



MODERN WORLD CLINIC
ROSEDALE CLINIC



Name: _____
 Street: _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Fax Number: _____
 E-Mail Address: _____
 Date of Birth: _____ Social Security #: _____
 Occupation: _____
 Emergency Contact: _____
 Marital Status: _____ Age: _____ Height: _____ Approx Blood Pressure: _____
 Physician: _____
 By whom were you referred? _____

What is your chief complaint or reason(s) for this visit?

When did you first notice symptoms? _____

What improves the condition? _____

What worsens the condition? _____

What treatments have you tried? _____

How would you rate your condition today?

 1 (no problem) (unbearable) 10

Have you received Acupuncture treatments before? YES NO

Where? _____ When? _____

By whom? _____

Are you willing to take Chinese Herbs if so prescribed by your practitioner? YES NO



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PAST MEDICAL HISTORY

- | | | | |
|--|---|---|--|
| Addiction (drugs, food, smoking)
AIDS
Alcoholism
Anemia
Appendicitis
Arteriosclerosis
Arthritis
Asthma
Bladder Disease
Breast Lumps
Breathing Problems
Bulimia
Bursitis
Cancer (type)
Candida
Chicken Pox
Chronic Fatigue
Colitis/Bowel Disease | COPD
Diabetes
Digestive Disorders
Eating Disorder(anorexia/bulimia)
Elevated Liver Enzymes
Emotional Imbalance
Emphysema
Epilepsy
Fybromyalgia
Food,Chem,Drug Poisoning
Gall Stones
German Measles
Glaucoma
Goiter
Gout
Heart Disease
Hernia
Hepatitis (type?) _____ | High Cholesterol
Hypertension
HIV Positive
Malaria
Measles
Mononucleosis
Multiple Sclerosis
Mumps
Nephritis
Neuralgia
Paralysis
Polio or Meningitis
Prostate problems
Rheumatism
Scarlet Fever
Small Pox
Stroke
Thyroid problems | Tonsillitis
Tuberculosis
Typhoid Fever
Ulcers
Venereal Disease |
|--|---|---|--|

Other: _____

Surgeries: _____

Significant Traumas (auto accidents, death of loved one): _____

Allergies (drugs, chemicals, foods, airborne): _____

Medications taken in last two months (include vitamins, over-the-counter drugs, herbs): _____

Do you follow a regular exercise program? _____ If so, please describe: _____



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CURRENT MEDICAL INFORMATION (FOR PREVIOUS 3 MONTHS)

Do you consider your diet healthy?	YES	NO	
Do you drink water everyday?	YES	NO	How many glasses? _____
Do you consume dairy?	YES	NO	How much a day? _____
Do you drink coffee?	YES	NO	How many cups a day? _____
Do you drink soda?	YES	NO	How much a day? _____
Do you drink alcohol?	YES	NO	How much a week? _____
Do you use tobacco products?	YES	NO	How much a day? _____
Do you use recreational drugs?	YES	NO	What kind & how much? _____
Do you use artificial sweetener?	YES	NO	

GENERAL

- | | | |
|--|---------------------|----------------------|
| Poor appetite | Sleep too much | Spontaneous sweating |
| Localized weakness | Hard to fall asleep | Night sweats |
| Sudden energy drop (what time?) | Hard to stay asleep | Feel hot often |
| Bleed or bruise easily | Excessive dreaming | Fever |
| Significant change in appetite | Disturbing dreams | Chills |
| Cravings (what?) | | Feel cold often |
| Strong thirst (hot or cold) | | |
| Excessive antibiotic use (episodes per year _____) | | |

SKIN AND HAIR

- | | | |
|--------------------------------|--------------|----------------|
| Rashes | Ulcerations | Hives |
| Itching | Eczema | Dandruff |
| Dry skin | Acne | Premature gray |
| Oily skin | Recent moles | Loss of hair |
| Change in hair or skin texture | Boils | |

Other: _____

HEAD, EYES, EARS, NOSE, AND THROAT

- | | | |
|-------------------------|---------------------------------------|-------------------------|
| Dizziness | ringing in ears (occasional/constant) | Headaches (chronic?) |
| Recent change in vision | Poor hearing | Migraine |
| Cataracts | Earaches | Cluster Headaches |
| Spots in front of eyes | Sinus problems (acute or chronic) | Tension Headaches |
| Night blindness | Runny nose | Recurrent sore throats |
| Blurry vision | Sneezing | Sores on lips or tongue |
| Eye pain | Nasal congestion | Grinding teeth |
| Dry eyes | Nose bleeds | Jaw clicks |
| Red & itchy eyes | Facial pain | Gum problems |

Other: _____



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GASTROINTESTINAL

Constipation	No smell to stools	Hemorrhoids	Nausea
Diarrhea	Black stools	Chronic laxative use	Vomiting
Blood in stool	Light colored stools	Gas	Belching
Undigested food in stools	Burning at anus	Indigestion	Bad breath
Foul smelling stools	Rectal pain	Abdominal cramps	

How many bowel movements do you have a day? _____

Do you feel exhausted after a BM? _____ Do you feel you have adequate evacuation during a BM? _____

Other: _____

GENITO-URINARY

Pain on urination	Frequent urination	Kidney stones
Urgency to urinate	Wake more than once to urinate	Impotence
Decrease in urine flow	Unable to hold urine	Sore on genitals
Blood in urine	Urinary Tract Infections (chronic or acute)	Herpes (outbreaks how often?)

