

New Acupuncture Patient Information

Your first visit will last about 90 minutes. Follow-up treatments will take 45 - 60 minutes. For your first visit, please arrive 15 minutes prior to your scheduled appointment time to make sure all paperwork is completed and we can get your treatment started on time.

Acupuncture has been practiced for centuries, but may be very different from any health care experience you've had before. I will ask you a number of questions about your health and history, some of which may be unfamiliar to you. You may never have had a health intake that includes looking at your tongue and taking multiple pulses. It will only be unfamiliar the first time! I encourage you to ask me questions about your treatment and progress. Your treatment is individual, as is your response to it. By asking questions you are learning how your own body heals.

To prepare for your first visit:

1. Complete Forms:

- *Prior to your appointment print and complete **Health History** and **Consent Forms** and bring them with you. The questionnaire will form the basis of an in-depth conversation we'll have at your initial consultation and enable me to customize an effective treatment plan for you.*

2. What to Bring

- *List of medications, supplements, or herbs, etc. that you are currently taking. Bring any medical and lab reports that are related to your health concern.*

3. What to Wear

- *Wear loose-fitting, comfortable clothing that is convenient for accessing areas such as the arms, legs, abdomen and back of the body during treatments.*
- *Refrain from wearing any perfume, cologne or scented lotions. Many of our patients are sensitive to fragrances.*

4. What to Eat/Drink

- *Eat a light meal prior to your appointment to prevent any possible light-headedness or nausea.*
- *Don't drink caffeinated beverages (coffee, tea, energy drinks, etc.) or take any pain medications for at least 4 hours prior to your visits.*
- *Don't eat or drink anything that changes the color of your tongue, and don't brush your tongue the morning of your appointments. In Chinese medicine, the tongue gives us valuable information about your health.*
- *Use the restroom prior to your appointment. Acupuncture treatments can stimulate your bladder!*


5. After Treatment

- *Go home: continue to relax. You may feel sleepy or hazy as your body responds to the treatment.*
- *Refrain from overexertion, drugs or alcohol for at least six hours after treatment.*

HEALTH HISTORY

DATE: ___/___/___

NAME _____		GENDER _____	AGE _____	DATE OF BIRTH ___/___/___
ADDRESS _____		CITY _____	STATE _____	ZIP CODE _____
PHONE # <input type="checkbox"/> HOME _____ <input type="checkbox"/> CELL _____ <input type="checkbox"/> OTHER _____ EMAIL _____		EMERGENCY CONTACT _____ CONTACT PHONE # _____ RELATIONSHIP _____		
OCCUPATION: _____	HEIGHT _____ WEIGHT _____	PHYSICIAN NAME _____ PHYSICIAN ADDRESS _____ PHYSICIAN PHONE # _____		
HAVE YOU BEEN TREATED BY ACUPUNCTURE OR ORIENTAL MEDICINE BEFORE? <input type="checkbox"/> NO <input type="checkbox"/> YES LAST TREATMENT ___/___/___		RELATIONSHIP STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LIVING W/PARTNER <input type="checkbox"/> OTHER <input type="checkbox"/> SEPARATED		
HOW DID YOU HEAR ABOUT OUR CLINIC? _____				

MAIN CONCERNS	OTHER HEALTH CONCERNS
WHEN DID THIS START? _____ PAIN LEVEL- PLEASE CIRCLE Pain Scale  HEAT MAKES IT: BETTER NO CHANGE WORSE COLD MAKES IT: BETTER NO CHANGE WORSE DAMP MAKES IT: BETTER NO CHANGE WORSE EXERCISE MAKES IT: BETTER NO CHANGE WORSE	1 _____ 2 _____ 3 _____

