

TIGER ACUPUNCTURE

Sports Medicine & Pain Management

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

TELEPHONE: (Check your preferred contact number)

HOME: _____ WORK: _____ CELL: _____

EMAIL: _____ OCCUPATION/SCHOOL: _____

BIRTHDAY: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____ GENDER: _____

MARITAL STATUS: SINGLE MARRIED LIFE PARTNER DIVORCED WIDOWED

DATE OF FIRST VISIT: _____ REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO: _____

ADDRESS: _____

ID#: _____ GROUP#: _____

NAME OF SUBSCRIBER: _____ RELATIONSHIP: _____

DOB OF SUBSCRIBER: _____

 SECONDARY INSURANCE CO: _____

ADDRESS: _____

ID#: _____ GROUP#: _____

NAME OF SUBSCRIBER: _____ RELATIONSHIP: _____

DOB OF SUBSCRIBER: _____

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT- I certify that the information given by me is correct. I hereby authorize release of any information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign benefits to my physician and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered.

PATIENT OR GUARDIAN'S SIGNATURE

DATE

Joseph Bonacci, M.S., L.Ac.
20 Nassau St., Suite 206
Princeton, NJ 08542
Tel 609.751.4654
Fax 609.228.5839

CONTACTS

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
TELEPHONE: _____
ADDRESS: _____

PHYSICIAN'S NAME: _____
TELEPHONE: _____
ADDRESS: _____

MAJOR COMPLAINT

1. _____
2. _____
3. _____

Was there any physical or emotional trauma at the time when you first noticed this problem?

How long have you experienced this condition?

What makes it better? What makes it worse?

On a scale of 1 to 10, with 10 being the worst, how would you rate the pain?

Have you tried the following therapies:
 ACUPUNCTURE HERBAL MEDICINE PHYSICAL THERAPY MASSAGE CHIROPRACTIC

YOUR MEDICAL HISTORY

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Hepatitis A/B/C/D | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Birth Trauma | _____ |
| <input type="checkbox"/> Significant Trauma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Date of last physical exam? _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> HIV/AIDS | |

FAMILY MEDICAL HISTORY

(Select all that apply and specify which relative)

- | | |
|--|---|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Rheumatic Fever _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Emotional Disorder _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other conditions: _____ |

MEDICATION, ALLERGIES, AND PAST HOSPITALIZATION

What medications, supplements or herbs are you currently taking?

Allergies? (foods, drugs, etc.) No Yes (please specify): _____

Have a cardiac pacemaker? No Yes

Hospitalized in the past year? No Yes (please specify why): _____

Had any major surgeries? No Yes (list when and why): _____

DIET AND LIFESTYLE

(Select all that apply and indicate frequency)

- | | |
|--|--|
| <input type="checkbox"/> Coffee _____ | <input type="checkbox"/> Alcohol _____ |
| <input type="checkbox"/> Black Tea _____ | <input type="checkbox"/> Tobacco _____ |
| <input type="checkbox"/> Caffeinated beverages _____ | <input type="checkbox"/> Recreational drugs _____ |
| <input type="checkbox"/> Soda/soft drinks _____ | <input type="checkbox"/> Exercise _____ |
| <input type="checkbox"/> Water _____ | <input type="checkbox"/> Time spent outdoors _____ |

What types of foods are a part of your regular diet?

- | | | | | |
|-------------------------------------|---------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Beans | <input type="checkbox"/> Fresh Fruit | <input type="checkbox"/> Yogurt | <input type="checkbox"/> Cereal |
| <input type="checkbox"/> Red Meat | <input type="checkbox"/> Nuts | <input type="checkbox"/> Dark Leafy Greens | <input type="checkbox"/> Milk | <input type="checkbox"/> Chips |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Tofu | <input type="checkbox"/> Other Vegetables | <input type="checkbox"/> Cheese | <input type="checkbox"/> Candy |
| <input type="checkbox"/> Chicken | <input type="checkbox"/> Whole Grains | <input type="checkbox"/> Pizza | <input type="checkbox"/> Butter | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Pork/Bacon | <input type="checkbox"/> Potatoes | <input type="checkbox"/> Fast food/Take-out | <input type="checkbox"/> Non-dairy Milk | <input type="checkbox"/> Ice Cream |
| <input type="checkbox"/> Cold cuts | <input type="checkbox"/> Bread/Bagels | <input type="checkbox"/> Other (please list): _____ | | |