Other: _____

MUSCULOSKELETAL

Neck pain	Hand/wrist pain	Muscle weakness	Hip pain
Back pain	Muscle pain	Shoulder pain	Elbow pain
Back pain (radiates down back of leg)		Knee pain	Cortisone shots (how many?)
Back pain (radiates down side of leg)		Foot/ankle pain	(when was the last shot?)

Other: _____

CARDIOVASCULAR

High blood pressure	Chest pain	Swelling of hands
Low blood pressure	Fainting	Swelling of feet
Blood clots	Dizziness	Cold hands and/or feet
Irregular heartbeat	Diagnosed mitral valve prolapse	High Cholesterol
Palpitations	Heart murmur	Anemia

Other: _____

RESPIRATORY

Cough (dry or productive)	Coughing blood	Production of phlegm (color?)
Bronchitis (acute or chronic?)	Pain with deep breath	Pneumonia
Difficulty breathing when lying down	Shortness of breath	Asthma
		Frequent colds/flu

Other: _____



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NEUROPSYCHOLOGICAL

Stress	Considered suicide	Poor memory
Anxiety	Physically abused	Seizures
Bad temper	Emotionally abused	Concussion
Worry	Sexually abused	Loss of balance
Depression	Mania	Lack of coordination
Cry often	In therapy	Areas of numbness
Hospitalized for emotional issues		Unfocused/confused thoughts

Do you feel you get adequate affection in your life? _____

Other: _____

REPRODUCTIVE & GYNECOLOGICAL (Women Only)

_____ # of Pregnancies	_____ # of Births	_____ # of Miscarriages
Long periods (7 days or more)	Irregular periods	Vaginal discharge (color & odor)
Short periods (3 days or less)	Clotting	Yeast infections
Painful periods	PMS - breast distension	Menopausal symptoms
Painful ovulation	PMS - emotional symptoms	Birth control (what type?)

Other: _____

**Please let your practitioner know if there is any chance you may be pregnant today.
Some acupuncture points and herbs are contraindicated during pregnancy.**

Pursuant to the requirements of Section 6.11, Subsection (d) V. A. C. S., article 4495b, governing the practice of Acupuncture

I, (patient's name), _____, am notifying the Acupuncturist, Lisa Stuesser or Lesley Hamilton, of the following:

I have been evaluated by a physician or dentist for the condition being treated within the six months before this acupuncture treatment was performed. YES NO

I recognize that I *should* be evaluated by a physician for the condition being treated by the acupuncturist.
_____ (initials of patient)

I have received a referral from my chiropractor within the last 30 days for acupuncture. YES NO NA

After being referred by a chiropractor, after 30 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the Acupuncturist is required to refer me to a physician. It is my responsibility and *choice* whether to follow this advice.

Signature of Patient _____ Date: _____

Signature of Acupuncturist _____ Date: _____



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Informed Consent

Each person is different in their response to acupuncture. During your course of acupuncture treatments, it is possible that your symptoms may get worse, either later that day or evening, or even the next day. This does not happen with every client. However, we do feel it is necessary to inform you of the possibility so that you will not be surprised or concerned if and when it occurs. Increased sensitivity can happen after the first, second, or any subsequent treatment. If this sensitivity happens, it usually occurs only once and lasts for a few hours up to the full duration of that day. A response of hypersensitivity is actually a good sign that your system is responding to the acupuncture stimulation.

Do not overuse the area that is being treated. Overuse can irritate your condition.

We feel it is important to inform you of the possible side effects of acupuncture:

1. There is a slight chance that a bruise may appear at the site of the needle insertion. This is due to lightly brushing a blood vessel. The bruise should dissipate within a few days. Gently rub the area to keep the blood circulating. This may or may not occur at any time during your course of treatments.
2. Slight swelling may occur around the insertion site. The swelling will usually dissipate within 2 to 24 hours. This is just a skin reaction and happens very rarely.
3. Slight redness may appear around the site of insertion. This is usually due to an increase of blood circulation around the needle. This is fairly common and disappears after a couple minutes or hours.
4. If the needle brushes the sheath of a nerve, the area will be sore during and after that treatment for several days. This occurs very rarely.
5. You may experience some light-headedness or dizziness after a treatment. This usually lasts only a few minutes. There is no hurry for you to leave. If you need to sit for awhile, please feel free to do so in the lobby.
6. You may be slightly tired after a treatment, this is due to the deep relaxation state that is created. We ask that you take your time in getting up off the treatment table.

Acupuncture has been found to work on approximately 90% of the population. Ten percent of the population does not respond. To date, we have no known means to determine who will respond and who will not. Thus, the only way to know is to keep note of all changes. If after ten acupuncture treatments we see no change, we will consider you to be part of that ten percent.

Your good health and welfare are our prime objective and concern.

Lisa Stuesser, M.S., L. Ac.
 Client Signature _____

Lesley Hamilton, M.S., L.Ac.
 Date _____



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Cancellation Policy

Clients with same day cancellations or missed appointments ("no shows") will be charged a fee equal to the cost of their scheduled appointments.

Please sign below indicating that you have read the policy and agree to its terms.

Name: _____

Please charge the fee for my missed or late cancelled appointment to my credit card.
cc # _____ exp. _____

Please invoice me to the following address:

Signature _____ Date: _____



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CLIENT COPY

Lisa Stuesser, M.S., L.Ac.

Lesley Hamilton, M.S., L.Ac.