!Please Print! TODAY'S DATE _____/_____/_____

Your Name_____ Sex: M / F Birth date ____/____/_____ Age _____

Address: _____ Phone: ( ) _____

City _____ State _____ Zip:_____ Email:_____

Social Security # _____ Driver's License # _____

Current Occupation: _____ Employer's Address and Phone: _____

_____

How were you referred to this office: friend / internet / newspaper / yellow pages / other_____

Name and phone of Your Primary Health Care Provider_____

Previous Diagnosis Regarding Your Condition_____

Other diagnosis or surgeries from your doctor _____

Prescribed medications/vitamins/supplements/herbs you are currently taking. Please list.

_____

Allergies to any drug or food that you know _____

Please check any of the following that applies to you:

DIABETES_____ HEPATITIS a,b,c _____ HYPERTENSION_____ PREGNANCY_____
TB _____ CHEMO/RAD_____ SEIZURES_____ HEMOPHILIA _____PACEMAKER_____
HIV/AIDS_____ NONE OF THE ABOVE APPLIED TO ME_____

Present Complaints: symptoms and how long time?

I need a bill from you to send to my insurance company: Yes / No (please circle)

By signing at the next consent page, I certify that I have read, understood and filled out the above questionnaire to the best of my knowledge.

(Please turn over and sign at the bottom of the second page)

INFORMED CONSENT TO ACUPUNCTURE AND HERBAL THERAPY

Qisheng Guan, L. Ac. OMD **Tel: (805) 965-6070**
1532 Anacapa Street, Suite 7 **(805)689-1979**
Santa Barbara, CA 93101

Print Patient's Name _____
Last Name First Name Middle Initial

I hereby request and consent to the performance of procedures that are within the scope of practice of acupuncture and oriental medicine, including but not limited to acupuncture, moxibustion, cupping, electro-acupuncture, herbal therapy, nutritional consultation and various modes of physiotherapy on me (or on the patient named above, for whom I'm legally responsible) by the acupuncturist named above.

I have had an opportunity to discuss with the acupuncturist named above the nature and purpose of acupuncture, moxibustion, cupping, electroacupuncture, herbal therapy, physiotherapy and other procedures. I understand that results are not guaranteed.

I understand and am informed that there might be some risks with acupuncture and herbal therapy, including but not limited to, slight bruising, tingling near the needling sites that may last a few days, dizziness, possible nausea or loose stool due to certain herbs depending on the sensitivity level and response of the individuals. I understand that I should inform the acupuncturist any allergic reactions to certain food and drugs I know. If I suspect I am pregnant, I will immediately inform the acupuncturist. If I experience any gastro-intestinal upset or allergic reactions to the herbs, I will inform the above named practitioner immediately.

I do not expect the acupuncturist named above to be able to anticipate and explain all possible risks and complications. I wish to rely on the acupuncturist to exercise judgments during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known, is my best interests. I accept arbitration if deemed necessary.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this content, and by signing below I agree to the above named proceures. I intend this consent form to cover the entire course of treatment for my present conditions and for any future conditions for which I seek treatment.

Cancellation Policy:
If you have to cancel or reschedule, please call at least 24 hours prior to the appointment to avoid being charged in full for your missed appointment. However, in order to serve our patients better we appreciate if you call as soon as possible if you know you can't keep your appointment.

Return Policy:
Patent herbs (not opened) can be returned for a refund or exchange for credit within 14 days. All the raw herbs or granules prescribed in a formula form cannot be returned, since the herbs are mixed together and wouldn't be used again if returned.

Signature of Patient or Patient's Representative **Date**

Relation or Authority of Representative ***Print Name of Patient's Representative***

PLEASE CHECK ALL THAT APPLY FOR YOU! THANK YOU!

□angery □ joyful □grief and sadness □ happy □fear
□ fright □ overthinking □drinking alcohol □smoking □allergies
□ anxiety □ depression □easily frightened □ irritable □bleeding, where ____
□bronchitis □easy bruising □brittle nails □couvulsions/spasm/tremors
□dull and dry hair/hair loss □indecisiveness □lumps, mass, tumors
□hysteria □sensation of object stuck in throat □ sighing
□shortness of breath/asthma □ulcers □weight gain/loss

□Always cold □always hot □ chills and fever together □alternate chills/ fever
□hot in palms / soles □ hot flushes □ night sweating □spontaneous sweating
□Sweat in palms/soles □shivering sweating □head sweat □half body sweat
□dry cough □cough with phlegm □dislike of wind □hoarse voice
□nasal congestion □sore throat □clear throat often

□headache □backache □lower back pain □shoulder pain
□toothache/swollen gum □knee pain □elbow pain □foot pain
□chest pain /fullness □ abdominal pain □stomach pain □leg pain
□general aching □hypochondriac pain □bearing down sensation in groin/scrotum
□muscle pain □neck/scapular pain □ numbness, where_____
□other pain,where_____ □paralysis/hemiplegia □edema

□dizziness/vertigo □heavy/tight head □heavy body □ low energy/fatigue easily
□numbness, where_____ □ tinitus □deafness □eye itching
□eyeache/red eyes □blurred vision /floaters □dry eyes □black-out
□night blindness □chest stuffines/distension □forgetfulness/memory loss
□palpitation □insomnia □dream-disturbed sleep □sleepiness □difficult wakeup

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□tastelessness □thirsty □ like cold drinks □ like warm/hot drinks □room temperature drinks □dry skin □not thirsty □dry mouth/nose/throat □dry throat □sore throat □poor appetite □very good appetite □dislike food □ craving_____ □bitter taste in mouth □sour taste in mouth
□salty in mouth □stickiness in mouth □nausea/vomiting □constipation
□hemorrhoids □incomplete stool □diarrhea /loose stool □ tenusmus
□smelly stool □gas and bloating □indigestion □acid regurgitation/reflux
□beltching/hiccups □bad breath □burning in anus/rectum □skin rash

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□scanty urine □yellow urine □profuse colorless urine □nocturnal urination
□frequent urination □enuresis □incontinence of urine □ painful urination
□burning urination □ incomplete urination □bladder/kidney stones □ Bloody urine
□cloudy urine □descending or sinking sensation in abdomen

□irregualr menses □early menses □delayed menses □painful menses
□clots/dark color □fresh red menses □pink menses □ light yellow pink
□irregular uterine bleeding □heavy menses □ no menstruation □breast tenderness
□excessive yellow/white leukorrhea □PMS □impotence
□low sex drive □infertility □nocturnal emission □premature ejaculation