HEALTH HISTORY							
	YOU	YEAR	FAMILY		YOU	YEAR	FAMILY
<input type="checkbox"/> CANCER – TYPE(S) _____		<input type="text"/>		<input type="checkbox"/> OSTEOPOROSIS		<input type="text"/>	
<input type="checkbox"/> DIABETES		<input type="text"/>		<input type="checkbox"/> HERPES		<input type="text"/>	
<input type="checkbox"/> HEPATITIS		<input type="text"/>		<input type="checkbox"/> AIDS/HIV		<input type="text"/>	
<input type="checkbox"/> HIGH BLOOD PRESSURE		<input type="text"/>		<input type="checkbox"/> OTHER STD		<input type="text"/>	
<input type="checkbox"/> HEART DISEASE		<input type="text"/>		<input type="checkbox"/> RHEUMATIC FEVER		<input type="text"/>	
<input type="checkbox"/> STROKE		<input type="text"/>		<input type="checkbox"/> ALCOHOLISM		<input type="text"/>	
<input type="checkbox"/> SEIZURE		<input type="text"/>		<input type="checkbox"/> ALLERGIES –TYPES _____		<input type="text"/>	
<input type="checkbox"/> THYROID DISEASE		<input type="text"/>		<input type="checkbox"/> MENTAL ILLNESS		<input type="text"/>	
<input type="checkbox"/> ASTHMA		<input type="text"/>		<input type="checkbox"/> KIDNEY DISEASE		<input type="text"/>	
<input type="checkbox"/> PACEMAKER		<input type="text"/>		<input type="checkbox"/> ANEMIA		<input type="text"/>	

HABITS	EXERCISE
<p style="text-align: center;">AMOUNT/FREQUENCY</p> COFFEE/TEA _____ TOBACCO _____ ALCOHOL _____ DRUGS _____	<p>REGULARLY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF SO, WHAT AND HOW OFTEN: _____</p>

MEDICATIONS

PLEASE NOTE WHAT MEDICATIONS, HERBS OR SUPPLEMENTS YOU USE REGULARLY

MEDICINE/VITAMINS	DOSAGE	REASON	HOW LONG?

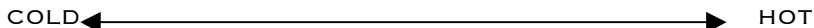
INJURIES & SURGERIES

PLEASE NOTE AREA OF BODY & DATE

TEMPERATURE

HOW WARM / COLD YOU FEEL (NOT IN DEGREES) RELATIVE TO OTHER PEOPLE?
DO YOU WEAR MORE OR LESS LAYERS, ETC.

PLEASE INDICATE YOUR BODY'S OVERALL RELATIVE TEMPERATURE ALONG THE LINE WITH AN **X**



- COLD HANDS/ FEET
- CHILLS
- COLD "IN THE BONES"
- AREAS OF NUMBNESS

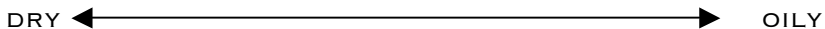
- EXCESSIVE THIRST
- THIRST FOR COLD /HOT DRINKS
- THIRST, NO DESIRE TO DRINK
- ABSENCE OF THIRST

- NIGHT SWEATS
 - UNUSUAL SWEATS
- WHEN? _____ AM / PM
WHERE ON
BODY _____

- HOT HANDS, FEET, CHEST
- HOT FLASHES
- HOT IN AFTERNOON
- HOT AT NIGHT

MOISTURE

PLEASE INDICATE YOUR BODY'S RELATIVE MOISTURE LEVEL ALONG THE LINE WITH AN **X**
HAIR, SKIN, MOUTH, ETC.



- DRY SKIN
- DRY HAIR
- DRY EYES
- DRY BRITTLE NAILS

- DRY MOUTH
- DRY LIPS
- DRY THROAT
- DRY NOSE /NOSEBLEEDS

- EDEMA /SWELLING _____
- RASHES _____
- ITCHING _____
- DANDRUFF

- WEIGHT GAIN / LOSS
- OILY SKIN
- OILY HAIR
- PIMPLES

DIGESTION

PLEASE INDICATE YOUR BODY'S OVERALL DIGESTION ALONG THE LINE WITH AN **X**

DIARRHEA ←————→ CONSTIPATION

- BM: HOW OFTEN? ____X / EVERY ____DAYS
- ALTERNATING DIARRHEA & CONSTIPATION (IBS)
 - INDIGESTION
 - GAS
 - BELCHING
 - BLOATING

