Sean Rachlin, L.Ac., LMT

Personal Information

This record will be used to aid us in providing the best treatment possible for you. It will be kept strictly **CONFIDENTIAL**. Please read carefully and print or write legibly.

First Name_____ Last Name_____

Home Phone_____ Work/Mobile Phone_____ Email_____

Date of Birth_____ Age_____ Sex: M / F Height_____ Weight_____

Marital Status: Married / Single / Divorced / Widowed # of children_____ Occupation: _____

Primary Care Physician: _____ Specialty: _____ Phone #: _____

Emergency Contact Person: _____ Phone Number: _____

Have you received Acupuncture or Massage Therapy before? yes / no If yes, with whom? _____

Who should we thank for referring you to this office? _____

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What are the main health problems/concerns for which you are seeking treatment?_____

_____

What other forms of treatment have you sought? _____

List any other health problems you currently have. _____

Allergies, food sensitivities or food cravings? _____

Surgeries / Hospitalizations (include dates)_____

_____

Please list current medications and reason for taking them. (Include vitamins, drugs, herbs, etc)

Lab results (include copies)_____

Date of Last Check-up _____

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Family Medical History: (Mom, Dad, Siblings, Grandparents)				
	Diabetes	Cancer	Asthma	High Blood Pressure
	Seizures	Stroke	Heart Disease	Emotional Disorders
	Tuberculosis	Hepatitis	Rheumatic Fever	Infectious Disease

Do any of the above apply to you? If yes, please list_____

Occupational Stress (chemical, physical, psychological): Please Describe:_____

Do you have a regular exercise program? Yes / No Please Describe: _____

Have you ever been on a restricted diet? Yes / No Please Describe: _____

Please indicate the use and frequency of the following:

Coffee / Black tea _____ Tobacco _____

Alcohol _____ Soda _____

Water _____ Non-medical drugs _____

How do you feel about the following areas of your life? (family, diet, sex life, self, work, exercise, spirituality)

Comments:

Please Answer the Following Questions

1. Do you have a tendency to faint?	Yes	No
2. Do you have a pacemaker?	Yes	No
3. Do you bleed for a long time?	Yes	No
4. Have you ever had Hepatitis	Yes	No
5. Do you have HIV or AIDS?	Yes	No
6. Are you hungry now?	Yes	No
7. Are you tired?	Yes	No
8. Are you pregnant?	Yes	No

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The following is a list of symptoms which you may or may not have experienced. Please indicate as follows:
S = Sometimes Experience **F** = Frequently Experience

Cardiovascular: ____Shortness of Breath ____High Blood Pressure ____Irregular Heart Beat ____Heart Palpitation ____Dizziness ____Chest Pain or Pressure ____Leg Cramps

Respiratory: ____Cough ____Cough up Blood ____Sore Throats ____Nasal Problems ____Nose Bleed ____Pneumonia ____Hay fever ____Bronchitis

Gastrointestinal: ____Indigestion ____Abdominal Pain or Cramps ____Gall Stones ____Heartburn ____Belching or Burping ____Nausea and Vomiting ____Excess Appetite ____Decreased Appetite ____Excess Thirst ____Constipation ____Diarrhea ____Bloody or Black Bowel Movement ____Colitis/Diverticulitis

Skin: ____Ulcerations ____Rash ____Eczema ____Edema ____Acne ____Itchy ____Dry ____Greasy

Genitourinary: ____Frequent Urination ____Painful Urination _____Retention of Urine ____Incontinence ____Kidney Stones ____Bloody Discharge ____Genital Pain ____Decreased Sex Drive ____Venereal Disease

Men Only: ____Prostate Problems ____Testicular Pain ____Impotence ____Premature Ejaculation

Women Only: ____Pre-menstrual pain ____Menstrual Pain ____Irregular Menstrual Cycle ____ Hot Flashes ____Swelling/Pain of Breasts

Musculoskeletal: ____Back Pain ____Arthritis ____Muscle Pain or Cramps ____Muscle Spasms ____Joint Pain

Miscellaneous: ____Eye Problems ____See Spots or Floaters ____Blurry Vision ____Memory Loss ____Hearing Loss ____Ringing in Ears ____Headaches ____Insomnia ____Nightmares _____Mental Restlessness ____Easily Angered or Agitated ____Fatigue ____Fever ____Chills ____Night Sweats _____Intolerance to Cold ____Intolerance to Heat ____Cold Hands and/or Feet ____Soft or Brittle Nails ____Jaundice

Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or other Chinese Medicine procedures by Sean Rachlin, L.Ac., LMT. I understand that in addition to treatment by Sean Rachlin, L.Ac., LMT, care by a licensed physician is important and is strongly recommended.

Acupuncture, Moxibustion: I understand that acupuncture is performed by the insertion of pre-sterilized, one time use, surgical stainless steel needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Acupressure, Massage Therapy, Cupping, Gua-Sha: I understand that I may also be given Acupressure, Massage Therapy, Cupping or Gua-Sha as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment or stop the treatment if it is too uncomfortable.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and inform Sean Rachlin, L.Ac., LMT as soon as possible.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

HIPPA Privacy Act: Ensures that all of your personal and health information remains confidential at all times between this office, your insurance company and you. Should you have any questions about the privacy of your information at this office, you may ask Sean Rachlin, L.Ac., LMT at any time.

Payment Policies: Payment is expected at the time of your visit. I agree to pay for treatment sessions, co-payments, deductibles, and coinsurances for the services performed in the event that my health insurance policy does not cover those services or as required by my policy. I agree to pay for treatment if I cancel my appointment with less than 12 hours notice.

I have carefully read and understand all of the above information and I am fully aware of what I am signing. I understand that I may ask Sean Rachlin, L.Ac., LMT for a more detailed explanation of the procedures or treatment, other alternative procedures or methods of treatment and information about the material risks of the procedures or treatment. I give my permission and consent to treatment.

Signature of Patient or Legal Representative: _____ **Date:** _____