# Wang's Acupuncture & Herbal Clinic

**BALLANTYNE OFFICE LOCATION:**
**12610 N. Community House Road Suite 204, Charlotte, NC 28277: 704.968.0351**

Patient Name: _____ Age: _____ Birth Date: ___/___/___ Gender: M/F

Address: _____City: _____State: _____ Zip: _____

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

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 Acupuncturists & Chinese Herbologists. 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 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: _____

**Please complete the next two pages of this form.**

## New Patient Intake Form

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

Your family Physician/heath care provider: _____ Phone: _____

Insurance Co. _____ Policy # _____

Address: City, State, Zip _____

Phone: _____ Who referred you to us? _____

In an emergency notify: Name: _____

Phone: _____ Relationship to you _____

Main conditions you would like us to help you with? _____

_____

How long have you had this problem? _____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? _____

Effectiveness: _____

### 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:

_____

Medicines: (Include prescriptions, 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
❑ Join 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
❑ Migraine
❑ Eye Strain
❑ Teeth Grinding
❑ Floaters
❑ Spots in front of Eyes
❑ Nose Bleeds
❑ Recurrent Sore Throat
❑ Sores on Lips
❑ Sores on Lips
❑ Mouth Ulcers
❑ Toothache

**Respiratory:**

❑ Cough
❑ Wheezing
❑ Coughing Blood
❑ Bronchitis
❑ Phlegm
❑ Asthma
❑ Shortness of Breath
❑ Easily Winded
❑ Painful Breathing

**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
❑ Gastric 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
❑ Duration 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**