What types of tastes do you crave? Salty Sweet Fried/greasy Fatty Sour Spicy

What triggers your cravings? Stress Depression Boredom Menses Other (specify): _____

When do you notice your cravings most? _____

Stress Level (rank 0-10) _____

Do you sleep well? Yes No How many hours? _____ Do you wake up at night? _____

Why? _____

GENERAL HEALTH

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor balance | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Large appetite | <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sweat Easily |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Food cravings | <input type="checkbox"/> Disturbed sleep | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Bruise/bleed easily | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Catch colds easily | _____ |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Chills | |

SKIN AND HAIR

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Hives | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Dry skin/hair | <input type="checkbox"/> Other (please specify): _____ | |

CARDIOVASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> Palpatations | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: (please specify): _____ |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> Low Blood Pressure | _____ |
| <input type="checkbox"/> Chest pain/tightness | <input type="checkbox"/> Swelling of hands/feet | |

HEAD, EYES, EARS, NOSE & THROAT

- | | | |
|--|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Change in smell |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dry eyes or redness | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Facial pain or numbness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Trigeminal Neuralgia | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Change in Taste |
| <input type="checkbox"/> Bells' Palsy | <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Oral ulcers |
| <input type="checkbox"/> TMJ or jaw clicking | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Eye Floaters | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Other: (please specify): _____ |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Hay fever/allergies | _____ |

RESPIRATORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Frequent/chronic colds |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Coughing phlegm | <input type="checkbox"/> Flu | <input type="checkbox"/> Other: (please specify): _____ |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Asthma | |

GASTROINTESTINAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Chronic gastritis | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Frequent laxative use |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn/Acid reflux | <input type="checkbox"/> Gallstone |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Lack of appetite | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Other: (please specify): _____ |
| <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Bloody/black stools | _____ |

UROGENTIAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Waking at night to urinate | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Genital sores |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Bladder infection | <input type="checkbox"/> Other: (please specify): _____ |
| <input type="checkbox"/> Decrease in urine flow | <input type="checkbox"/> Blood in urine | _____ |
| <input type="checkbox"/> Increase in urine flow | <input type="checkbox"/> Impotence | |

MUSCULOSKELETAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Finger pain | <input type="checkbox"/> Chronic lumbar muscle strain |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Leg cramps | <input type="checkbox"/> Sprained ankle |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Rib pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> Cervical spondylopathy | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Tennis Elbow | <input type="checkbox"/> Other joint/bone problems (specify): _____ |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Acute lumbar sprain | _____ |

NEUROPSYCHOLOGICAL

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Concussion | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Depression | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hemiplegia |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Stress | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> History of psychiatric treatment | _____ |

METABOLISM, ENDOCRINE, AND IMMUNE

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic arthritis | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Lupus | <input type="checkbox"/> Simple obesity |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Other (please specify): _____ |

MALE REPRODUCTIVE SYSTEM / GENITALIA

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain/itching of genitalia | <input type="checkbox"/> Lumps in testicles | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Genital lesions/discharge | <input type="checkbox"/> Impotence | <input type="checkbox"/> Other (please specify): _____ |

FEMALE REPRODUCTIVE SYSTEM/ GYNOCOLOGICAL

- | | | |
|--|--|---|
| <input type="checkbox"/> Painful Menses | <input type="checkbox"/> Pelvic Inflammatory Disease | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> No Menses | <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Decreased sex drive |
| <input type="checkbox"/> Scanty menstrual flow | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Vulvodynia |
| <input type="checkbox"/> Irregular menses | <input type="checkbox"/> Breast lumps/swelling | <input type="checkbox"/> Vomiting during pregnancy |
| <input type="checkbox"/> Premenstrual syndrome | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Menstrual odor | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> STD | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Other: (please specify): _____ |

Age at first Period? _____ Age at Menopause? _____ No. Days period flow? _____ Length of Cycle? _____

Color: Brown Dark Red Light red/pink Bright red

Quantity: Heavy Moderate Light

Clots: Large Small None

PMS Symptoms: _____

No. of pregnancies: _____ No. of live births: _____ No. of miscarriages: _____ No. of abortions: _____

Currently trying to conceive? Yes No Contraception (if any): _____

Pertinent Pregnancy History: _____

Tiger Acupuncture
Joseph Bonacci, M.S., L.Ac.
20 Nassau St., Suite 206
Princeton, NJ 08542
(609) 751-4654

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient or person
with authority to consent for patient

_____/_____/_____
Date

Relationship to Patient