

New Patient- Stellar Healing, Dr. Miranda Gensler

Contact Information

Today's Date: ____ / ____ / ____

Name: _____ Sex: F M O DOB: ____ / ____ / ____

Age: _____

Street: _____ Email Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Marital Status: M S D W # of Children: _____ Alternative Phone Number: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

How did you find out about us? Direct Mail Location or Walk By Friend/Relative Website

Periodicals Yellow Pages Other Referred By: _____

Have you had acupuncture before? Y N Allow email/mail/phone contact by Stellar Healing? Y N

Primary Insurance Company: _____ ID #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: Self Spouse Parent

Customer Service Phone Number: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: Self Spouse Parent

Customer Service Phone Number: _____

Major Health Complaint(s)

Please list in order of significance to you and **check which you would like us to focus on today.**

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

When did the checked problem begin? _____

What are the precipitating factors? _____

Have you been given a diagnosis for this problem? If so, please describe. _____

What kind of treatments have you tried? _____

What makes this problem worse? _____ Better? _____

Is there anybody in your family with the same problem? _____

Please describe how these conditions affect or impair your daily activities? Examples may include your overall quality of life, work, family life, hobbies or self-esteem.

Past Medical History

Check any conditions that you have had in the past or are currently experiencing: **P=Past C=Current**

P C <input type="checkbox"/> <input type="checkbox"/> Alcohol/Drug Abuse	P C <input type="checkbox"/> <input type="checkbox"/> Digestive Disorder	P C <input type="checkbox"/> <input type="checkbox"/> Hypertension	P C <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> <input type="checkbox"/> Jaundice	<input type="checkbox"/> <input type="checkbox"/> Pneumonia
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> <input type="checkbox"/> Auto Immune	<input type="checkbox"/> <input type="checkbox"/> Heavy Bleeding/Hemorrhage	<input type="checkbox"/> <input type="checkbox"/> Mental Illness	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/> Hepatitis	<input type="checkbox"/> <input type="checkbox"/> Migraines	<input type="checkbox"/> <input type="checkbox"/> Vein Condition
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> High Cholesterol	<input type="checkbox"/> <input type="checkbox"/> Other: _____	<input type="checkbox"/> <input type="checkbox"/> Venereal Disease
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> HIV/Hepatitis		

Known allergies (food, medications, or other): _____

Significant trauma (car accident, sports injuries etc.): _____

Immunizations: _____

Hospitalizations/Surgeries (procedures and dates): _____

Dental Procedures (include any silver fillings/mercury amalgams): _____

Do you have a history of frequent antibiotic use? Please Describe. _____

Allergy shots? Currently In the past Never

Please briefly describe your health as a child. (e.g. allergies/asthma, prone to illness, etc):

Family Medical History (please specify family member)

<input type="checkbox"/> Alcoholism/Drug Abuse _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Asthma/Allergies _____	<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Miscarriage _____
<input type="checkbox"/> Depression/Mental Illness _____	<input type="checkbox"/> Osteoporosis _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Other _____	

Current Health & Lifestyle

Do you smoke? Y N If yes, how many per day? _____ For how long? _____

Do you exercise? Y N If yes, how many times per week? _____ Please Describe. _____

Do you travel frequently? Y N Have you traveled overseas to 'developing' countries? Y N

Do you sit in traffic/commute as a daily routine? Y N

Height: _____ Weight: Now _____ One year ago _____ Maximum _____ @ Year _____

How many hours do you sleep in general? _____ When do you usually go to bed? _____

List 3 things you do currently that support overall health. _____ List your 3 favorite vices (eg smoking, social drinking, sweet tooth...)

Overall, do you feel that your lifestyle contributes to or takes away from your health?

