

Sun & Moon Acupuncture Clinic

Nancy Goodwin, LAc

61 Greywolf Rd

Sequim, WA 98382

360-355-5989

www.sunandmoonacupuncture.com

Name _____ Phone: Home _____ Cell/Work _____

Address _____ City _____ State _____ Zip _____ Email _____

Date of Birth _____ Age _____ Height _____' _____" Weight _____ Occupation _____

Marital Status _____ Number of Children _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you find me?

Phonebook _____ Newspaper Ad _____ Friend / Relative _____ Who? _____ Physician _____

What are your primary concerns, conditions, injuries, or illnesses? List date each began.

- 1. _____ 3. _____
- 2. _____ 4. _____

Describe what caused it or how it started.

- 1. _____ 3. _____
- 2. _____ 4. _____

Personal Medical History including dates

Major Surgeries _____

Illnesses _____

Diseases _____

Accidents _____

Please list all prescriptions, over the counter medications, vitamins, and other supplements you are taking.

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Are you hypersensitive or allergic to _____ Any drugs? _____
Any foods? _____

Age Parents Died and Cause of Death Mother _____
Father _____

Contagious Diseases Check if you have ever had any of the following:
____ Hepatitis A, B, C ____ Herpes ____ HIV ____ AIDS ____ Other _____

Lifestyle

Please mark box with "P" for past use and "C" for current use. If "C" then state quantity.

____ Cigarettes _____ packs ____ Soft Drink _____ ____ Energy Drinks _____
____ Coffee _____ 8 oz. cups ____ Alcohol _____ ____ Plain Water _____ ____ Tea _____

Exercise ____ None ____ Some ____ Moderate Type? _____

Patient Name _____ DOB _____ Date _____

Emotions

Check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Easily Irritable | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Cry Easily | <input type="checkbox"/> Hurry to do things |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stressed | <input type="checkbox"/> Anxiety / Anxious |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Other _____ | |

Do you have a history of: Physical Abuse Emotional Abuse

Have you experienced any major traumas? Yes No

More than 2 in 1 year? Yes No
(ex. Divorce, change of residence, injury, loss of job, death in family, bankruptcy, etc.)

Do you enjoy your work? Yes No

Do you have a supportive relationship? Yes No

Diet

List your typical breakfast: _____

List your typical lunch: _____

List your typical dinner: _____

List your typical snacks: _____

List your cravings: _____

Energy

Low Normal Excess Low after Eating

Spiritual

Do you have a religious or spiritual practice? Yes No If yes, what? _____

Body Temperature

- | | | |
|--|---|---|
| <input type="checkbox"/> Warm Natured | <input type="checkbox"/> Flushed Face | <input type="checkbox"/> Feel Warmer Late Afternoon / Night |
| <input type="checkbox"/> Cold Natured | <input type="checkbox"/> Aversion to Heat | <input type="checkbox"/> Aversion to Cold |
| <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Aversion to Wind | <input type="checkbox"/> Normal |

Perspiration

Night Sweats Palms / Feet Normal

Digestion

- | | | |
|--|--|---|
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nervous Stomach | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomit |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Bitter Taste | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Difficulty Digesting Fatty Food | <input type="checkbox"/> Normal |

Patient Name _____ DOB _____ Date _____

Bowels

- | | | |
|---|---|---|
| <input type="checkbox"/> Loose Stool | <input type="checkbox"/> Undigested Food in Stool | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hard Stool | <input type="checkbox"/> Laxatives Used |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Mucous in Stool | <input type="checkbox"/> Stool with Bad Smell |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> IBS | <input type="checkbox"/> Normal |

Urination

- | | | |
|---|-------------------------------------|---|
| <input type="checkbox"/> Frequent | <input type="checkbox"/> Burning | <input type="checkbox"/> Bladder Infections |
| <input type="checkbox"/> Urgent | <input type="checkbox"/> Night Time | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Profuse | <input type="checkbox"/> Strong Smell |
| <input type="checkbox"/> Kidney Stones / Infections | <input type="checkbox"/> Painful | <input type="checkbox"/> Normal |

