

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

I, the undersigned, do affirm that I have been advised by Noran Malouf L.Ac to consult a physician regarding the condition for which I am seeking treatment..

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional Oriental Medicine. I understand that methods of treatment may include but are not limited to acupuncture, moxabustion, cupping, electrical stimulation, and Tui Na (Chinese Massage), herbal medicine, nutritional counseling, and lifestyle adjustments.

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, infections, and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after the cupping. Burns and/or scarring are a potential risk of moxabustion.

The herbs and nutritonal supplements (which are from plant, animal, and mineral sources) that have been recommended are considered safe. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue. I will notify the acupuncturist if I am or become pregnant. I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbal tea or supplements.

I understand the acupuncturist may review my medical records and that portions of my records may be used for teaching or research purposes; however, my name and identifying information will not be disclosed. Otherwise, all of my records will be kept confidential and will not be released to any party without my written consent.

III. OFFICE POLICY

We value your time, and we pride ourselves on keeping your wait to a minimum. We understand travel in Manhattan can be challenging and we will accommodate late arrivals the best we can. While most practitioners treat multiple patients at the same time, I specialize in focusing upon only one patient per hour (unless there's an emergency) Please recognize that the entire time has been exclusively appointed to you. Therefore we appreciate that all scheduling changes be made with as much advanced notice as possible. Please notify us by 12:00 noon on the day before your appointment. For clients wishing to have extended treatments (2 hours or more) please notify us by 12:00 noon 3 days prior to your appointment. . Failure to follow the policies will result in a charge to your account for the full amount of the treatment (with the exception of medical, trauma or family emergencies). If another client fills your appointment you will not be billed for the missed appointment.

If you have health insurance, we will provide you with a detailed receipt for your paid visit, which you will then use to submit to your insurance carrier, or accountant.

By voluntarily signing below I show that I have read, or have had read to me, the office policy and consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have 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.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated.)

Print Name of Patient

Print Name of Acupuncturist

Signature of Patient or Representative

Signature of Acupuncturist

Print Name of Patient Representative

Date Consent Completed

*Note: This is a confidential record of your medical history. Information contained here will not be released to any person without your authorization.

IDENTIFICATION DATA: Please fill in completely. **Please Print.**

Name: _____ Date : _____
Address: _____ Date of Birth: _____ Age : _____

Occupation : _____
Home / Mobile Phone () _____ Business Phone () _____
Email Address : _____ Referred by : _____
Emergency Contact: Name _____ Phone # _____
Name of Physician : _____ Phone # of physician : _____
Date of Last Physical Exam : _____ Reason (s) For Visit: _____

FAMILY HISTORY : Please list any pertinent information regarding your family's health history.

Grandparents: _____
Parents: _____
Siblings: _____
Do you live with someone who is ill, or are you close to someone who is ill? _____ If Yes, please describe the situation: _____

MAJOR HOSPITALIZATIONS : For **serious** medical illnesses/operations. Do not include normal pregnancies.
_____ Check here if you have had more than three such hospitalizations.

| YEAR | REASON FOR OPERATION/ ILLNESS |
|-------|-------------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

MEDICATIONS : Please list the names and duration of any medications, vitamins, or herbs that you are currently taking.

HABITS:

Alcohol. # of Drinks per week _____ Age Began _____ Stopped _____
Caffeine. # of Coffees per day _____ # of Teas per Day _____ # of sodas per day _____
Tobacco _____ cigarettes / packs a day Age Began _____ Stopped _____
Marijuana. Use Per Day _____ Age Began _____ Stopped _____
Other Street Drugs. Please specify Drug (s) _____ Frequency _____ Stopped _____

PERSONAL HEALTH HISTORY . Please place a “ C ” next to any conditions that you are currently experiencing, and a “ P ” next to any pertinent conditions that you may have experienced in the past.

GENERAL

- Aversion To Cold / Heat / Damp
- Chills
- Fever
- Sweat easily ___only with exertion
- Low Energy ___Uneven Energy
- High ___Low Blood Pressure
- Hyper ___Hypo Thyroid Disorder
- Diabetes ___Low Blood Sugar
- Cancer
- Chemical Dependency
- History Of Psychiatry
- HIV
- TB
- Hepatitis A, B, C, D, E
- Herpes
- Frequent Exposure To Blood
- Transfusion before 1985
- Other _____

CARDIOVASCULAR

- Sleep Disorder
- Palpitations
- Chest Pain ___Tightness
- Rapid Heart Beat
- Irregular Heart Beat
- Pacemaker
- Poor Circulation
- Cold Hands ___Feet
- Swelling of Ankles
- Phlebitis
- Other _____

GASTROINTESTINAL

- Poor Appetite
- Excessive Hunger
- Anorexia ___ Bulimia
- Tastes In The Mouth
- Chronic Bad Breath
- Never Thirsty ___Always Thirsty
- Nausea
- Vomiting
- Vomiting Blood
- Indigestion
- Gas
- Bloating
- Belching
- Heartburn
- Ulcers
- Stomach Cramps ___Pain
- Bowel Changes
- Constipation ___Diarrhea
- Rectal Bleeding ___Bloody Stools
- Hemorrhoids
- Mucus / Phlegm in stool
- Recent Changes in Weight
- Gallbladder Disorder
- Other _____

