LAURA FARB, L.Ac
ACUPUNCTURE & NUTRITION

Welcome to Laura Farb, L.Ac. Please fill out this form and bring it to your first appointment.
To help us provide you with the best possible care, please fill out this form as completely as you can.
All the information provided here will be held in strictest confidence. Feel free to ask if you have any questions.

Name _____

Age _____ Date of Birth _____ Sex _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Email _____ Occupation _____

Emergency Contact _____ Telephone _____

Physician _____ Telephone _____ May We Contact This Person? ___

Have you been treated with acupuncture or Chinese herbs before? _____

How did you hear about Jade Lotus Wellness? _____

PRIMARY REASON(S) FOR SEEKING TREATMENT

1) _____

2) _____

3) _____

When did this/these problem(s) begin? _____

What were the causes? _____

What makes your symptom(s) better? _____ Worse? _____

Please rate your current pain or discomfort on a scale of 1 to 10:

Very Slight: 1 2 3 4 5 6 7 8 9 10 :Unbearable

Have you received a diagnosis? _____ If so, what? _____

What other treatments have you tried? _____

MEDICAL HISTORY (Include Dates) Date of last physical exam _____

Medications you are currently taking _____

Supplements you are currently taking _____

Allergies (food, drugs, chemicals, etc.) _____

Major illnesses or significant traumas _____

Surgeries _____

Check All That Apply:

- ❍ Anemia
- ❍ Asthma
- ❍ Cancer
- ❍ Diabetes
- ❍ Hepatitis
- ❍ Heart Disease
- ❍ High Blood Pressure
- ❍ HIV/AIDS
- ❍ Lyme Disease
- ❍ Pneumonia
- ❍ Seizures
- ❍ Stroke
- ❍ Tuberculosis
- ❍ Other _____

FAMILY MEDICAL HISTORY (Check All That Apply):

- ❍ Alcoholism / Addiction
- ❍ Arthritis
- ❍ Cancer
- ❍ Diabetes
- ❍ Heart Disease
- ❍ High / Low Blood Pressure
- ❍ Psychological Disorders
- ❍ Stroke

PERSONAL

Height _____ Weight _____ Weight Maximum _____ When? _____

Exercise (please describe) _____

Stress (occupational, emotional, etc.) _____

Do you smoke? _____ Did you used to smoke? _____ How much? _____ For how long? _____

Do you drink alcohol? _____ How many drinks per week? _____

Do you drink caffeinated beverages? _____ What kind? _____ How many per day? _____

Please list any other drug use _____

PERSONAL SIGNS AND SYMPTOMS (Please check any that apply to you)

General

- ❍ Bleed or Bruise Easily
- ❍ Chills
- ❍ Cravings
- ❍ Fatigue
- ❍ Fever
- ❍ Localized Weakness
- ❍ Night Sweats
- ❍ Poor Appetite
- ❍ Poor Balance
- ❍ Poor Sleep
- ❍ Strong Thirst
- ❍ Sudden Energy Drop
- ❍ Sweat Easily
- ❍ Tremors
- ❍ Weight Gain
- ❍ Weight Loss

Musculoskeletal

- ❍ Back Pain
- ❍ Cold Hands / Feet
- ❍ Foot / Ankle Pain
- ❍ Hand / Wrist Pain
- ❍ Hernia
- ❍ Hip Pain
- ❍ Joint Pain / Stiffness
- ❍ Knee Pain
- ❍ Muscle Atrophy
- ❍ Muscle Pain
- ❍ Muscle Twitches
- ❍ Muscle Weakness
- ❍ Neck Pain / Tightness
- ❍ Numbness
- ❍ Paralysis
- ❍ Sciatica
- ❍ Shoulder Pain
- ❍ Spinal Curvature
- ❍ Swollen Hands / Feet
- ❍ Tingling
- ❍ Tremors
- ❍ Vertebral Disorder

