WANG'S ACUPUNCTURE & HERBAL CLINIC

12610 N. Community House Rd. Ste. 204
Charlotte, N.C 28277

704.968.0351
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 your 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: _____

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