Thirst

- | | | |
|--|---|---|
| <input type="checkbox"/> Not Thirsty | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Thirsty but do not Drink |
| <input type="checkbox"/> Prefer Hot Drinks | <input type="checkbox"/> Prefer Cold Drinks | <input type="checkbox"/> Normal |

Sleep

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficulty Falling Asleep | <input type="checkbox"/> Awaken Easily | <input type="checkbox"/> Lots of Dreams |
| <input type="checkbox"/> Difficulty Going Back to Sleep | <input type="checkbox"/> Restless | <input type="checkbox"/> Vivid Dreams |
| <input type="checkbox"/> Sleep too Much | <input type="checkbox"/> Tired on Rising in Morning | <input type="checkbox"/> Normal |

Headaches / Dizziness

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Dizzy on Standing |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Faint Easily | <input type="checkbox"/> Normal |

Skin

- | | | |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Oily | <input type="checkbox"/> Hives | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Shingles | <input type="checkbox"/> Itching | <input type="checkbox"/> Normal |

Hair

- | | | | |
|------------------------------|------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Early Grey | <input type="checkbox"/> Normal |
|------------------------------|------------------------------------|-------------------------------------|---------------------------------|

Eyes

- | | | |
|---|--|---|
| <input type="checkbox"/> Sensitive to Light | <input type="checkbox"/> Dark Under the Eyes | <input type="checkbox"/> Eyelids Swollen |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Normal |

Nose

- | | | | |
|--|---------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Stuffy Nose | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Bleeding | |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Sneeze a Lot | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Normal |

Mouth & Throat

- | | | |
|--|--|---|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Dry Cracked Lips | <input type="checkbox"/> TMJ Syndrome |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Feel Lumps in Throat | <input type="checkbox"/> Grind Teeth |
| <input type="checkbox"/> Bitter Taste in Mouth | <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Normal |

Patient Name _____ DOB _____ Date _____

Ears

- | | | |
|---|--|---|
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sensitive to Cold | <input type="checkbox"/> Sensitive to Noise |
| <input type="checkbox"/> Ringing in Ears – High Pitch | <input type="checkbox"/> Ringing in Ears – Low Pitch | <input type="checkbox"/> Normal |

Respiratory

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sigh a Lot | <input type="checkbox"/> Dry Cough |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cough with Phlegm |
| <input type="checkbox"/> Difficulty Inhaling | <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Difficulty Exhaling | <input type="checkbox"/> Difficulty Breathing when Lying Down | |

Cardiovascular

- | | | |
|---|--|--|
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Murmur | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> History of Anemia | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Slow Heartbeat | <input type="checkbox"/> Fast Heartbeat | <input type="checkbox"/> Hand Swelling |
| <input type="checkbox"/> Numb Arms / Legs | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Average BP _____ | <input type="checkbox"/> Normal |

Pain

- | | | |
|--|--|---|
| <input type="checkbox"/> Low Back | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder Joint |
| <input type="checkbox"/> Sciatica / Gluteals | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hip Joints |
| <input type="checkbox"/> Hands or Wrists | <input type="checkbox"/> Foot or Ankle | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Damp Weather Bothers You |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Nerve Pain / Neuropathy | <input type="checkbox"/> Normal |

Males

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Genital Pain | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Painful or Burning Urination |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Dribbling of Urine | <input type="checkbox"/> Normal |

Other Please list any other issues you would like to discuss.

Informed Consent for Acupuncture Treatment and Care

Sun & Moon Acupuncture Clinic, Inc.

Nancy Goodwin, LAc

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 indicated 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.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, electrical stimulation, Tui-Na (Chinese massage), gua sha, cupping, Chinese or Western herbal medicine, nutritional counseling, botanical medicine, homeopathy, and acupuncture (point) injection therapy.

I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs, or any nutrition/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods 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 involves the use of heat lamps. Bruising is a common side effect of acupuncture, cupping, and injection therapy. 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 at all times.

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, stomach ache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I will notify a clinical staff member who is caring for me if I experience any of these or other side effects and/or if I become pregnant.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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 staff and administrative staff may review my medical records and lab reports, but all of my records will be kept confidential and will not be released without my written consent.

