Welcome to Hillcrest Community Acupuncture!

NEW PATIENT INFORMATION:

Date: _____

Name: _____

Age: _____ Date of Birth: _____/_____/_____

Address: _____

City:_____ State: _____ Zip: _____

Home Number: _____

Cell Number: _____

Occupation: _____

Employer: _____

E-mail address: _____

Top 3 Health Concerns (why you came in today, ex. "anxiety" or "knee pain":

1. _____ **2.**_____

3. _____

Current Medications/Supplements:

_____

_____

Do you have a pacemaker? Y N Are you pregnant? Y N

Have you ever had hepatitis? Y N Are you HIV positive? Y N

ALTERNATE CONTACT IF NEEDED:

Name: _____Relationship: _____

Phone Number: _____

Primary Physician: _____

Phone Number: _____

How did you hear about us? _____

1807 Robinson Avenue, Suite 205 San Diego CA 92103 619-298-2228
www.hillcrestacu.com

MEDICAL HISTORY

PLEASE MARK A CHECK ✔ FOR SYMPTOMS YOU EXPERIENCE

CARDIOVASCULAR		RESPIRATORY			
shortness of breath		cough		prostate problems	
high blood pressure		coughed up blood		erectile dysfunction	
irregular heart beat		sore throat		pain in testes	
heart palpitations		nasal problems			
dizziness		nose bleed			
chest pain or pressure		asthma or wheezing			
leg cramps		pneumonia		pre-menstrual symptoms	
		hay fever		menstrual pain	
GASTROINTESTINAL		bronchitis		irregular menstrual cycle	
				pain in breasts	
indigestion		**GENITOURINARY**		infertility	
abdominal pain/cramps					
gallstones		frequent urination		**MISCELLANEOUS**	
constipation		painful urination			
diarrhea		bloody discharge		jaundice	
blood in stool		venereal disease		hepatitis	
black colored stool		pain in genital area		memory loss	
excess appetite		decreased sex drive		hearing loss	
decreased appetite				ringing in ears	
excess thirst		**MUSCULAR-SKELETAL**		headaches	
nausea and vomiting				insomnia	
colitis or divierticulitis		back pain		fever	
belching or burping		arthritis		chills	
heartburn		muscle pain or cramps		night sweats	
		painful joints		weather intolerence	
SKIN				kidney stones	
		OTHER			
ulcerations					
rash					
eczema					
psoriasis					
edema					

SIGN: _____ DATE: _____

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ACUPUNCTURE INFORMATION AND INFORMED CONSENT

I understand that acupuncture involves the insertion of pre-sterilized, disposable needles through the skin at specific point and additional therapies (such as herbal therapy, Asian nutrition therapy, acupressure, bodywork, cupping, gua sha, electrical stimulation to the skin and TDP heat lamp) may be suggested to support the treatment process. All therapies will be fully explained before administration. Side effects such as local bruising, needle sickness, broken needles, pain at site of insertion, infection, pneumothorax, spontaneous miscarriage, and allergic reaction (with herbs) are rare but possible. If I agree to take herbal medicine, I understand that I must follow all administration and dosage instructions. I understand that my practitioner is providing dietary guidance based on Asian medicine principles of nutrition and is not a licensed dietician. During the course of treatment, I agree to inform my practitioner of all health and medication changes, especially possible pregnancy. I agree to contact my practitioner immediately if I experience any problem which I associate with the treatments listed above and will go immediately to the hospital if I experience a medical emergency. Physician care is recommended. I consent to receive the therapies listed above, understand the risks, and understand that I may refuse any treatment at any time. I understand that the practice of Acupuncture and Oriental Medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment. I understand that acupuncture is conducted in a group setting at *Hillcrest Community Acupuncture*. I understand that my conversations in the group room may be heard by others sitting nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone, by email, or by scheduling an appointment to talk privately. I understand *that Hillcrest Community Acupuncture* may record medical and other information concerning my treatment. I understand that *Hillcrest Community Acupuncture* abides by federal regulations regarding patient privacy as defined under 45 CFR 164.528. I know that I can ask for more information regarding this procedure. I permit a copy of this authorization to be used in place of the original. This authorization is not intended to allow the release of records regarding my treatment for services requiring a restricted release under State or Federal law.

Patient's Signature _____ Date _____

Patient's Printed Name _____

CONSENT TO TREAT A MINOR I authorize *Hillcrest Community Acupuncture* to administer Acupuncture and Oriental Medicine as deemed necessary to _____ who is my _____ (relationship).

Adult's Signature _____ Date _____