MINDBODYMED
2705 NE 65th St.
Seattle, WA 98115

ACUPUNCTURE REGISTRATION

Please help me become familiar with how I can serve you best.

IDENTIFICATION

Name_____Gender Identity_____DOB _____

Address_____City_____State_____ZIP _____

Telephone: cell_____ Preferred pronoun _____

□Single □Married □Partnered □Widowed □Separated/Divorced

Height_____Weight_____Occupation _____

Education _____

Emergency Contact_____Relation _____

Emergency Contact Telephone: Home_____Cell _____

Name of Physician_____Phone _____

Address _____

Name of Counselor/Psychologist_____Phone _____

Address _____

Name of Gynecologist_____Phone _____

Address _____

Special Problems or Symptoms _____

_____

_____

Your Signature: _____ Date:_____

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FAMILY HISTORY

	self	mother	father	sibling	spouse/partner	children
Adopted						
Good Health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney or Liver disease						
High blood pressure						
Heart disease or stroke						
Seizures						
Allergies						
Alcohol or drug abuse						
Mental illness/depression						
Musculoskeletal disorders						
HIV/AIDS						
Deceased						

LIFESTYLE HABITS

Cigarettes (packs/day) _____ Coffee/Tea (cups/day)_____ Soda (#/day) _____

Alcohol (drinks/week)_____ Drug use (recreational) _____

Exercise: Frequency_____Type _____

MEDICAL

Hospitalizations, emergency room visits, or serious medical problems or surgeries, please list:

Year	Operation/Illness	Hospital or Treatment Location

MEDICINES

_____

_____

_____

_____

MEDICAL PROBLEMS BY BODY SYSTEM (CURRENT AND PAST)

General
- ☐ Insomnia ☐Dreams/Nightmares
- ☐ Fatigue ☐ Poor memory

Strongly like ☐cold ☐hot drinks
- ☐ Recent weight loss/gain
- ☐ Cold hands/feet
- ☐ Chills ☐Fever

Head & Neck
- ☐ Headaches ☐Migraines
- ☐ Dizziness ☐Fainting
- ☐ Swollen Glands

Ears
- ☐ Ringing ☐Hearing loss
- ☐ Hearing aids
- ☐ Infections ☐Earache
- ☐ Vertigo

Eyes
- ☐ Glasses/contacts
- ☐ Blurred vision
- ☐ Poor night vision
- ☐ Spots of floaters
- ☐ Eye inflammation
- ☐ Double vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Lazy eye

Nose, Throat, Mouth
- ☐ Sinus Infection ☐Hay Fever
- ☐ Allergies
- ☐ Frequent sore throat
- ☐Mouth and tongue ulcers
- ☐ Frequent colds
- ☐ Nose bleeds ☐Dry nose
- ☐ Nasal congestion
- ☐ Loss of voice
- ☐ Thirst, dry mouth
- ☐ Excessive phlegm
- ☐ TMJ ☐Facial pain
- ☐ Dental or gum problems

Skin
- ☐ Hives, rashes, eczema
- ☐ Night or excess sweating
- ☐ Itching ☐moles/lumps

Respiratory
- ☐ Difficulty breathing
- ☐ Wheezing/Asthma
- ☐ Wet or Dry cough
- ☐ Cough up phlegm/blood
- ☐ Shortness of breath
- ☐ Tight chest
- ☐ Pneumonia
- ☐ Chronic cough

Cardiovascular
- ☐ High or low blood pressure
- ☐ Chest pain
- ☐ Palpitations
- ☐ Irregular heartbeat
- ☐ Bruise or bleed easily
- ☐ On blood thinners
- ☐ Swollen ankles
- ☐ Poor circulation
- ☐ History of heart disease
- ☐ Anemia
- ☐ Night sweats
- ☐ Heart attack or stents

