New Patient- Stellar Acupuncture, Dr. Miranda Gensler

Contact Information Today's Date:_____ /_____ /_____

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

Age:_____

Street:_____ Email Address:_____

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

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

Occupation:_____ Employer:_____

Emergency Contact:_____ Phone:_____

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

_____ Referred By:_____

Have you had acupuncture before? Y ☐ N ☐ Allow email/mail/phone contact by Stellar Acupuncture for appointment reminders? 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		P	C		P	C		P	C	
☐	☐	Alcohol/Drug Abuse	☐	☐	Digestive Disorder	☐	☐	Hypertension	☐	☐	Nervous Disorder
☐	☐	Anemia	☐	☐	Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	Pneumonia
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Liver Disease	☐	☐	Thyroid Disorder
☐	☐	Auto Immune	☐	☐	Heavy Bleeding/Hemorrhage				☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Hepatitis	☐	☐	Mental Illness	☐	☐	Vein Condition
☐	☐	Cancer	☐	☐	High Cholesterol	☐	☐	Migraines	☐	☐	Venereal Disease
☐	☐	Diabetes	☐	☐	HIV/Hepatitis	☐	☐	Other:_____			

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)

☐ Alcoholism/Drug Abuse_____ ☐ Heart Disease_____
☐ Asthma/Allergies_____ ☐ Hypertension_____
☐ Cancer_____ ☐ Miscarriage_____
☐ Depression/Mental Illness_____ ☐ Osteoporosis_____
☐ Diabetes_____ ☐ Stroke_____
☐ 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 your 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:_____

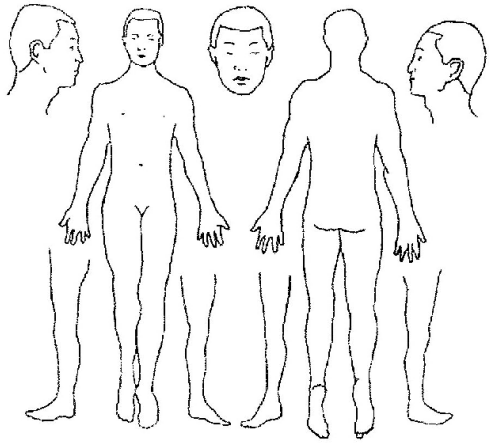
Lunch:_____

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

- [ ] Cold feet
- [ ] Cold body temperature
- [ ] Lack of perspiration
- [ ] Fever
- [ ] Sweaty hands
- [ ] Afternoon flushing
- [ ] Perspire easily
- [ ] Strong thirst
- [ ] Sweaty feet
- [ ] Hot flashes
- [ ] Night sweating
- [ ] Lower back pain

- [ ] Frequent cavities
- [ ] Hearing loss
- [ ] Weak knees
- [ ] Cold lower back
- [ ] Broken/loose teeth
- [ ] Ringing in ears/tinnitus
- [ ] Knee soreness
- [ ] Cold hips/buttocks
- [ ] Weak bones
- [ ] Early graying of hair
- [ ] Hair loss
- [ ] Cold knees

- [ ] Dizziness
- [ ] Forgetfulness
- [ ] Fainting
- [ ] Weak nails

Emotions
- [ ] Mood swings
- [ ] Anxiety
- [ ] Fits of laughter
- [ ] Fear
- [ ] Sadness
- [ ] Panic attacks
- [ ] Depression
- [ ] Frequent worrying
- [ ] Nervousness
- [ ] Irritability
- [ ] Anger
- [ ] Easily stressed
- [ ] Bipolar
- [ ] Obsessive/Compulsive
- [ ] Mania

Skin
- [ ] Acne
- [ ] Dry or Flaky Skin
- [ ] Hives
- [ ] Rashes
- [ ] Dandruff
- [ ] Eczema
- [ ] Psoriasis
- [ ] Ulcerations/Boils

Neuro-Muscular
- [ ] Seizures
- [ ] Lack of coordination
- [ ] Tingling in extremities
- [ ] Numbness
- [ ] Paralysis
- [ ] Loss of balance
- [ ] Muscle spasms

Cardiovascular
- [ ] Heart palpitations
- [ ] Chest Pain/Angina
- [ ] Tongue ulcers
- [ ] Speech impediment
- [ ] Restless dreams
- [ ] Mental restlessness
- [ ] Insomnia
- [ ] Hallucinations

Respiratory
- [ ] Persistent cough
- [ ] Nasal dryness
- [ ] Chest congestion
- [ ] Chest tightness
- [ ] Nosebleeds
- [ ] Chronic allergies
- [ ] Sneezing
- [ ] Difficulty Breathing
- [ ] Sinus congestion
- [ ] Sore throats
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] Frequent colds/flu

Gastrointestinal
- [ ] Indigestion
- [ ] Low or weak appetite
- [ ] Fatigue following a meal
- [ ] Hypoglycemia
- [ ] Abrupt weight gain
- [ ] Gurgling in intestines
- [ ] Easily fatigued
- [ ] Strong cravings
- [ ] Abrupt weight loss
- [ ] Bruise easily
- [ ] Gas
- [ ] Hemorrhoids

- [ ] Stomach ache
- [ ] Ravenous appetite
- [ ] Stomach ulcer
- [ ] Nausea
- [ ] Acid reflux
- [ ] Bleeding gums
- [ ] Belching
- [ ] Vomiting
- [ ] Bad breath
- [ ] Heartburn
- [ ] Hiccups
- [ ] Mouth ulcers

- [ ] Loose stools
- [ ] Blood in stools
- [ ] Less than 1 BM per day
- [ ] Constipation
- [ ] Mucous in stools
- [ ] Difficulty moving bowels
- [ ] Small, hard, dry stools
- [ ] Diarrhea

Lymphatic System/Accumulated Dampness
- [ ] Swollen hands
- [ ] Mental fogginess
- [ ] Edema in the legs
- [ ] Heavy limbs/head
- [ ] Swollen feet
- [ ] Mental sluggishness
- [ ] Edema in the abdomen
- [ ] Joint stiffness

Liver/Gall Bladder Function
- [ ] Headaches
- [ ] Migraines
- [ ] Pain in ribcage
- [ ] Gall stones
- [ ] Chronic neck or shoulder tension

Eyes
- [ ] Itchy eyes
- [ ] Watery eyes
- [ ] Poor night vision
- [ ] Cataracts
- [ ] Dry eyes
- [ ] Red and irritated eyes
- [ ] Floaters/Seeing spots
- [ ] Glaucoma
- [ ] Blurry vision

Urinary

☐Cloudy ☐Small amount ☐Night-time urination ☐Incontinence
☐Dark yellow ☐Large amount ☐Difficulty initiating urination ☐Strong odor
☐Clear color ☐Dribbling ☐Very frequent ☐Pain or burning
☐Reddish color

Male

☐Prostate Problems ☐Testicular pain/swelling ☐Ejaculation problems
☐Low sex drive ☐Premature ejaculation ☐Erectile dysfunction/impotence
☐Nocturnal emission ☐Infertility ☐Difficulty maintaining an erection
☐Low sperm count ☐Poor sperm motility ☐Irregular sperm morphology
☐Feeling of coldness or numbness of genitalia ☐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

☐Pelvic infection ☐Endometriosis ☐Vaginal dryness ☐Frequent vaginal infections
☐Fibroids ☐Ovarian cysts ☐Abnormal pap smear ☐Abnormal vaginal discharge
☐Breast tenderness ☐Breast lumps ☐Spotting between periods ☐Hot flashes
☐Low sex drive ☐Fertility problems ☐Pain during intercourse ☐Night sweats

Do you experience any of the following associated with your period each month?
☐Water retention ☐Migraine/headache ☐Lower back pain ☐Change in bowel movement
☐Mood swings ☐Irritability ☐Abdominal cramps ☐Breast tenderness/swelling ☐
Food cravings ☐Acne ☐Heavy bleeding ☐Scanty/light bleeding
☐Clots ☐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 - **Please Fill This Out Only If You Did Not Book Online**

Stellar Acupuncture 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