Head & Throat

- ❍ Blurry Vision
- ❍ Cataracts
- ❍ Concussions
- ❍ Difficulty Swallowing
- ❍ Dizziness
- ❍ Dry Eyes
- ❍ Earaches
- ❍ Eye Pain / Strain
- ❍ Facial Pain
- ❍ Frequent Sore Throats
- ❍ Headaches
- ❍ Head Injury
- ❍ Hearing Loss
- ❍ Jaw Clicks / TMJ
- ❍ Migraines
- ❍ Mouth / Lip Sores
- ❍ Night Blindness
- ❍ Nose Bleeds
- ❍ Ringing in Ears
- ❍ Sinus Problems
- ❍ Spots in Vision
- ❍ Tearing
- ❍ Teeth Grinding
- ❍ Tooth Pain

Skin & Hair

- ❍ Acne
- ❍ Change in Hair Texture
- ❍ Change in Skin Texture
- ❍ Dandruff
- ❍ Dry Skin
- ❍ Eczema
- ❍ Hair Loss
- ❍ Hives
- ❍ Itching
- ❍ Psoriasis
- ❍ Purpura
- ❍ Rashes
- ❍ Recent Moles
- ❍ Ulcerations

Respiratory

- ❍ Allergies
- ❍ Asthma
- ❍ Bronchitis
- ❍ Chest Pain
- ❍ Coughing Blood
- ❍ Coughing Up Phlegm
- ❍ Difficulty Breathing
- ❍ Emphysema
- ❍ Frequent Common Colds
- ❍ Persistent Cough
- ❍ Pleurisy
- ❍ Wheezing

Cardiovascular

- ❍ Blood Clots
- ❍ Chest Pain
- ❍ Fainting
- ❍ Heart Murmurs
- ❍ High Blood Pressure
- ❍ Irregular Heartbeat
- ❍ Low Blood Pressure
- ❍ Palpitations
- ❍ Phlebitis
- ❍ Rapid Heartbeat
- ❍ Varicose Veins

Gastrointestinal

- ❍ Abdominal Pain / Cramps
- ❍ Acid Reflux
- ❍ Bad Breath
- ❍ Belching
- ❍ Black Stools
- ❍ Blood in Stools
- ❍ Crohn's Disease
- ❍ Constipation
- ❍ Diarrhea
- ❍ Gallbladder Problems
- ❍ Gas / Bloating
- ❍ Heartburn
- ❍ Hemorrhoids
- ❍ IBS
- ❍ Indigestion
- ❍ Mucus in Stools
- ❍ Nausea
- ❍ Parasites
- ❍ Rectal Pain
- ❍ Ulcers
- ❍ Undigested Food in Stools
- ❍ Vomiting

Neuro-Psychological

- ❍ ADD / ADHD
- ❍ Anxiety
- ❍ Bad Temper / Irritability
- ❍ Bipolar
- ❍ Concussion
- ❍ Depression
- ❍ Dizziness
- ❍ Lack of Coordination
- ❍ Loss of Balance
- ❍ Memory Loss
- ❍ Mood Swings
- ❍ Panic Attacks
- ❍ Seizures
- ❍ Stress
- ❍ Vertigo
- ❍ Worries Easily

Genito-Urinary

- ❍ Blood in Urine
- ❍ Burning Urination
- ❍ Dribbling
- ❍ Frequent Urination
- ❍ Frequent Urination at Night
- ❍ Genital Itching
- ❍ Genital Pain
- ❍ Inability to Hold Urine
- ❍ Kidney Stones
- ❍ Painful Urination
- ❍ Pause of Urine Flow
- ❍ Urinary Tract Infection
- ❍ Urinary Urgency

FEMALE

- ❍ Breast Lumps
- ❍ Breast Tenderness
- ❍ Clotting During Menstruation
- ❍ Difficult / Painful Intercourse
- ❍ Endometriosis
- ❍ Frequent Vaginal Infections
- ❍ Infertility
- ❍ Irregular Menstruation
- ❍ Menopausal Symptoms
- ❍ Nipple Discharge
- ❍ Ovarian Cysts
- ❍ Painful Menstruation
- ❍ Pelvic Infection
- ❍ PMS
- ❍ Polycystic Ovarian Syndrome
- ❍ Sexually Transmitted Disease
- ❍ Spotting
- ❍ Uterine Fibroids
- ❍ Vaginal Discharge
- ❍ Vaginal Dryness

