INFORMACION CONFIDENCIAL DEL PACIENTE

Nombre: ___________________________________ Tel #:______________________ Cel #________________

Dir: ______________________________________ Ciudad: _______________ Estado_____ Co. Postal_________

Fecha de Nacimiento _____________Edad: ____ M _ F _ Estatura: ____Peso:_____ Lic. Cond: ___________

Seguro Social__ ______________________Como escucho de nosotros? _________________________________

Razon de su visita ____

Alguna otra terapia ____

Nombre del Doctor: _____________________________ Tel # _______________ Fax #_______________

Direccion: ________________________________ Ciudad ___________________ Est_____ Co. Postal________

Diagnostico ____

Como esta respondiendo a su terapia? Mejor ______Peor ______ Igual _____

En caso de Emergencia: _________________________________ Tel:_____________________

Empleador: _________________________________ Ocupacion _____________________________

Direcciod de Trabajo_______________________________ Ciudad____________ Est_____ Co. Postal________

Accidente de trabajo?_______ Fecha del accidente_______________ Tel trabajo: _______________________

__________________________________ #Reclamo__________________ ____________________________

Aseguranza primaria | Tel. Aseguranza

____

Direccion | Ciudad | Estado | Codigo Postal

____

Ajustador de reclamo/Ext #

_________________________________ # Reclamo____________________ ___________________________

Aseguranza secundaria | Tel. Aseguranza

____

Direccion | Ciudad | Estado | Codigo Postal

Certifico que la informacion sometida en esta forma es verdadera en todo mi conocimiento.

Firma: ____ Fecha: ___________________________

HISTORIA MEDICA

Nombre:_______________________________ **Fecha :**___________

HISTORIAL MEDICO PASADO (include dates)
( ) Cancer ( ) Diabetes ( ) Cardiovascular ( ) Cerebral ( ) Enfermedad Venerea ( ) Convulsiones
( ) Hepatitis ( ) Tiroides ( ) Alcoholismo ( ) Alta presion
( ) Otra (explique) ____

HISTORIAL MEDICO FAMILIAR
( ) Cancer ( ) Diabetes ( ) Cardiovascular ( ) Cerebral ( ) Enfermedad Venerea ( ) Convulsiones
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( ) Otra (explique) ____

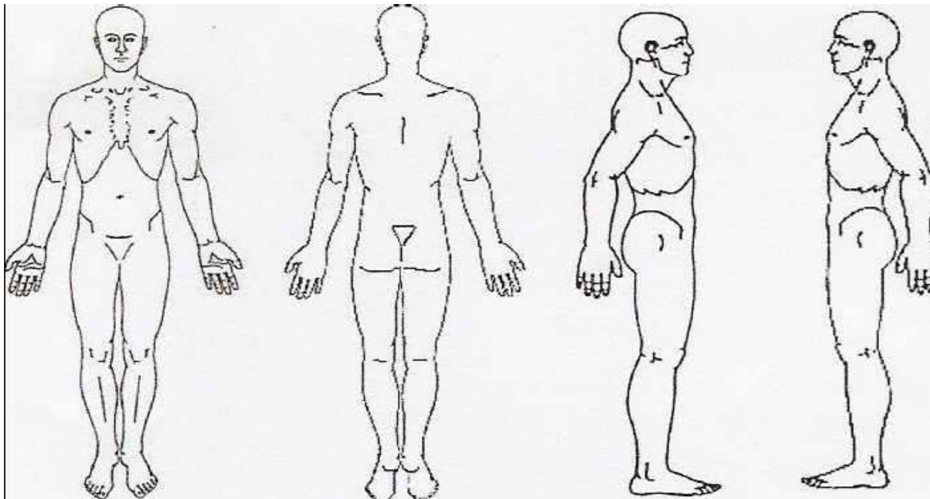
CIRUGIAS____

ALERGIAS (medicina, comida, ambiente) ____

MEDICAMENTOS (medicinas, vitaminas, and suplementos)
Name
___________________________ Dosis ___________________________
___________________________ Dosis ___________________________
___________________________ Dosis ___________________________
___________________________ Dosis ___________________________
___________________________ Dosis ___________________________

MUSCULOESKELETAL (Favor indicar en el diagrama abajo):

( ) Cuello ( ) Muscular ( ) Espalda ( ) Articulaciones ( ) Rodillas ( ) Manos/Munecas ( ) Pies/Tobillos



Como describiria el dolor:____

Que empeora lo sintomas:____

Que mejora los sintomas:____

Algun tipo de ejercicio? (duracion, frequencia)____

ACUPUNCTURE INFORMED CONSENT FOR EXAMINATION & TREATMENT

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 licensed acupuncturist or other licensed acupuncturists who now or in the future treat me while associated with or serving as back-up for the licensed acupuncturist working at the present clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, tui-na (Chinese massage), infrared light, gua-sha, Chinese herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including temporary pain and discomfort, possible temporary aggravation of prior existing symptoms, bruising and/or numbness near the needle sites that may last a few days. Dizziness or fainting may occur. 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.

Burns and/or scarring are potential risks of moxibustion, infrared light and cupping. Bruising is a common side effect of cupping and some types of tui-na (Chinese massage).

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that may be recommended are 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 gastrointestinal symptoms, headache, and rashes. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical and administrative staff to be able to anticipate and explain all possible risks and complications of treatment. I understand that results are not guaranteed and that judgment exercised by the clinical staff during the course of treatment will be based upon the facts then known is in my best interest.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent

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 understand that while this document describes the major risks of treatment, other side effects and risks may occur. 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 or Guardian Signature Date