- NAUSEA / VOMITING
- BAD BREATH
- DRY STOOLS
- DIFFICULT TO PASS
- TIRED AFTER BM

- EXCESSIVE HUNGER
- POOR APPETITE
- ULCER
- HEMORRHOIDS

ENERGY

PLEASE INDICATE YOUR BODY'S OVERALL ENERGY LEVEL ALONG THE LINE WITH AN **X**

LOW ←————→ HIGH

- SUDDEN ENERGY DROP
TIME OF DAY: ____ AM / PM
- ENERGY DROP AFTER EATING
- FATIGUE
- DEPENDENCE ON CAFFEINE
- WIRED / UNGROUNDED FEELING
- BODY / LIMBS FEEL HEAVY
- BODY / LIMBS FEEL WEAK

- SHORTNESS OF BREATH
- HEART PALPITATIONS
- BLOOD PRESSURE HIGH / LOW
- BLEED / BRUISE EASILY
- HARD TO CONCENTRATE
- POOR MEMORY
- DIZZINESS / LIGHTEADED
- HEADACHES ____X / WEEK

FEMALE REPRODUCTIVE

ARE YOU SEXUALLY ACTIVE? Y N

MENSES (IF APPLICABLE)

AGE AT FIRST MENSES _____
 LENGTH OF FULL CYCLE _____ DAYS
 LENGTH OF MENSES ____ DAYS
 LAST MENSES START DATE ____ / ____
 # OF PREGNANCIES ____
 # OF BIRTHS ___PREMATURE ___MISCARRIAGES
 ___ABORTIONS

- BIRTH CONTROL PILL (HORMONAL)
- HEAVY PERIODS
- LIGHT PERIODS
- PAINFUL PERIODS
- IRREGULAR PERIODS
- CHANGES IN BODY/PSYCHE PRIOR TO MENSTRUATION (PMS)

- CRAMPS BEFORE BLEEDING____
FIRST DAY__DURING PERIOD__
- FATIGUE W/ MENSES
- DIGESTIVE CHANGES W/ MENSES
- MID-CYCLE SPOTTING
- YEAST INFECTIONS

MENOPAUSE

AGE CHANGES BEGAN _____
 AGE AT LAST MENSES _____

- HOT FLASHES ____X/ DAY
- VAGINAL DRYNESS
- NIGHT SWEATS ____X / WEEK
- LOSS OF SEX DRIVE

MALE REPRODUCTIVE

ARE YOU SEXUALLY ACTIVE? Y N

- CHANGE OF SEXUAL DRIVE
- ERECTILE DYSFUNCTION
- PREMATURE EJACULATION
- SORES ON GENITALS
- DISCHARGE

- PROSTATE DISEASE
- GENITAL PAIN
- JOCK ITCH
- VASECTOMY
- HERNIA
- HEMORRHOIDS

EMOTIONS

WHAT EMOTION(S) DOMINATE YOUR EXPERIENCE?

- | | | |
|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> ANGER | <input type="checkbox"/> OBSESSIVE THINKING | <input type="checkbox"/> FEAR |
| <input type="checkbox"/> IRRITABILITY | <input type="checkbox"/> SADNESS | <input type="checkbox"/> TIMID / SHY |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> GRIEF | <input type="checkbox"/> INDECISION |
| <input type="checkbox"/> WORRY | <input type="checkbox"/> DEPRESSION | |

URINARY (IF APPLICABLE)

- | | | |
|---|---|--|
| <input type="checkbox"/> DECREASE IN FLOW | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> BURNING SENSATION |
| <input type="checkbox"/> DRIBBLING | <input type="checkbox"/> URGENCY TO URINATE | <input type="checkbox"/> CLOUDY URINE |
| <input type="checkbox"/> DIFFICULTY STARTING / STOPPING | <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> BLOOD IN URINE |
| <input type="checkbox"/> INCONTINENCE | <input type="checkbox"/> PAIN ON URINATION | |

SLEEP

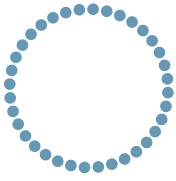
HOURS PER NIGHT _____

- | | |
|--|---|
| <input type="checkbox"/> DIFFICULTY FALLING ASLEEP | <input type="checkbox"/> DISTURBING DREAMS |
| <input type="checkbox"/> WAKE ___X/ NIGHT @ _____AM / PM | <input type="checkbox"/> RESTLESS SLEEP |
| <input type="checkbox"/> WAKE TO URINATE <i>HOW OFTEN?</i> _____ | <input type="checkbox"/> NOT RESTED UPON WAKING |