Is there any possibility that you may be pregnant? _____ Do you practice birth control? ____ What form? _____

Age at first menses _____ Date of last menses _____ Length of menstrual cycle _____ Duration of period _____

Number of pregnancies _____ Number of births _____ Number of miscarriages _____ Number of abortions _____

MALE

- ❍ Erectile Dysfunction
- ❍ Fertility Problems
- ❍ Frequent Nocturnal Emissions
- ❍ Frequent Seminal Emissions
- ❍ Painful / Swollen Testicles
- ❍ Penile Discharge
- ❍ Premature Ejaculation
- ❍ Prostate Problems
- ❍ Sexually Transmitted Disease

OFFICE POLICIES - PLEASE READ AND SIGN BELOW

1) If you wish to change an appointment, please give at least 24 hours advance notice. Laura Farb, L.Ac. will charge the full treatment price for any missed appointments or late cancellations.

2) All herb and supplement sales are final. Laura Farb, L.Ac. is not able to offer refunds on any herbs, herbal products, or supplements.

3) Herbal prescriptions are intended only for the person for whom they are prescribed. Please do not give your herbal prescriptions to anyone else.

I understand the above information and guarantee this form was completed to the best of my knowledge:

Signature _____ Date _____

LAURA FARB, L.Ac
ACUPUNCTURE & NUTRITION

Informed Consent to Oriental Medicine

I hereby request and consent to the performance of the following on myself (or the patient named below for whom I am legally responsible) by Laura Farb, L.Ac., for today and in the future: acupuncture and other oriental health procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; heat and/or cold therapy and electrical and/or magnetic stimulation; cupping; mild bleeding therapy; the prescription of herbal medicines as well as dietary supplements; dietary recommendations; and healthy lifestyle counseling.

I have had an opportunity to discuss with an acupuncturist the nature and purpose of acupuncture and the other Oriental Medicine procedures. Although I am aware that acupuncture and the other procedures have helped many people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of Oriental Medicine there are some risks. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms, general aches, pneumothorax (punctured lung), or puncture of other organs. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish the acupuncturist to exercise such judgment based on the known facts, during the course of my treatment, to be in my interest. I authorize the acupuncturist to perform any necessary services needed during the diagnosis and treatment.

I have read, or have had read to me, this informed consent form. I have had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment from Laura Farb, L.Ac.

_____

Patient Name (Print)

_____ _____

Patient Signature **Date**

If patient is a minor or has a legal guardian, a parent or guardian needs to sign below:

_____ _____

Name of Guardian (Print) **Relationship**

_____ _____

Guardian Signature **Date**

LAURA FARB, L.Ac
ACUPUNCTURE & NUTRITION

HIPPA Acknowledgment and Appointment Reminder Form

I acknowledge that Laura Farb, L.Ac. "Notice of Privacy Policies" has been provided to me. I understand I have a right to review Laura Farb, L.Ac. "Notice of Privacy Policies" prior to signing this document. The "Notice of Privacy Policies" for Laura Farb, L.Ac. is also provided on request at the front desk of this practice.

Members of the staff may need to contact you with appointment reminders or information related to your treatment. If this contact is made by phone, and you are not at home, a message will be left on your voice mail or with whomever answers the phone. By signing this form you are giving us authorization to contact you with these reminders and information.

_____

Patient Name (printed)

_____ _____

Patient Signature **Date**

Authorization for Release of Health Information (Optional)

I, _____, hereby authorize Laura Farb, L.Ac. the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive my information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Persons/Organizations authorized to receive information: (please print)

_____ _____

_____ _____

_____ _____

Patient Signature **Date**