Food Cravings. If Yes For What:

RESPIRATORY

- Chronic Cough
- Coughing up Blood
- Coughing up Phlegm
- Difficulty Breathing
- Shortness of Breath
- Wheezing ___Asthma
- Bronchitis
- Excess Sputum
- Frequent Colds
- Sinus Bleeding
- Sinus Infection
- Hay Fever / Allergies
- Changes in Smell
- Sore Throat
- Hoarseness. Difficulty Swallowing
- Other _____

SKIN

- Itching
- Hives
- Rashes
- Acne
- Eczema
- Boils
- Nonhealing sores
- Scars
- Changes in Moles ___Lumps
- Dryness
- Bruise Easily
- Other _____

HEAD & NECK

- Dizziness
- Fainting
- Headaches
- Neck Stiffness
- Enlarged Lymph Glands
- Hairloss / Thinning
- Visual Changes
- Double Vision
- Dry Eyes
- Blurred Vision
- Poor Night Vision
- Spots / Floaters
- Eye inflammation
- Oral Ulcers
- Jaw Problems/ TMJD
- Discharge from Ear
- Ear Infection
- Ringing in the Ears
- Decreased Hearing
- Other _____

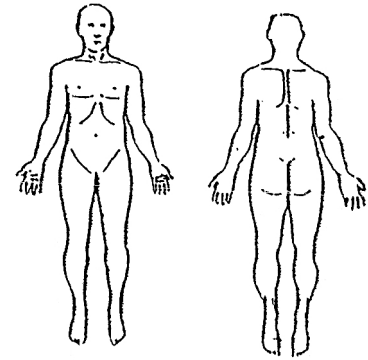
NEUROLOGICAL

- Poor Coordination
- Difficulty Walking
- Seizures
- Tremors
- Numbness / Tingling Of Limbs
- Nerve Pain
- Paralysis
- Other _____

STRUCTURAL HEALTH

- Pain
- Arthritis / Joint Disorder
- Weak / Sore Muscles
- Spinal Curvature
- Other _____

Please circle the areas that are Structurally problematic.



How many times per week do you Work out? _____

What do you do for exercise? _____

How do you relieve stress? _____

MALE REPRODUCTIVE

- Weak/ Frequent/ Dripping Urinary Stream
- Painful Urination
- Burning Urination
- Blood In The Urine
- Cloudy Urination
- Pain in the Genitalia
- Itching Of The Genitalia
- Genital Lesions
- Discharge
- Impotence
- Low Sex Drive / Difficult Erection
- Premature Ejaculation
- Painful Intercourse
- Prostate Disorder
- Lumps In The Testicle
- Other _____

GYNECOLOGICAL

- Frequent UTI
- Frequent Vaginal Infections
- Pain Itching Of Genitalia
- Genital Lesions
- Discharge
- Pelvic Inflammatory Dis
- Abnormal Pap Smear
- Abnormal Bleeding
- Breast Lumps
- Fibroids
- Painful Intercourse
- Low Sex Drive
- Nipple Discharge
- Water Retention
- Hot Flashes
- Irregular Menstruation
- Painful Menstruation
- PMS. What are your symptoms? _____

Date Of Last Pap Smear _____ Date Of Last Mammogram _____

Age Of First Menstruation _____ End Of Last Menstrual Period (Date) _____ Intervals (Days) _____

Duration Of Flow (Days) _____ Amount _____ Color _____ Clots _____ Consistency _____

Age Of Menopause _____ Any Bleeding Since _____ Menopausal / Perimenopausal Symptoms _____

Current Method Of Contraception _____

Pertinent Contraception History _____

Currently Pregnant. Yes No Unsure

Previous Pregnancies. Please Fill In

| <i>Year</i> | <i>Length Of Pregnancy</i> | <i>Labor Hours</i> | <i>Sex</i> | <i>Weight</i> | <i>Name</i> | <i>Complications</i> |
|-------------|----------------------------|--------------------|------------|---------------|-------------|----------------------|
| 1. | _____ | _____ | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ | _____ | _____ |

Total Pregnancies _____ # Living _____ # Ectopic _____ # Of Miscarriages _____ # Of Induced Abortions _____

Is there anything that you feel is important that has not been covered?

Daily Record of Food Intake

Each day for 1 week (preferably before your visit), record all the foods you eat and drink. Be sure to include the approximate amount. Your diet may be the key to excellent health.

Patient: _____

| Day 1 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| | | |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |
| | | |

| Day 2 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| | | |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |
| | | |

| Day 3 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| | | |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |
| | | |

| Day 4 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |

| Day 5 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |

| Day 6 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |

| Day 7 – Date: _____ | | |
|---------------------|----------------------|------------------|
| Breakfast: | Lunch: | Dinner: |
| Mid-morning snack: | Mid-afternoon snack: | Nighttime snack: |