YIN YANG HOUSE
Acupuncture & Wellness Center

Patient # _____

Print Form | Submit by Email

Acupuncture & Massage Therapy

Patient Information and Health History

Name _____ **Today's Date** _____

Address _____ **Date of Birth** _____

_____ **Age** _____

City _____ **State** _____ **Zip** _____ **Sex** ☐ M ☐ F

Phone _____ **Cell** _____ **Height** _____

Email Address _____ **Weight** _____

Occupation _____ **Employer** _____

Marital Status ☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed

Emergency Contact _____ **Emergency Phone** _____

Physician _____ **Referred by** _____

Main Health Issues

What is the main issue that you would like to address? _____

When did the problem begin (be specific)? _____

To what extent does this interfere with your life? _____

Have you been given a diagnosis for this problem? _____

What other treatment(s) have you tried? _____

Personal Medical History

Surgeries (types & dates)? _____

Significant Traumas? _____

Allergies (drugs, chemicals, foods, etc.)? _____

Stressors (chemical, physical, psychological)? _____

☐ Cancer	☐ HIV/AIDS	☐ Thyroid Fever
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Hepatitis	☐ Heart Disease	☐ Venerreal Disease

History of other Medical Conditions? _____

Family Medical History

- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Seizures
- ☐ Asthma
- ☐ Allergies
- ☐ Emotional Disorders

Other medical conditions in the family? _____

Lifestyle, General Health and Medications

Are you taking any medications/supplements? Why? _____

Do you have a regular exercise program? Describe: _____

Are you (or have you been) on a restricted diet? Why? _____

Please describe your average daily diet (times, foods &drinks):

Morning: _____

Afternoon: _____

Evening: _____

Please indicate your usage per day or per week:

Cigarettes		**Tea**	
Alcohol		**Soft Drinks**	
Drugs		**Sugar**	
Coffee		**Other**	

In general how do you feel physically, emotionally, etc.? _____

Is there anything else you feel we should know? _____

Have you experienced any of the health issues listed below? (Past or Present)

General

- ☐ Recurrent Infections
- ☐ Night Sweats
- ☐ Sweat Easily
- ☐ Bleed or Bruise Easily
- ☐ Fatigue
- ☐ Poor Sleep/Insomnia
- ☐ Edema

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Dry Skin/Scalp
- ☐ Recent Moles
- ☐ Changes in Hair/Skin
- ☐ Sores on Lip/Mouth

Head/Eyes/Ears/Nose/Throat

- ☐ Headaches
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Night Blindness
- ☐ Spots in Front of Eyes
- ☐ Excessive Tearing
- ☐ Grinding Teeth
- ☐ Recurrent Sore Throat

Health Issues (continued)

Cardiovascular

- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest discomfort/pain
- ☐ Heart Palpitations
- ☐ Cold Hands or Feet
- ☐ Swelling of Hands or Feet
- ☐ Fainting

Neuro-Psychological

- ☐ Anxiety
- ☐ Depression
- ☐ Emotional/Moody
- ☐ Substance Abuse
- ☐ Attempted/Considered Suicide
- ☐ Seizures
- ☐ Dizziness
- ☐ Coordination Issues

Respiratory

- ☐ Difficulty Breathing
- ☐ Shallow Breathing
- ☐ Shortness of Breath
- ☐ Recurrent Cough
- ☐ Asthma/Wheezing

Digestion

- ☐ Change in appetite
- ☐ Nausea
- ☐ Indigestion/Reflux
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loose Stools/Diarrhea
- ☐ Constipation
- ☐ Anorexia/Bulimia

Musculo-Skeletal

- ☐ Muscle Weakness
- ☐ Sciatica
- ☐ Pain - where?

Gynecological

- ☐ PMS
- ☐ Irregular Periods
- ☐ Light Periods
- ☐ Heavy Periods
- ☐ Clots
- ☐ Urinary Tract Infections
- ☐ Hot Flashes
- ☐ Practice Birth Control?

If (y) what type(s)? _____

Are you pregnant? _____

# of pregnancies _____

# of births _____

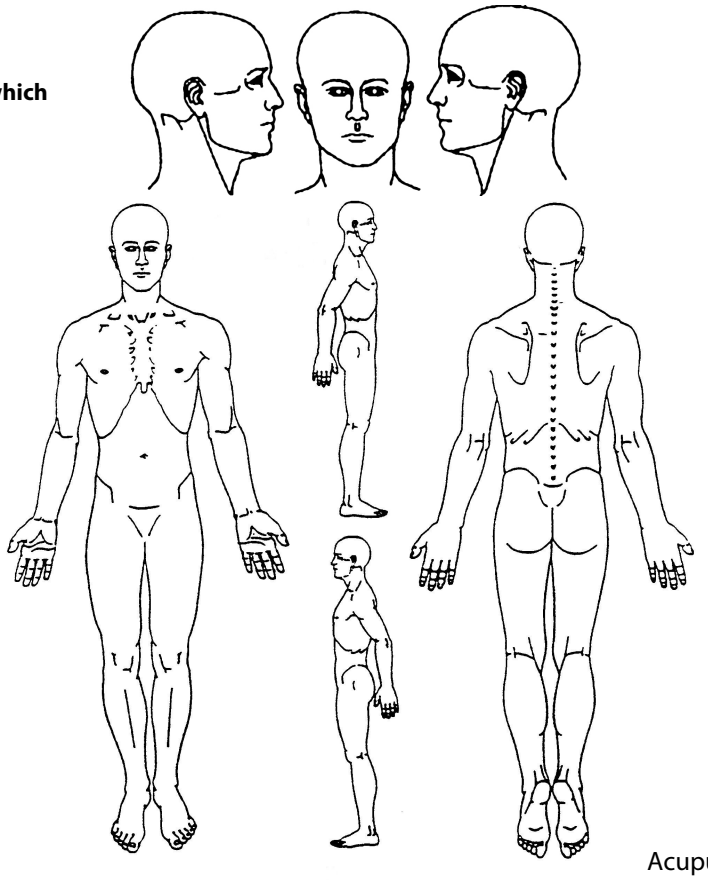
 # abortions _____

age of 1st menses _____

duration of menses _____

age of menopause _____

Please indicate the area(s) in which you are experiencing pain



Informed Consent for Treatment & Financial Policies

I hereby request and consent to the performance of acupuncture, massage, and other medical procedures offered within the Yin Yang House by our licensed practitioners.

I understand that methods of treatment may include but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, massage, gua sha, and nutritional counseling. I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my presenting condition and for any future conditions for which I seek treatment. I hereby release Chad J. Dupuis, L.Ac. of the Yin Yang House and all licensed practitioners practicing within our facilities from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and discontinue participation.

I also understand and agree to the following financial policies:
Payment is due at the time of service. Our office is setup for cash, checks, and credit cards. Our office does not bill insurance companies, however, we will provide you with a coded receipt that may be acceptable to your insurance company for reimbursement.

Cancellations:
Failure to provide 24 hour advance notice of cancellation may result in a cancellation fee from $25 - 50% of the cost of the treatment. This fee varies per service and whether you have booked online or in person. For patients who miss appointments without canceling, particularly numerous times, we reserve the right to refuse the scheduling of any future dates both online and in person.

Patient's Name (Print) _____

Patient's Signature _____

Date Signed _____

To be completed by the patient's representative, if the patient is a minor or physically/legally incapacitated:

Patient's Name (Print) _____

Patient's Representative _____

Representative Signature _____

Witness Signature _____