WANG'S ACUPUNCTURE & HERBAL CLINIC

12610 N. Community House Rd. Ste. 204 704.968.0351
Charlotte, N.C 28277 www.ballantyneacupuncture.com

Patient Name: _____ Age: _____Birth Date: __/__/___ Gender: M/F _____

Address: _____ City: _____ State: Zip: _____

Telephone: (H) _____ (C) _____ (W) _____

Email Address: _____ Occupation: _____

Welcome *to Wang's Acupuncture & Herbal Clinic*! We are glad you have chosen us to help serve your healthcare needs. For you information, we use disposable sterile acupuncture needles, which are disposed of following OSHA guidelines for biochemical waste. We are state licensed acupuncturists, and national board-certified Acupuncturist's & Chinese Herbalists. Thank you again for choosing our clinic.

Consent for Treatment

I the undersigned, freely consent to treatment at *Wang's Acupuncture & Herbal Clinic* by national certified and state licensed acupuncturists. I understand that treatment may include the use of acupuncture needles, electrical acupuncture, infrared heat lamps, cupping, Chinese herb medicine (raw granules and patent forms, etc.), acupressure, Chinese massage (Tui Na), Chinese food therapy, and Chinese fitness and nutritional counseling.

I fully understand that the risks of treatment, although very limited, could include the following: slight burns from a heat lamp, slight bruising from cupping and needles, herbal side effects, or allergic reactions. (Some herbs and certain acupuncture points should not be used with pregnant females.) If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I understand that there is no guarantee that I will notice measurable results and that many factors such as lifestyle, motivation and willingness to participate in my own health care may affect the outcome of any alternative therapies. I understand that *Wang's Acupuncture & Herbal Clinic* does not promote the cessation of any prescription medications without a physician's approval.

I accept that *Wang's Acupuncture & Herbal Clinic* cannot be held liable for any intentional misrepresentations by me. I state that I have read the "Consent for Treatment" form in its entirety and understand and accept the risks involved in treatment.

Patient Signature: _____ Date: _____

New Patient Intake Form

Name: _____ Marital Status: M S W D Height: _____ Weight: _____

Your family physician/health care provider: _____ Phone: _____

Insurance Company _____ Policy # _____

Address: City, State, Zip _____

Phone: _____ Who referred you to us? _____

Emergency Contact: Name: _____ Phone: _____

Relationship to you: _____

Main conditions you would like us to help with: _____

_____

How long have you had this problem(s)? _____ Caused by: _____

Have you been given a diagnosis for this problem? If so, what is it? _____

_____

What kinds of treatment have you tried for the problem? _____

_____ How long? _____

Effectivness: _____

Past Medical History

Illness: _____

Surgeries: _____

Significant Trauma (e.g. Motor vehicle accidents, sports injury, etc.): _____

_____

Do you have or have you ever had any infectious diseases? Yes/No. If yes, please describe:

_____

Medications: Include prescritpions, over-the-counter drugs, vitamins, herbs, etc. taken within the last 3 months

_____

_____

Allergies: _____

Family Medical History General Health

Are there any hereditary diseases in your family? Yes/No. If yes, please describe:

_____

_____

Signature: _____ Date: _____

Personal Medical History
Significant Illnesses

- [ ] Cancer
- [ ] Hepatitis
- [ ] HIV (AIDS)
- [ ] Allergies
- [ ] Asthma
- [ ] Seizures
- [ ] Heart Disease
- [ ] Weight Problem
- [ ] Tuberculosis
- [ ] Herpes
- [ ] Diabetes
- [ ] Thyroid Disease
- [ ] Venereal Disease
- [ ] Addictive Disorders
- [ ] High Blood Pressure
- [ ] Rheumatic Fever
- [ ] Stroke
- [ ] Mental Illness
- [ ] Other:

Please check if you have experienced any of the following in the last 3 months

General:

- [ ] Poor Appetite
- [ ] Fevers
- [ ] Fatigue
- [ ] Tremors
- [ ] Cravings
- [ ] Headaches
- [ ] Localized Weakness
- [ ] Insomnia
- [ ] Strong Thirst
- [ ] Poor Balance
- [ ] Chills
- [ ] Sudden Energy Drop
- [ ] Peculiar Tastes or Smells
- [ ] Bleeding
- [ ] Weight Loss
- [ ] Weight Gain
- [ ] Joint Pain
- [ ] Hearing Loss
- [ ] Sweat Easily
- [ ] Change in Appetite
- [ ] Night Sweats
- [ ] Depression
- [ ] Emotional Changes
- [ ] Bruising Easily

Skin & Hair:

- [ ] Rashes
- [ ] Eczema
- [ ] Recent Moles
- [ ] Itching
- [ ] Hair Loss
- [ ] Change in Hair Texture
- [ ] Change in Skin Texture
- [ ] Dandruff
- [ ] Hives
- [ ] Ulcers
- [ ] Acne
- [ ] Psoriasis

ENT + Head & Eyes (HEENT):

- [ ] Dizziness
- [ ] Ringing in Ears
- [ ] Gum Problems
- [ ] Night Blindness
- [ ] Facial Pain
- [ ] Color Blindness
- [ ] Eye Pain
- [ ] Glasses
- [ ] Sinus Problems
- [ ] Headaches
- [ ] Blurred Vision
- [ ] Jaw Click
- [ ] Earaches
- [ ] Glaucoma
- [ ] Poor Vision
- [ ] Cataracts
- [ ] Concussion
- [ ] Poor Hearing
- [ ] Recurrent Sore Throat
- [ ] Sores on Lips
- [ ] Mouth Ulcers