I understand that my appointment times are my commitment to being here and I agree to cancel 24 hours in advance or I will pay for the treatment.

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.

Print Patient's Name _____

Date _____

Patient's Signature _____

Pregnant? [] Yes [] No

If Minor or Under Guardianship, Patient's Representative Signature _____

Sun & Moon Acupuncture Clinic, Inc.

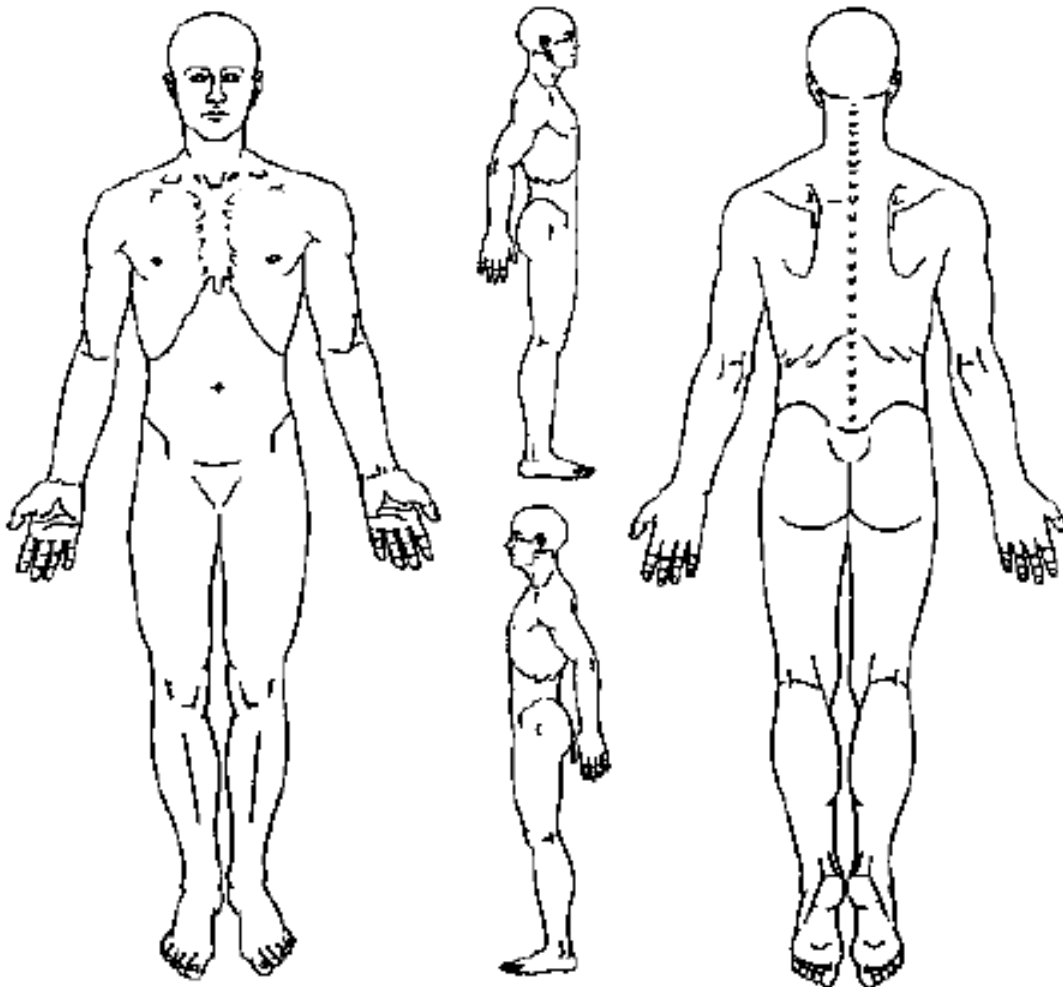
61 Greywolf Rd
Sequim, WA 98382
360-355-5989
Nancy Goodwin, LAc

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE B = BURNING N = NUMBNESS
P = PINS & NEEDLES S = STABBING O = OTHER