HEAD, EYES, EARS, NOSE, THROAT

- | | |
|---|---|
| <input type="checkbox"/> POOR HEARING | <input type="checkbox"/> SINUS CONGESTION |
| <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> NOSE BLEEDS |
| <input type="checkbox"/> EXCESS EARWAX | <input type="checkbox"/> LOSS OF SMELL |
| <input type="checkbox"/> SORE THROAT | <input type="checkbox"/> PHLEGM (COLOR _____) |
| <input type="checkbox"/> FREQUENT COUGHS | <input type="checkbox"/> RED EYES |
| <input type="checkbox"/> SWOLLEN GLANDS | <input type="checkbox"/> ITCHY EYES |
| <input type="checkbox"/> HOARSENESS | <input type="checkbox"/> TEARY EYES |
| <input type="checkbox"/> TROUBLE SWALLOWING | <input type="checkbox"/> DRY EYES |
| <input type="checkbox"/> POOR VISION | <input type="checkbox"/> CATARACTS |
| <input type="checkbox"/> NIGHT BLINDNESS | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> HEADACHE | <input type="checkbox"/> SPOTS IN FRONT OF EYES |
| <input type="checkbox"/> MIGRAINE | <input type="checkbox"/> DENTAL PROBLEMS |
| <input type="checkbox"/> HEAD INJURY | <input type="checkbox"/> MOUTH SORES |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> JAW PROBLEMS /TMJ |
| <input type="checkbox"/> VERTIGO | <input type="checkbox"/> TEETH GRINDING |
| <input type="checkbox"/> HAY FEVER | |

THANK YOU FOR TAKING THE TIME TO COMPLETE PRIOR TO YOUR FIRST TREATMENT



NewportCare[®]

MEDICAL GROUP

3300 WEST COAST HIGHWAY
NEWPORT BEACH, CA 92663

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices

Patient Name(Print) _____

Signature _____

Relationship to Patient _____

Date _____

DOCUMENTATION OF ATTEMPT TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Attempt to Obtain Acknowledgment

An attempt was made to obtain an acknowledgment of Notice of Privacy Practices on

The Acknowledgment was not obtained because:

*The patient was undergoing emergency treatment

*The patient declined to sign the Acknowledgment

*Other _____

Patient Name(Print) _____

Signature _____

Relationship to Patient _____

Date _____

INFORMED CONSENT FOR ACUPUNCTURE

I hereby request and consent to the performance of Acupuncture treatments and other Chinese Medicine procedures on me by **Juline Busuioc** or other licensed acupuncturists who may be employed by or contracted with **Juline Busuioc**.

“Acupuncture” is the stimulation of a certain point or points on or near the surface of the body by the insertion of special needles. Acupuncture may allow for the relief of one’s symptoms without the need for medications or other invasive therapies, and improve the balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

I understand that methods or treatments may include, but are not limited to: Acupuncture, Moxabustion, Cupping, Electro- Acupuncture, Tui-Na (Chinese massage), Gua-sha, and Nutritional Counseling.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment.

I understand that in the practice of acupuncture there are some risks including but not limited to: slight pain or discomfort at the site of needle insertion, infection, minor bruising/bleeding, weakness, fainting, nausea, burning, pneumothorax, spontaneous miscarriage, and aggravation of problematic symptoms existing prior to acupuncture treatment.

I understand that it may be necessary for my acupuncturist to contact another one of my health care providers in order to coordinate medical treatment, to discuss an emergency situation and/or to share appropriate medical information. My signature gives permission to release any medical records for the reasons set forth in this paragraph.

I have read the above consent form. I have had an opportunity to ask questions, and by signing below, I agree to the above-mentioned procedures. I intend this consent form to cover the entire course of treatment, present and future.

“With this knowledge, I voluntarily consent to the above procedures.”

Patient Name *(Please Print)*

Signature of Patient

Date