Respiratory:

- [ ] Cough
- [ ] Wheezing
- [ ] Coughing Blood
- [ ] Bronchitis
- [ ] Phlegm
- [ ] Asthma

Cardiovascular:

- [ ] Blood Clots
- [ ] Phlebitis
- [ ] Chest Pain
- [ ] Fainting
- [ ] Dizziness
- [ ] Swelling of Feet
- [ ] Cold Hands or Feet
- [ ] Swelling of Hands
- [ ] Irregular Heartbeat
- [ ] Low Blood Pressure
- [ ] Shortness of Breath
- [ ] Difficult Breathing

Gastrointestinal:

- [ ] Nausea
- [ ] Belching
- [ ] Diarrhea
- [ ] Indigestion
- [ ] Bloating
- [ ] Constipation
- [ ] Hemorrhoids
- [ ] Parasites
- [ ] Blood in Stools
- [ ] Black Stools
- [ ] Bad Breath
- [ ] Intestinal Gas
- [ ] Abdominal Pain
- [ ] Vomiting
- [ ] Gastgric Ulcers

Genito/Urinary:

- [ ] Painful Urination
- [ ] Blood in Urine
- [ ] Genital Sores
- [ ] Urgent Urination
- [ ] Impotence
- [ ] Kidney Stones
- [ ] Scanty Urination
- [ ] Unable to Hold Urine
- [ ] Discolored Urine
- [ ] Frequent Urination
- [ ] Frequent Night Urination

Gynecology & Pregnancy (females only):

- [ ] Irregular period
- [ ] Clots
- [ ] Light Flow
- [ ] Heavy Flow
- [ ] PMS

Duratin of Flow _____
Painful Periods _____
Age of First Menses _____
Date of Last Menses _____
Last PAP _____

# of Pregnancies _____
# of Births _____
# of Miscarriages _____
# of Abortions _____
# of Premature Births _____

- [ ] Difficult Births
- [ ] Fertility Problems
- [ ] Breast Lumps
- [ ] Vaginal Discharge
- [ ] Vaginal Sores

Personal Medical History
Significant Illnesses

Neuro-Psychological

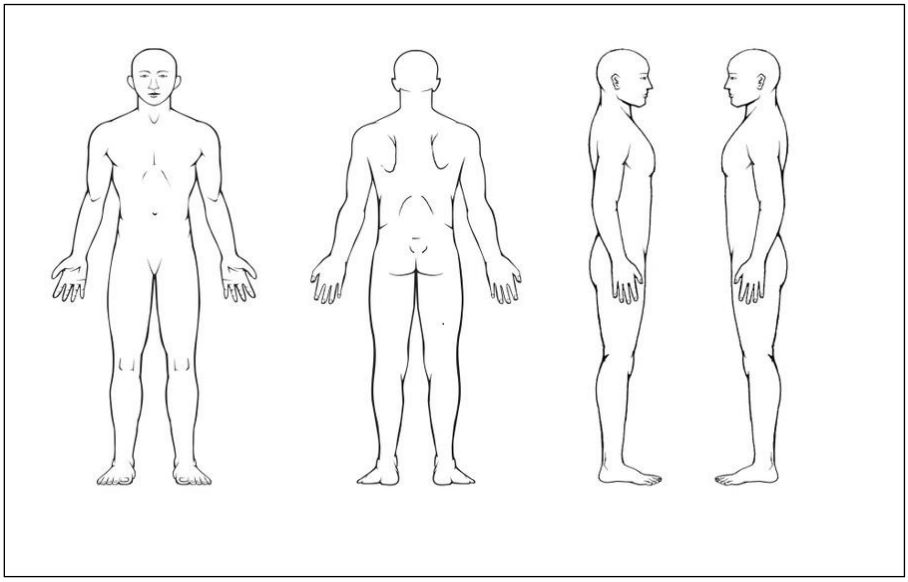
☐ Seizures	☐ Areas of Numbness	☐ Concussion	☐ Loss of Balance
☐ Dizziness	☐ Lack of Coordination	☐ Depression	☐ Mood Swings
☐ Stress	☐ Poor Memory	☐ Anxiety	☐ Irritability
☐ Disorientation	☐ Migraines	☐ Easily Angered	☐ Headache

Have you ever received psychiatric treatments? _____
Have you ever considered or attempted suicide? _____
Any nervous habits? _____
Any other problems you would like us to be aware of? _____

Musculo-Skeletal

☐ Neck Pain	☐ Back Pain	☐ Joint Pain	☐ Muscle Spasms	☐ Hand/Wrist Pain
☐ Scoliosis	☐ Shoulder Pain	☐ Knee Pain	☐ Muscle Cramping	
☐ Hip Pain	☐ Arthritis	☐ Muscle Weakness	☐ Muscle Soreness	
☐ Recent Sprains	☐ Weak Joints	☐ Injuries	☐ Foot/Ankle Pain	

Please Circle Any Areas of Pain or Injury
Please be prepared to describe the type and quality of pain



COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:
  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell _____
- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient Signature:	_____	Parent / Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name:	_____
Date	_____	Date	_____	Date:	_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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:

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)