**PATIENT INFORMATION CHINOOK FAMILY ACUPUNCTURE**

Dr.Rita Wendrich TCMD, Reg. Acupuncturist

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*AGE: \_\_­­­­\_\_\_\_\_\_\_ BIRTHPLACE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSTAL CODE: \_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER(S): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT, NAME AND NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_ \*WEIGHT (ACTUAL & IDEAL):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # OF CHILDREN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION & HOURS WORKED PER WEEK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MAIN HEALTH CONCERNS:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURGERIES WITH APPROXIMATE DATES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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MAJOR TRAUMAS (CAR ACCIDENTS, FALLS ETC): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL HISTORY – PLEASE MARK AND CIRCLE ALL THAT APPLY:**

|  |  |  |  |
| --- | --- | --- | --- |
| * AIDS/HIV
 | * ALLERGIES
 | * ARTHRITIS R. OR O.
 | * ASTHMA
 |
| * AUTOIMMUNE DIS.
 | * \*BP HIGH OR LOW
 | * CANCER
 | * \*CHOLESTEROL
 |
| * CHRONIC FATIGUE
 | * \*DIABETES I OR II
 | * EPILEPSY/SEIZURES
 | * FIBROMYALGIA
 |
| * \*HEART DISEASE
 | * HEPATITIS A/B/C
 | * HERPES Z OR V
 | * LUNG DISEASE
 |
| * LYME DISEASE
 | * MENTAL ILLNESS
 | * MULT.SCLEROSIS
 | * POLIO
 |
| * STROKE
 | * SKIN DISORDERS
 | * THYROID HI/LOW
 | * TB
 |
| * ULCERS
 | * OTHER:
 |

**ALLERGIES & SENSITIVITIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS AND SUPPLEMENTS**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**EXERCISE LEVEL:** ACTIVE DAILY \_\_\_\_\_\_\_\_\_MODERATE \_\_\_\_\_\_\_\_\_INACTIVE\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| * \*NICOTINE (PER DAY):
 | * \*ALCOHOL (PER WEEK):
 | * DRUGS (TYPE&FREQUENCY):
 |

|  |
| --- |
| **BASIC NUTRITION & DIET OF A TYPICAL DAY:** |
| BREAFAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | LUNCH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DINNER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | SNACKS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\*FAMILY HEALTH HISTORY (SIBLINGS, PARENTS AND GRANDPARENTS IF KNOWN):**

|  |  |  |  |
| --- | --- | --- | --- |
| * ALCOHOLISM
 | * ARTHRITIS
 | * AUTOIMMUNE DIS.
 | * BLOOD PRESSURE
 |
| * CHOLESTEROL
 | * DEPRESSION
 | * DIABETES I OR II
 | * \*HEART DISEASE
 |
| * MENTAL ILLNESS
 | * M.SCLEROSIS
 | * SEIZURES
 | * STROKE
 |

WAIVER/RELEASE FORM CHINOOK FAMILY ACUPUNCTURE

I understand that with the practice of acupuncture there can be minor risks associated such as slight bruising, local soreness, and a low risk of infection. This risk can be decreased further by observing proper hygiene and cleanliness before and after treatments.

I understand that Dr. Rita Wendrich has been trained in risk management in relation to acupuncture and carefully observes clean needle technique, and universal precaution protocols in order to protect her patients and herself from any infectious disease or cross-contamination of body fluids.

I understand that Dr. Rita Wendrich uses only sterile, one-time-use, disposable needles to eliminate any risk of needle contamination.

I understand that there can be emotional and physical changes as a result of an acupuncture treatment and that sometimes with acupuncture, ailments can appear to get worse before they get better and that this is a normal response.

I understand that if I have any concerns about my treatments, or my results I will contact Dr. Rita Wendrich immediately and directly, or in case of emergency I will contact another health care provider, regarding these concerns so that my treatments can be adjusted or I can be referred to another type of practitioner as my condition dictates.

I understand that I am to do my best to keep the points used clean and warm after a treatment and I will protect them from cold and wind especially.

I understand that although Dr. Rita Wendrich is in a position to assist me with balancing and maintaining my health and well-being, it is ultimately up to me, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to care and nurture for myself, as well as engage in appropriate lifestyles for my constitution in order to receive maximum health and healing.

I understand that if a I am under western medical care I will disclose to my doctor that I am receiving acupuncture and or herbs. I also understand that if my doctor has any concerns I can give him/her permission to speak with Dr. Rita Wendrich directly regarding my condition(s).

I understand that traditional Chinese herbs are sometimes potent and are prescribed to me specifically. I will disclose any and all pharmaceuticals, supplements, or any other medicines I am taking to Dr. Rita Wendrich in order to negate the possibility of interactions with this. I also understand while taking some pharmaceuticals such as blood-thinners, some Chinese herbs cannot be prescribed and this is in my best interest.

I acknowledge and consent to receiving traditional Chinese medical treatments for Dr. Rita Wendrich and I will do my best to take part in my own health and wellbeing.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_