Diet

Soft drinks per day _____ Cups of tea per day _____ Cups of coffee per day _____

Glasses of water per day _____ Alcoholic beverages per week _____

Are you a vegetarian? Y N Yes, but not strict Explain: _____

Please describe your average daily diet:

Breakfast: _____

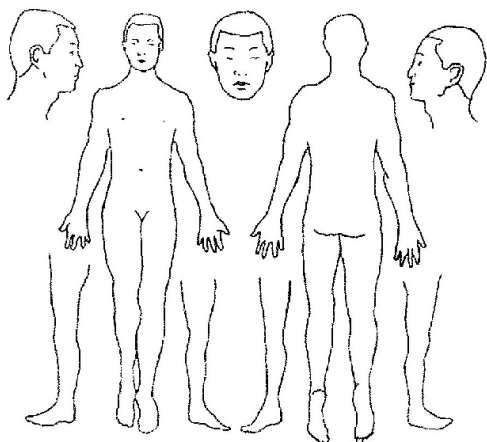
Lunch: _____

Dinner: _____

Snacks: _____

Foods you tend to crave: _____

Please indicate painful or distressed areas by using the symbol that best describes the feeling:



Mark with appropriate symbols:	
XXX	Sharp / Stabbing
PPP	Pins and Needles
DDD	Dull / Aching
NNN	Numbness

Please rate your **current** level of pain: Very mild 1 2 3 4 5 6 7 8 9 10 Very severe

Medications and Supplements

Medications you are currently taking (please include prescription medicines, vitamins, supplements, over the counter drugs, herbal supplements, etc.):

Profile

Please check any of the following symptoms that **currently** pertain to you.

General

Cold hands

Hot body temperature

Profuse perspiration

Chills

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold body temperature | <input type="checkbox"/> Lack of perspiration | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Sweaty hands | <input type="checkbox"/> Afternoon flushing | <input type="checkbox"/> Perspire easily | <input type="checkbox"/> Strong thirst |
| <input type="checkbox"/> Sweaty feet | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweating | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Frequent cavities | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Weak knees | <input type="checkbox"/> Cold lower back |
| <input type="checkbox"/> Broken/loose teeth | <input type="checkbox"/> Ringing in ears/tinnitus | <input type="checkbox"/> Knee soreness | <input type="checkbox"/> Cold hips/buttocks |
| <input type="checkbox"/> Weak bones | <input type="checkbox"/> Early graying of hair | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Cold knees |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weak nails |

Emotions

- | | | | |
|--------------------------------------|---|---|--|
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fits of laughter | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Depression | <input type="checkbox"/> Frequent worrying |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Anger | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Mania | |

Skin

- | | | | |
|-----------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry or Flaky Skin | <input type="checkbox"/> Hives | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Ulcerations/Boils |

Neuro-Muscular

- | | | | |
|------------------------------------|---|--|-----------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Tingling in extremities | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Muscle spasms | |

Cardiovascular

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Tongue ulcers | <input type="checkbox"/> Speech impediment |
| <input type="checkbox"/> Restless dreams | <input type="checkbox"/> Mental restlessness | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hallucinations |

Respiratory

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Nasal dryness | <input type="checkbox"/> Chest congestion | <input type="checkbox"/> Chest tightness |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Chronic allergies | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Frequent colds/flu | | | |

Gastrointestinal

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Low or weak appetite | <input type="checkbox"/> Fatigue following a meal | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Abrupt weight gain | <input type="checkbox"/> Gurgling in intestines | <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Strong cravings |
| <input type="checkbox"/> Abrupt weight loss | <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Gas | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Stomach ache | <input type="checkbox"/> Ravenous appetite | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Belching | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hiccups | <input type="checkbox"/> Mouth ulcers |
| <input type="checkbox"/> Loose stools | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Less than 1 BM per day | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Difficulty moving bowels | <input type="checkbox"/> Small, hard, dry stools | <input type="checkbox"/> Diarrhea |

Lymphatic System/Accumulated Dampness

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Swollen hands | <input type="checkbox"/> Mental fogginess | <input type="checkbox"/> Edema in the legs | <input type="checkbox"/> Heavy limbs/head |
| <input type="checkbox"/> Swollen feet | <input type="checkbox"/> Mental sluggishness | <input type="checkbox"/> Edema in the abdomen | <input type="checkbox"/> Joint stiffness |

Liver/Gall Bladder Function

- | | | | | |
|------------------------------------|------------------------------------|--|--------------------------------------|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Pain in ribcage | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Chronic neck or shoulder tension |
|------------------------------------|------------------------------------|--|--------------------------------------|---|