Neurological
- ☐ Stroke ☐Seizures
- ☐ Tremors ☐Numbness
- ☐ Paralysis ☐Trauma

Gastrointestinal
- ☐ Nausea ☐Vomiting
- ☐ Acid reflux ☐Pain
- ☐ Bloating/Gas
- ☐ Poor/Excessive Appetite
- ☐ Hiccups ☐Bloody stool
- ☐ Constipation ☐Diarrhea

Mental/Emotional

- ☐ Depression
- ☐ Mood swings
- ☐ Irritability
- ☐ Difficulty relaxing
- ☐ Loneliness
- ☐ Sensitive
- ☐ Shyness
- ☐ Frequent crying
- ☐ Worries frequently
- ☐ Compulsive behaviors
- ☐ Difficulty focusing
- ☐ Hopeless outlook
- ☐ Suicidal thoughts
- ☐ Lose temper
- ☐ Frustration
- ☐ Other _____

Urinary system

- ☐ Painful urination/UTI history
- ☐ Frequent or urgent urination
- ☐ Incontinence
- ☐ Incomplete urination
- ☐ Bedwetting
- ☐ Wakes up to urinate
- ☐ Kidney issues _____

Gynecology

- ☐ Pregnancies: ☐Current ☐ Past:____Gravida____Para
- ☐ Menopause
- ☐ Irregular periods
- ☐ Excessive or ☐light flow
- ☐ Menstrual cramps
- ☐ Breast tenderness
- ☐ Abnormal PAP smear
- ☐ Vaginal infection
- ☐ Vaginal itching
- ☐ Uterine fibroids
- ☐ Endometriosis
- ☐ Breast lumps
- ☐ Increased or ☐Decreased libido
- ☐ Other _____

Trauma, Other Information

_____
_____
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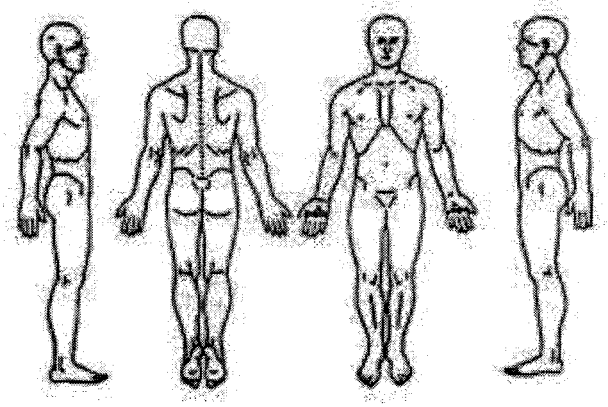
Pain

Please indicate below where you have issues you want addressed:



Informed Consent for Acupuncture Treatment at MindBody Med Seattle

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or the patient named below, for whom I am legally responsible) by Bethany De Marco, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while working or associated with, or serving as a backup for Bethany De Marco, L.Ac., including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to:

- *Acupuncture:* insertion of special sterilized needles or lancets at specific points or areas of the body
  - *electrical stimulation:* adding electrical impulses to the acupuncture needles
- *Moxibustion:* warming or indirect burning of mugwort on or near an acupuncture point
- *Cupping:* technique using glass or plastic cups on the surface of the skin with a heat-created or suction-created vacuum
- *Gua sha*: rubbing on an area of the body with a blunt, round instrument
- *Qi gong:* system of body postures, movements, breathing, and meditation techniques
- *Tui-Na* (Chinese massage): literally translated "pinch and pool" refers to a wide range of Traditional Chinese Medicine (TCM) therapeutic massage and bodywork techniques
- *Chinese nutritional counseling:* practice of using natural foods for healing

I have been informed that while not common, side effects can potentially occur from acupuncture treatment, including, but not limited to: pain, discomfort, bruising, bleeding, numbness or tingling near the needling sites that may last a few days, dizziness, fainting, headaches, burns, and temporary aggravation of symptoms existing prior to treatment. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising and general skin discoloration is a common side effect of cupping and gua-sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

To receive the safest, most beneficial care I agree to notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have read to me, this 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 Name (printed):_____

Patient Signature:_____Date:_____

Parent/Guardian Signature:_____Date:_____

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