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

□ Allergies	□ High Blood Pressure	□ Diabetes	□ Other (please specify)
□ Hepatitis A/B/C/D	□ High Cholesterol	□ Heart Disease	_____
□ Seizures	□ Rheumatic Fever	□ Birth Trauma	_____
□ Significant Trauma	□ Thyroid Disease	□ Ulcers	□ Date of last physical exam?_____
□ Cancer	□ Childhood Illness	□ HIV/AIDS	

FAMILY MEDICAL HISTORY

(Select all that apply and specify which relative)

□ Cancer_____	□ Seizures_____
□ Rheumatic Fever_____	□ Hepatitis_____
□ Heart Disease_____	□ Diabetes_____
□ Tuberculosis_____	□ Emotional Disorder_____
□ High Blood Pressure_____	□ 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)

□ Coffee_____ □ Alcohol_____

□ Black Tea_____ □ Tobacco_____

□ Caffeinated beverages_____ □ Recreational drugs_____

□ Soda/soft drinks_____ □ Exercise_____

□ Water_____ □ Time spent outdoors_____

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

□ Eggs	□ Beans	□ Fresh Fruit	□ Yogurt	□ Cereal
□ Red Meat	□ Nuts	□ Dark Leafy Greens	□ Milk	□ Chips
□ Fish	□ Tofu	□ Other Vegetables	□ Cheese	□ Candy
□ Chicken	□ Whole Grains	□ Pizza	□ Butter	□ Chocolate
□ Pork/Bacon	□ Potatoes	□ Fast food/Take-out	□ Non-dairy Milk	□ Ice Cream
□ Cold cuts	□ Bread/Bagels	□ 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

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

SKIN AND HAIR

□ Rashes	□ Hair loss	□ Recent moles
□ Warts	□ Psoriasis	□ Dandruff
□ Shingles	□ Acne	□ Eczema
□ Itching	□ Hives	□ Redness
□ Dry skin/hair	□ Other (please specify):_____	

CARDIOVASCULAR

- ☐ Palpatations
- ☐ Irregular heartbeat
- ☐ Coronary Heart Disease
- ☐ Chest pain/tightness
- ☐ Poor circulation
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Swelling of hands/feet
- ☐ Blood clots
- ☐ Other: (please specify):_____
  _____

HEAD, EYES, EARS, NOSE & THROAT

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

RESPIRATORY

- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Coughing phlegm
- ☐ Nasal congestion
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Difficulty breathing when lying down
- ☐ Flu
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent/chronic colds
- ☐ Bronchitis
- ☐ Other: (please specify):_____
  _____

GASTROINTESTINAL

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

UROGENTIAL

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Urgent urination
- ☐ Decrease in urine flow
- ☐ Increase in urine flow
- ☐ Waking at night to urinate
- ☐ Incontinence
- ☐ Bladder infection
- ☐ Blood in urine
- ☐ Impotence
- ☐ Kidney stones
- ☐ Genital sores
- ☐ Other: (please specify):_____
  _____

MUSCULOSKELETAL

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

NEUROPSYCHOLOGICAL

□ Seizures	□ Concussion	□ Insomnia
□ Epilepsy	□ Depression	□ Stroke/TIA
□ Dizziness	□ Anxiety	□ Hemiplegia
□ Loss of balance	□ Bad temper	□ Alcoholism
□ Numbness	□ Stress	□ Schizophrenia
□ Poor memory	□ Attempted Suicide	□ Other (please specify):_____
□ Lack of coordination	□ History of psychiatric treatment	_____

METABOLISM, ENDOCRINE, AND IMMUNE

□ Diabetes	□ Arthritis	□ Chronic Fatigue Syndrome
□ Gout	□ Rheumatic arthritis	□ High cholesterol
□ Hyperthyroidism	□ Lupus	□ Simple obesity
□ Hypothyroidism	□ Fibromyalgia	□ Other (please specify):_____

MALE REPRODUCTIVE SYSTEM / GENITALIA

□ Pain/itching of genitalia	□ Lumps in testicles	□ Enlarged prostate
□ Genital lesions/discharge	□ Impotence	□ Other (please specify):_____

FEMALE REPRODUCTIVE SYSTEM/ GYNOCOLOGICAL

□ Painful Menses	□ Pelvic Inflammatory Disease	□ Hot flashes
□ No Menses	□ Abnormal pap smear	□ Decreased sex drive
□ Scanty menstrual flow	□ Fibroids	□ Vulvodynia
□ Irregular menses	□ Breast lumps/swelling	□ Vomiting during pregnancy
□ Premenstrual syndrome	□ Endometriosis	□ Infertility
□ Menstrual odor	□ Ovarian Cysts	□ Polycystic Ovarian Syndrome
□ Vaginal discharge	□ STD	□ Yeast infections
□ Vaginal dryness	□ Urinary Tract Infection	□ 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:
_____

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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