Eyes

- | | | | |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Red and irritated eyes | <input type="checkbox"/> Floaters/Seeing spots | <input type="checkbox"/> Glaucoma |
| | | | <input type="checkbox"/> Blurry vision |

Urinary

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Cloudy | <input type="checkbox"/> Small amount | <input type="checkbox"/> Night-time urination | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Dark yellow | <input type="checkbox"/> Large amount | <input type="checkbox"/> Difficulty initiating urination | <input type="checkbox"/> Strong odor |
| <input type="checkbox"/> Clear color | <input type="checkbox"/> Dribbling | <input type="checkbox"/> Very frequent | <input type="checkbox"/> Pain or burning |
| <input type="checkbox"/> Reddish color | | | |

Male

- | | | |
|---|---|---|
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Testicular pain/swelling | <input type="checkbox"/> Ejaculation problems |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Premature ejaculation | <input type="checkbox"/> Erectile dysfunction/impotence |
| <input type="checkbox"/> Nocturnal emission | <input type="checkbox"/> Infertility | <input type="checkbox"/> Difficulty maintaining an erection |
| <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Poor sperm motility | <input type="checkbox"/> Irregular sperm morphology |
| <input type="checkbox"/> Feeling of coldness or numbness of genitalia | <input type="checkbox"/> Discharge | |

Do you have any bothersome symptoms? Y N Describe: _____

Do you get up at night to urinate? Y N How often? _____

To what extent do these conditions interfere with your daily activities (work, sleep, socializing, sex, etc.)?

Have you sought medical intervention for these problems? If so, when? _____

What treatment have you tried for these problems and how successful have they been?

Female

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Pelvic infection | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Frequent vaginal infections |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Abnormal vaginal discharge |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Pain during intercourse | <input type="checkbox"/> Night sweats |

Do you experience any of the following associated with your period each month?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Water retention | <input type="checkbox"/> Migraine/headache | <input type="checkbox"/> Lower back pain | <input type="checkbox"/> Change in bowel movement |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Irritability | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Breast tenderness/swelling <input type="checkbox"/> |
| Food cravings <input type="checkbox"/> | Acne <input type="checkbox"/> | Heavy bleeding <input type="checkbox"/> | Scanty/light bleeding <input type="checkbox"/> |
| <input type="checkbox"/> Clots | <input type="checkbox"/> Other: _____ | | |

_____ number of pregnancies _____ number of live births _____ miscarriages _____ abortions

_____ premature births _____ difficult delivery _____ cesareans

At what age did you get your first period: _____ First day of last menstrual period: _____

Are your menstrual cycles spaced regularly? Y N Cycle length: _____ Period length: _____

Are you currently using birth control? Y N If yes, what type and for how long? _____

Have you experienced menopause? Y N When? _____

If you are experiencing menopausal symptoms, please describe: _____

Is there any possibility you are pregnant now? Y N

Cancellation & Payment Policy

Stellar Healing has a 24-hour cancellation policy. A credit card is required to be held on file, that will only be charged if you cancel less than 24 hours prior to your appointment, or do not show up for your appointment.

Name on Card _____

Type of card _____

Credit Card # _____ Expiration Date ____/____

3 letter security code _____ Billing Zipcode _____

I _____ agree to the payment policy.

Signature _____ date _____

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 below 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 below, including those working at the clinic or office listed below 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involved the use of heat lamps. Bruise like marks are a common side effect of cupping. Unusual risks of acupuncture may 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.

I understand that while this document describes the major risks of treatment, other side effects 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.

HIPAA Privacy Practices Acknowledgement Form

Due to HIPAA compliance statutes, we as a healthcare provider are required to provide you with a Notice of Privacy Practices that describes your rights as a patient and must document that every patient or client has read and received it.

The form is found on our website

By voluntarily signing below, I acknowledge the receipt of the Notice of Privacy Practices at Stellar Healing & 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.

Patient Signature (or Patient Representative)

Date

(Indicate relationship if signing for patient)

Printed Name