ___ Sigh a Lot ___ Dry Cough
___ Shortness of Breath ___ Chest Pain ___ Cough with Phlegm
___ Difficulty Inhaling ___ Tightness in Chest ___ Normal
___ Difficulty Exhaling ___ Difficulty Breathing when Lying Down

Cardiovascular

___ High Cholesterol ___ Pacemaker ___ High Blood Pressure
___ Blood Thinners ___ Murmur ___ Low Blood Pressure
___ Chest Pain ___ History of Anemia ___ Ankle Swelling
___ Slow Heartbeat ___ Fast Heartbeat ___ Hand Swelling
___ Numb Arms / Legs ___ Irregular Heartbeat ___ Palpitations
___ Bruise Easily ___ Average BP _____ ___ Normal

Pain

___ Low Back ___ Neck ___ Shoulder Joint
___ Sciatica / Gluteals ___ Arthritis ___ Hip Joints
___ Hands or Wrists ___ Foot or Ankle ___ Knees
___ Upper Back ___ Muscle Cramps ___ Damp Weather Bothers You
___ Mid Back ___ Nerve Pain / Neuropathy ___ Normal

Females

Are you or might you be pregnant? ___ Yes ___No ___ Maybe
If YES, approximate date of delivery? _____
Are you experiencing reduced sex drive? ___ Yes ___ No
Do you have regular PAP Tests? ___ Yes ___ No Date of Last PAP _____

Menstrual Cycle

Age Started _____ Days of Flow _____ Age Stopped _____
How many days from the beginning of your period to the start of your next period? _____

___ Irregular Menses ___ Painful ___ Heavy Flow
___ Scanty Flow ___ Clots ___ Water Retention
___ Ovarian Cysts ___ Uterine Fibroids ___ Birth Control Pill
___ Painful Breasts ___ Emotional Changes ___ Spotting Between Periods
___ Constipation / Diarrhea ___ Backache ___ Hormonal Problems
___ Pain with Ovulation ___ Hysterectomy ___ Endometriosis
___ Vaginal Discharge – ___ Yellow ___ Thick ___ White ___ Clear

Menopause

___ Hot Flashes ___ Night Sweats ___ Insomnia
___ Moodiness ___ Poor Memory ___ Vaginal Dryness

Other Please list any other issues you would like to discuss.

_____

Informed Consent for Acupuncture Treatment and Care

Sun & Moon Acupuncture Clinic, Inc. Nancy Goodwin, LAc

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, electrical stimulation, Tui-Na (Chinese massage), gua sha, cupping, Chinese or Western herbal medicine, nutritional counseling, botanical medicine, homeopathy, and acupuncture (point) injection therapy.

I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutrition/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of acupuncture, cupping, and injection therapy. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment at all times.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I experience any of these or other side effects and/or if I become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff and administrative staff may review my medical records and lab reports, but all of my records will be kept confidential and will not be released without my written consent.

I understand that my appointment times are my commitment to being here and I agree to cancel 24 hours in advance or I will pay for the treatment.

By voluntarily signing below, I show that I have read or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print Patient's Name _____ Date _____

Patient's Signature _____ Pregnant? [ ] Yes [ ] No

If Minor or Under Guardianship, Patient's Representative Signature _____

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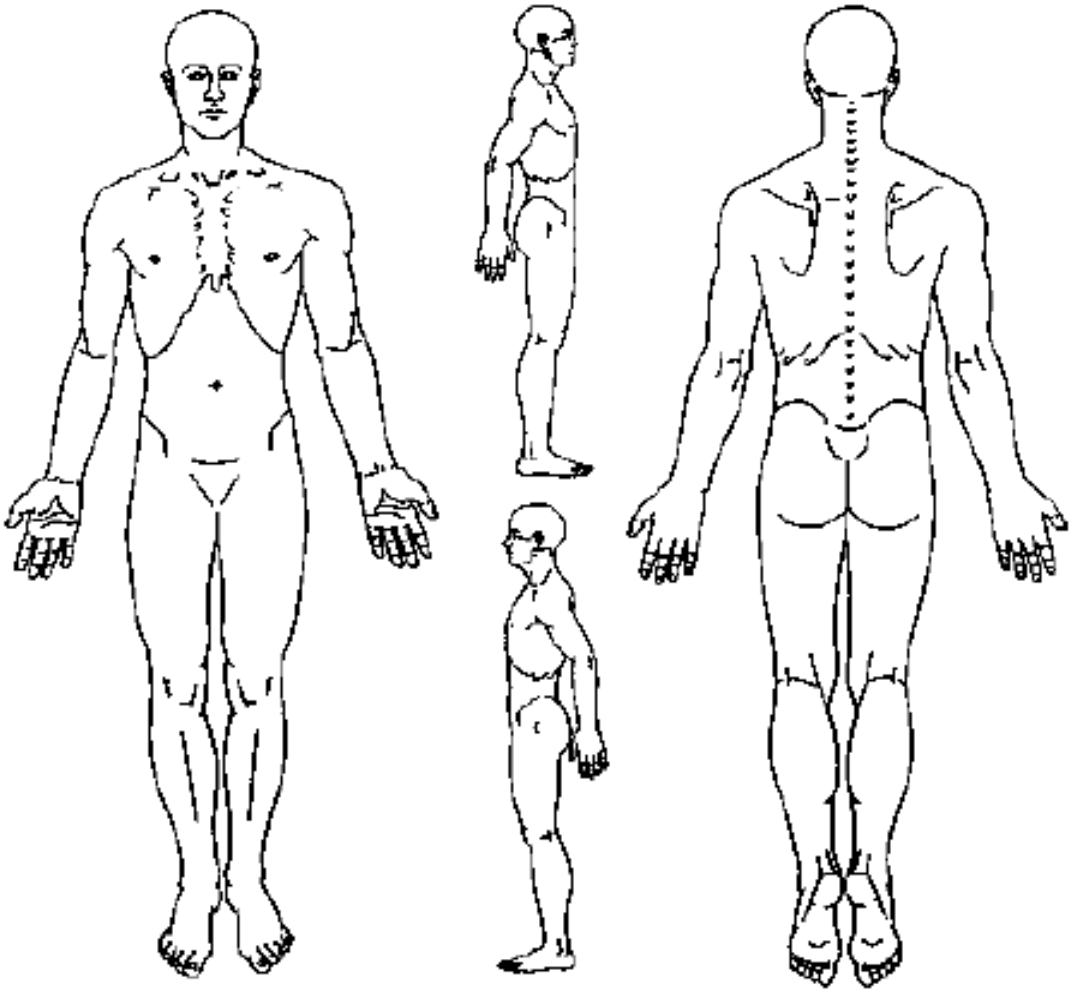
THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER