Jean Donati Acupuncture, LLC
Jean@East2WestMedicine.com |www.East2WestMedicine.com
410-984-3700

New Patient Information

Name _____ Today's Date _____

Street Address _____ Unit _____

City _____ State _____ Zip _____

Preferred Phone _____ Email _____

Birth Date (include year) _____ Age _____

Gender _____ Height _____ Weight _____

Occupation _____ Employer _____

Marital Status _____ Referred by _____

Emergency Contact: Name _____ Phone _____

Primary Care Physician: Name _____ Phone _____

Other Practitioners Involved In Your Care:

Name _____ Phone _____

Name _____ Phone _____

Fees:

It is our policy that you pay the entire session fee or co-pay at the time of each session. We will provide a minimum of one month's notice of any changes to our fees.

Insurance Company _____

Insurance Company Phone Number (Provider Line) _____

ID # _____

Please bring a photocopy of your insurance card (front and back) **or** bring your card to your first appointment so we can make a copy at the clinic.

Cancellation Policy:

If you need to change or cancel your appointment please notify us within a minimum of 24 hours notice. Failure to do so will result in being charged the equivalent of the cash rate of the missed appointment to your account.

☐ **I understand the cancellation policy.**

Signature:_____ **Date:** ____/____/____

New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone Mobile Phone SS# Date of Birth

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for?

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for?

Insurance Information

Insurance Company Phone Date Called

ID # Co-Pay $ Covered %

Visit # Deductible Amount

Contact Name Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

☐ Work ☐ Standing ☐ Sexually ☐ Other
☐ Sleep ☐ Emotional ☐ Recreation
☐ Walking ☐ Relationships ☐ Bending
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this?

Are you interested in:

☐ Pain Relief ☐ Holistic Health ☐ Stress Relief ☐ Other
☐ Preventative Care ☐ Stretching/Yoga ☐ Herbal Therapy
☐ Oriental Nutrition ☐ Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you have been or are currently involved in:

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Do you take medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? _____ Do you have a low point during the day? ☐ Yes ☐ No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

Female Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge

Other _____

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other _____

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of _____	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: _____
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	_____
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	_____
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	_____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain. Use the chart below to indicate pain intensity and limitations.

Pain intensity levels

☐ No Pain ☐ Moderate pain ☐ Severe pain ☐ Terrible pain

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

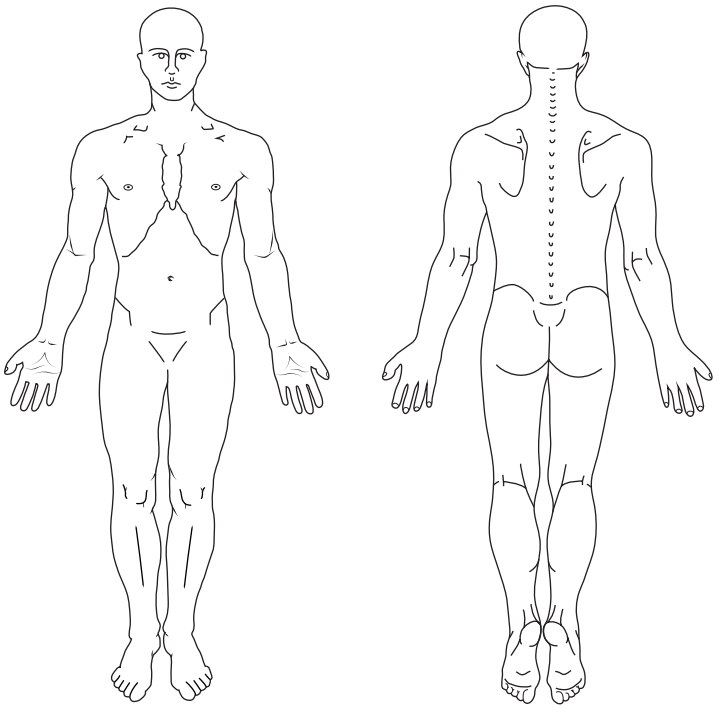
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

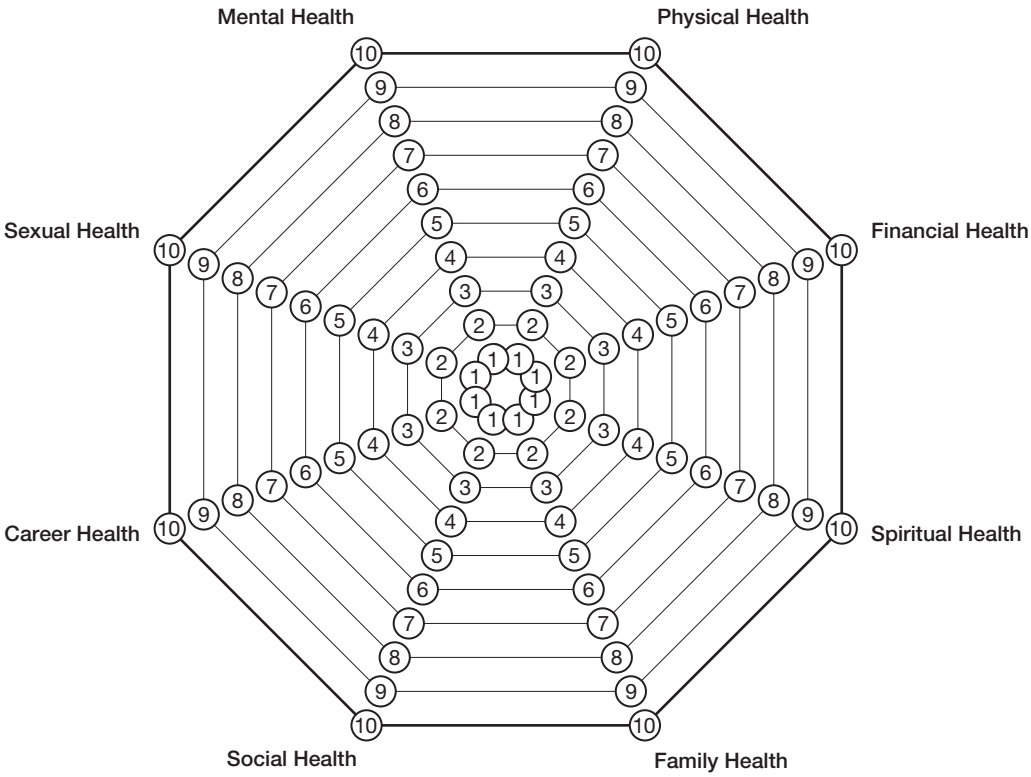
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the "10" circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

Jean Donati Acupuncture, LLC
Licensed Acupuncturist
410-984-3700

OFFICE POLICIES (Revised 10/4/2023)

1. Payment for services is due at the time of service unless other arrangements have been made.

2. Please call with cancellations 24 hours prior to appointment.

3. **Cancellations not made within 24 hours** of scheduled appointment, and missed appointments **are subject to current treatment fees.**

4. No Shows or Late Cancellations **are subject to current treatment fees.**

5. In the event that you are having symptoms of **COVID 19** (Cough, fever, loss of taste or smell) or have been exposed to someone with COVID 19, **please CALL the office, do not come in.**

   Seek medical attention and advise from your primary physician. Appointments missed due to COVID symptoms with **a documented positive Covid test result** will not be charged.

I have read and understand these policies. I have had the opportunity to ask any questions relating to these policies.

_____ _____

Client Signature Date

Jean Donati Acupuncture,LLC
Jean Donati M.Ac., L.Ac. Licensed Acupuncturist
604 E. Joppa Rd Towson, MD 21286 (410) 984-3700

Privacy Practices Notification

Incompliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, this office would like to inform you of its Privacy Practices. These practices are directed at protecting the privacy of your treatments and medical information.

The privacy practices insure you that:

1. All patient records are stored in a secured area.

2. You have the right to review your chart. Should you like to review your chart we request that you make an appointment with your practitioner to do so.

3. Your medical information is private. This office is unable to discuss your treatment or provide medical information or records with anyone without your explicit written consent.

4. Information shared with your insurance company will only be information required to secure payment for services. This information may include your name, diagnosis, CPT code, dates of service, treatment fees. If your insurer requires more information, they must obtain your consent before this office will share the requested information.

5. Should you like your Practitioner to speak with another of your health care providers you must sign the Records Release Form to allow your Practitioner to provide information to anyone.

6. You may review the Privacy Practices Policy at any time, though your Practitioner may request that you make an appointment to make sure your questions are answered in a timely fashion.

In signing below, I acknowledge receipt of the Privacy Practices Notification for Jean Donati Acupuncture, LLC.

Patient Name (please print)_____

Patient Signature_____

Date:_____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

Informed Consent For Facial Acupuncture

(Acupuncture Facial)

Instructions - This is an informed consent document that has been prepared to help your acupuncturist inform you concerning facial acupuncture treatments, the risks involved, and possible alternatives. Please be advised that this is not a surgical procedure. It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for facial acupuncture treatments, as proposed by your acupuncturist.

Introduction - An acupuncture facial treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Oriental medicine, the meridians or pathways of *Qi* (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely "cosmetic." An acupuncture facial involves the patient in an organic, gradual process, that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift". A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures.

Benefits - Facial acupuncture can increase facial tone, decrease puffiness around the eyes, as well as bring more firmness to sagging skin, enhance the radiance of the complexion, and flesh out sunken areas. Customarily, fine wrinkles will disappear, and deeper ones be reduced. As this treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health.

Contraindications for Treatment:

- High blood pressure
- Problems with bleeding or bruising
- Severe Migraine headaches
- Parkinson's disease
- Recent Microdermabrasion
- Diabetes mellitus
- Cancer
- AIDS
- Recent laser treatments
- Hepatitis
- Vertigo
- Hemophilia
- Botox treatments
- Dermal filler (Restylane, Juvederm, Radiesse etc)
- Any skin diseases (poison ivy, eczema, hives)
- Pregnancy
- Cold or flu
- Herpes outbreak
- Allergic reactions
- Extreme stress or tension

Alternative Treatment - Improvement of sagging skin, wrinkles and fatty deposits may be attempted by other treatments or surgery such as a surgical facelift, chemical face peels, or liposuction. Risk and potential complications are associated with these alternative forms of treatment.

Risks of an Acupuncture Facial - Every procedure involves a certain amount of risk and it is important that you understand the risks involved with an acupuncture facial. An individual's choice to undergo an acupuncture facial is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications, and consequences of an acupuncture facial.

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- **Bleeding** - It is possible, though very unusual, that you may have problems with bleeding during an acupuncture facial. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise, or *hematoma*, which will resolve itself.
- **Infection** - Infection is very unusual after an acupuncture facial. Should an infection occur, additional treatment, including antibiotics, may be necessary.
- **Damage to Deeper Structures** - Deeper structures such as blood vessels and muscles are rarely damaged during the course of a facial acupuncture treatment. If this does occur, the injury may be temporary or permanent.
- **Asymmetry** - The human face is normally asymmetrical. Thus, there can be a variation from one side to the other in the results attained from a facial acupuncture treatment.
- **Bruising And Puffiness** - There is a possibility of bruising (hematomas), puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.
- **Nerve Injury** - Injuries to the motor or sensory nerves rarely result from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.
- **Needle Shock** - Needle shock is a rare complication after an acupuncture facial.
- **Unsatisfactory Result** - There is the possibility of a poor result from an acupuncture facial. You may be disappointed with the results.
- **Allergic Reactions** - In rare cases, local allergies to topical preparations have been reported. Systemic reactions which are more serious may occur to herbs used during an acupuncture facial. Allergic reactions may require additional treatment.
- **Delayed Healing** - Delayed wound healing or wound disruption are a rare complication experienced by patients in the aftermath of an acupuncture facial. There is a greater risk for smokers, who frequently have dry, sagging skin, which does not heal as readily as that of non-smokers.
- **Long Term Effects** - Subsequent alterations in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, or other circumstances not related to an acupuncture facial. An acupuncture facial does not arrest the aging process or produce permanent tightening of the face and neck. Future facial acupuncture maintenance treatments, or other treatments, may be necessary to maintain the results of an acupuncture facial.

MICRONEEDLING- Micro needling is the insertion of very fine needles into the skin for the purpose of rejuvenating the skin.

Contraindications:

- Accutane within 6 months
- scleroderma
- collagen vascular disease
- cardiac abnormalities
- rosacea
- blood clotting problems
- platelet abnormalities
- anticoagulation therapy (i.e.: Warfarin)
- facial cancer (past and present)
- chemotherapy
- steroid therapy
- dermatological diseases affecting the face
- diabetes and other chronic conditions
- active bacterial infections
- fungal infections

- immune suppression
- scars less than 6 months old
- Botox/facial fillers in the past 2-4 weeks.
- Treatment is not recommended for patients who are pregnant or nursing.

Precautions: keloid or raised scarring, eczema, psoriasis, actinic keratosis, and herpes simplex.

Side Effects Typically Include:

- Skin may be pink or red and feel warm like mild sunburn, or tight and itchy. All of which typically subsides within 12-48 hrs.
- Minor flaking or dryness of the skin, with scab formation in rare cases.
- Crusting, discomfort, bruising and swelling may occur.
- Pinpoint bleeding.
- It is possible to have a cold sore flare if you have a history of outbreaks.
- Freckles may lighten temporarily or permanently disappear in treated areas.
- Infection is rare but if you see any signs of tender redness or pus notify our office immediately.
- Hyperpigmentation (darkening of the skin) rarely occurs and usually resolves itself after a month.
- Permanent scarring is extremely rare.

Health Insurance - Most health insurance companies exclude coverage for an acupuncture facial and/or any complications that might occur from an acupuncture facial. Please carefully review your health insurance subscriber information pamphlet.

Additional Care Necessary - There are many variable conditions in addition to risk and potential complications that may influence the long-term result from acupuncture facial treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with an acupuncture facial treatment. Other complications and risks can occur but are even more uncommon. Should complications occur, other treatments may be necessary. The practice of acupuncture is not an exact science. Although good results are expected, there is no guarantee or warranty, either expressed or implied, on the results that may be obtained.

Financial Responsibilities - The cost of an acupuncture facial involves several charges for the services provided. The total includes fees charged by your acupuncturist, the cost of acupuncture supplies, and topical preparations. Depending on whether the cost of your acupuncture facial is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered.

Disclaimer - Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve. It is important that you read the above information carefully and have all of your questions answered before signing the following consent.

Consent For Facial Acupuncture Procedure or Treatment

1. I hereby authorize _____ and such assistants as may be selected to perf acupuncture facial. I have received the INFORMED CONSENT FOR FACIAL ACUPUNCTURE.

2. I recognize that during the course of the acupuncture facial, unforeseen conditions may necessitate different procedure those above. I therefore authorize the above acupuncturist and assistants or designees to perform such other procedu are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this parag shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is b
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.
5. It Has Been Explained To Me In A Way That I Understand:
   A. The Above Treatment Or Exposure To Be Undertaken
   B. There May Be Alternative Procedures Or Methods Of Treatment
   C. There Are Risks To The Procedure Or Treatment Proposed

I Consent To The Treatment Or Procedure And The Above Listed Items (1-5). I Am Satisfied With The Explanation.

Patient *(or Person Authorized to Sign for Patient)*	**Practitioner**
Date	**Date**

COSMETIC ACUPUNCTURE HEALTH INTAKE FORM

Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile for you. All answers are confidential.

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Is it ok to contact you via email? Yes: _____ No:_____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Gender: _____ Marital Status: _____ Occupation: _____

Referred By: _____ Emergency contact & phone#_____

Primary Care Physician: _____ Phone #: _____

Are you currently/within the last year been under the care of your Primary Care Dr.?

What conditions? _____

Describe your main skin concerns and goals and use the picture below to draw areas of concern.

_____

_____

_____

_____

_____

_____

_____

What makes your skin condition better? _____

What makes your skin condition worse? _____

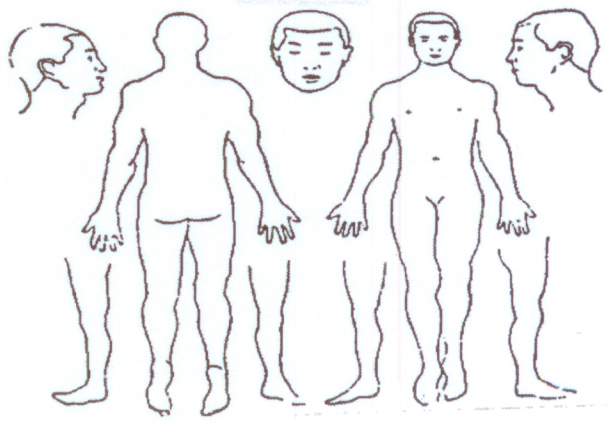
List any other medical diagnoses or concerns:

_____

Trauma (emotional, physical), Surgeries, accidents, injuries, chronic illness: (please include date).

_____

Note areas of concern, scars or areas of recent or past trauma.



We use essential oils in our treatments and suggest dietary considerations. Please notify us of the following:

Allergies/Intolerances: (Nuts, oils, food, chemical, environmental, drugs, etc.)_____

_____

Medications: (names & dosages) Please attach an additional page if necessary._____

_____

Vitamins/Supplements/Herbs: _____

_____

Exercise

Days per week _____ Length of workout _____ Type of Activity _____

Diet

Meals per day _____ Snacks _____ Caffeinated Drinks _____ Alcohol/week _____

	A lot	Some	A little	None
Veggies/fruit	☐	☐	☐	☐
Meat/seafood	☐	☐	☐	☐
Eggs/nuts/beans	☐	☐	☐	☐
Dairy	☐	☐	☐	☐
Whole grains	☐	☐	☐	☐
White flour carbs	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Fried foods	☐	☐	☐	☐

Personal History

Please check any conditions you have now or have had in the past.

- ☐ Migraine
- ☐ Seizure
- ☐ Oral Herpes
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Hypertension
- ☐ Vertigo or Dizziness
- ☐ Congestive Heart Failure
- ☐ Blood Thinning Medication
- ☐ Herpes
- ☐ Pituitary tumor/disorder
- ☐ Allergic Reactions
- ☐ Pregnancy
- ☐ Concussion
- ☐ Cancer

- ☐ Arthritis
- ☐ Cancer
- ☐ Ulcer
- ☐ Chronic Fatigue
- ☐ Alcoholism
- ☐ Liver/Gall Bladder Disease
- ☐ Hypo/Hyperglycemia
- ☐ Diabetes
- ☐ Anemia
- ☐ Asthma
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Allergies
- ☐ Hepatitis
- ☐ Thyroid Disorder
- ☐ Heart Disease
- ☐ Diverticulitis/IBS
- ☐ Multiple Sclerosis
- ☐ Gastritis/Pancreatitis
- ☐ Chronic Pain Condition

Skin Questions, check all that are current or relevant.

Allergies To: ☐Cosmetics ☐Topical creams ☐Airborne Particles ☐Other Explain _____.

Medications within last 3 months: Accutane Birth Control Pills Hormones Vitamin A.

Current Beauty Routine: Cleanser _____ Toner _____ Moisturizer _____ Masks _____ Other _____.

Face: Past Facelift surgery Yes No Full Partial ? When _____ Satisfied Yes No.
Facials- Type _____How often _____.
Microdermabrasion Chemical Peels Photolight rejuvenation Retin-A Renova Botox Collagen injections Fillers.

Skin: Wrinkles Fine lines Cracking Herpes Cold Sores Blemishes Acne Dryness Oily Herpes Rashes/Dermatitis Sagging Dullness Eczema Psoriasis Dry Skin.

Itching Fungal Infections Recent Moles Warts Discolorations Flushing Age Spots.

Complexion: Sallow (yellow) complexion Rosacea (Redness) Creamy-Burns never tans Light-Burns tans slightly Light/Med-Burns moderately tans gradually Med-Seldom burns tans well Brown-Rarely burns, deep tan Black-Never burns, deeply pigmented.

Eyes: Dark eye circles Puffy and swollen eye bags Puffy upper lids Wrinkles and Dry skin around eyes Stye.

Hair: Thinness Dandruff Alopecia (baldness) Excess Facial Hair
Electrolysis treatments Yes No If so how often_____.

Family Medical History

F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather)

☐ Diabetes ___	☐ Seizures ___	☐ Heart Disease ___	☐ Stroke ___
☐ High Blood Pressure __	☐ Allergies ___	☐ Cancer ___	☐ Asthma ___

Please take your time and **check** if you have had any of these items listed below in the last **year** or you feel they are a significant part of your medical history.

General

☐ Poor Appetite	☐ Poor Sleeping	☐ Fatigue	☐ Fevers
☐ Chills	☐ Night Sweats	☐ Sweats Easily	☐ Tremors
☐ Cravings	☐ Localized Weakness	☐ Poor Balance	☐ Change in appetite
☐ Bleed/Bruise easily	☐ Weight loss/gain	☐ Peculiar tastes/smells	☐ Dental/gum problems
☐ Muscle weakness/fatigue	☐ Sudden energy drop	☐ Prefer Hot or Cold drink	☐ Cold hands and feet

Head, Eyes, Ears, Nose, Throat

☐ Dizziness	☐ Difficulty swallowing	☐ Migraines	☐ Glasses
☐ Eye Strain	☐ Eye pain	☐ Poor night vision	☐ Night Blindness
☐ Color Blindness	☐ Cataracts	☐ Blurred vision	☐ Earaches
☐ Ringing in ears	☐ Poor hearing	☐ Spots in front of eyes	☐ Sinus problems
☐ Nose bleeds	☐ Recurrent sore throats/colds	☐ Grinding teeth	☐ Facial pain
☐ Sores on lips/tongue	☐ Dental problems	☐ Jaw clicks/locks/TMJ	☐ Headaches
	☐ Dry mouth	☐ Excess saliva	☐ Head other_____

Cardiovascular

☐ Chest pain or pressure	☐ Irregular heart beat	☐ Palpitations at rest	☐ Fainting
☐ Cold hands/feet	☐ Swelling of hands/feet	☐ Blood clots	☐ Phlebitis
☐ Shortness of breath	☐ Varicose/spider veins	☐ Pressure in chest	☐ High blood pressure
☐ Low blood pressure	☐ Spontaneous sweating		

Respiratory

☐Cough/Wheezing ☐Coughing blood ☐Asthma ☐Bronchitis
☐Pneumonia ☐Pain with deep inhalation ☐Tight sensation in chest ☐Difficult inhale/exhale
☐Difficulty breathing when lying down ☐Excess Production of phlegm…Color_____

Gastrointestinal

Frequency of Bowel Movements_____

☐ Loose stools (>2 per day) ☐Dry ☐Soft ☐Mucous ☐Incomplete ☐Undigested Food
☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation
☐Gas ☐Belching ☐Black stools ☐Blood in stool
☐Indigestion ☐Bad breath ☐Rectal pain ☐Hemorrhoids
☐Bloating ☐Chronic laxative use ☐Loose stools (>2 per day) ☐Abdominal pain/cramps
☐Changes in appetite ☐Acid reflux/GERD ☐Hernia ☐Poor appetite☐Excessive

☐Significant thirst ☐IBS/Crohn's Disease

Genito-Urinary

☐Pain on urination ☐Frequent urination ☐Blood in urine ☐Urgent urination
☐Unable to hold urine ☐Kidney stones ☐Scanty flow ☐Copious flow
☐Impotence ☐Sores on genitals ☐Urinary tract infection ☐Burning urination
☐Premature ejaculation ☐Decreased libido ☐Prostatitis ☐Dribbling after urination
☐Nocturnal emission ☐Pain in testicles ☐Herpes ☐Infections
☐Night urination… What time?_____ How often?_____ ☐Excessive libido

Gynecological/Reproductive

☐Difficult/Painful intercourse ☐Ovarian cysts ☐Age of first menses_____
☐Vaginal dryness ☐Endometriosis ☐Date of last menses_____
☐Vaginal sores ☐Uterine Fibroids ☐Date of last PAP/Pelvic_____
☐Vaginal discharge ☐Fibrocystic breast tissue ☐Number of pregnancies____
☐Infertility ☐Polycystic Ovarian Disease ☐Number of ectopic pregnancies_____
☐Irregular menstruation ☐PMS ☐Number of live births_____
☐Painful menstruation ☐Number of miscarriages_____

Type of birth control?_____ How long?_____

Musculoskeletal

☐Neck pain ☐Shoulder pain ☐Hand/wrist pain ☐Carpal Tunnel
☐Knee pain ☐Sprains/Strains ☐Sciatica ☐Foot/ankle pain
☐Hip pain ☐Muscle pain ☐Muscle weakness ☐Tendonitis
☐Back pain Low___ Middle___ Upper___ ☐Bursitis ☐Rotator Cuff

Neuropsychological

☐Seizures ☐Loss of balance ☐Vertigo/Dizziness ☐Areas of numbness
☐Anxiety/Panic attacks ☐Bad temper ☐Easily susceptible to stress ☐Seasonal Affective Disorder
☐Nervousness ☐ADD/ADHD ☐Manic Depression ☐Irritable
☐Numbness ☐Tics

Have you ever been treated for emotional problems? _____, Substance Abuse? _____, Suicide? _____

Jean Donati Acupuncture, LLC
Licensed Acupuncturist
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Informed Consent for Acupuncture Treatment and Care

I hereby request and consent to the performance of acupuncture treatments and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Jean Donati, LAc.

I understand that methods or treatment may include, but are not limited to: acupuncture, moxibustion, electrical stimulation, Chinese or Western herbal medicine, supplement recommendations, and nutritional counseling. **I understand that even though Jean Donati holds certification as a physician assistant, she will be acting as my acupuncturist only, and that if I am in need of any Western medical care, I will be referred to the appropriate Western medical provider.**

Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment during the course of the procedure, which the acupuncturist feels at the time, based upon the facts then known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

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 condition(s) for which I seek treatment.

I understand that payment for services is due when they are rendered. I am responsible for the full amount of the services and agree to submit any insurance paperwork and accept reimbursement from my insurance company as per my individual policy.

Patient's Name _____

Patient's/Patient Representative's Signature _____

Today's Date _____/_____/_____