

WIND GATE ACUPUNCTURE AND INTEGRATIVE MEDICINE

Main office: 5230 Carroll Canyon Rd #110 San Diego, CA 92121 (800) 442 0374

Internet: <http://www.windgatehealth.com>

PATIENT INFORMATION

Patient's Name: _____ SS# _____ - _____ - _____ Sex: Male Female

Date of Birth: _____ Age: _____

Home Address:

Contact Phone: (_____) _____ Occupation: _____

Employer (School, if student): _____

Work/School Phone: (_____) _____

Employer/School Address:

E-mail Address: _____

Fax Phone: (_____) _____

Driver's License Number: _____

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: _____ SS# _____ - _____ - _____

Date of Birth: _____

Home Address:

Home Phone: (_____) _____ Occupation: _____

Employer: _____ Work Phone: (_____) _____

Employer Address: _____

Driver's License No.: _____

Main purpose of the consultation (Please give a brief summary of the main problems)

PERSONAL LIFESTYLE HABITS (how much, how many, or how often)

Cigarettes (packs)_____ Coffee/Tea (cups)_____ Alcohol (drinks per week)_____

Recreational drugs_____

Vitamins & herbs

Dietary restrictions _____

Food cravings _____

Diet: What might you eat on a typical day?

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Exercise_____ How often? _____

What non-work activities do you enjoy doing? (reading, TV, meditation, music, etc.)

MEDICINES:

Prescription drugs you are currently taking:	For what condition?
_____	_____
_____	_____
_____	_____
_____	_____

Over-the-counter medication you are currently taking:	For what condition?
_____	_____
_____	_____

Have you ever been treated with acupuncture &/ or Chinese herbal medicine before? Yes No

What was your experience?

Why did you seek the evaluation at this time? What are your goals in being here?

Prior attempts to correct problem(s)

(Please include contact with other professionals, medications, types of treatment, etc.)

Medical History

Past medical problems/medications:

Other doctors/clinics seen regularly: _____

Any history of head trauma? (describe): _____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe): _____

Present Height _____ *Present Weight* _____

Current Life Stresses

Sleep behavior: How long, quality, sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

GYNECOLOGY

Age of first menses: _____ Date of last menstrual period: _____ Duration of flow _____

Blood clots: yes no when: _____ Length of cycle _____

Color of menstrual blood: pale / bright / red / dark / red / brown other _____

Texture of menstrual blood: thick / thin / watery / normal

Pain: yes no when: _____

Irregular periods (describe): _____

PMS (please describe): _____

Current method of contraception: _____ Past method of contraception: _____

Are you currently pregnant? yes / no

Number of pregnancies:

Number of live births:

Number of miscarriages:

Number of abortions:

Any premature births:

Breast (lumps, cysts, tenderness, etc.): _____

Urinary tract infections: _____ How frequent? _____

Vaginal infections/ discharges (describe color): _____

Pain/itching of genitalia: _____

Pap smear: normal / abnormal _____ Date of last Pap smear: _____

Uterine fibroids: _____ Endometriosis: _____ Other: _____

Menopause (date of onset): _____ Symptoms: _____

Any bleeding since? _____

Are you currently on Hormone Replacement Therapy (HRT)? yes / no Dose: _____

How long have you been on HRT? _____ Any side effects? _____

Other:

Consent to Treatment

I hereby voluntarily consent to be treated by M. Andrew Pierson, L.Ac., with Oriental medical procedures, which may include Neurofeedback, Sound therapy, acupuncture, moxibustion, cupping, gua sha, acupressure, massage, Chinese herbal medicine, or nutrition and lifestyle counseling. M. Andrew Pierson is a licensed acupuncturist in the state of California.

I understand that acupuncture is performed by the insertion of sterile needles through the skin, or by the application of heat to the skin, or by both, at certain points on or near the surface of the body in an attempt to treat body dysfunctions or diseases and to normalize the body's physiological functions.

I understand that all of my patient records as well as information I share with my acupuncturist will be kept confidential. No records or information will be released without my written consent.

While acupuncture is generally a safe method of treatment, I am aware that certain side effects may result. These could include, but are not limited to, some local bruising, bleeding, dizziness, fainting, temporary pain and discomfort, numbness or tingling near the needling sites that may last a few days and temporary aggravation of symptoms in existence prior to treatment.

I am aware that if there is a worsening of my ailment or condition or if it does not improve within the time estimated by the acupuncturist, or if a new ailment or condition appears that I should consult my personal physician or any other licensed physician.

I understand that I should inform my acupuncturist prior to being treated if I believe I might be pregnant.

I understand that no guarantees concerning acupuncture's use and effects are given to me, and that I am free to stop acupuncture treatment at any time.

None of the foregoing provisions preclude the administration to me of conventional medical therapy by a licensed physician when such therapy is deemed appropriate.

I understand I will be charged the full fee for appointments cancelled with less than 24 hours notice.

I have carefully read and understand all the foregoing and so am fully aware of what I am signing. I have felt free to ask any questions.

Patient _____ Date _____