Sloth Around Community Acupuncture & Wellness

10223 17th Ave. SW • Seattle, Wa • 98146

PATIENT INFORMATION

Date_____

Name_____

Address_____

City State Zip_____

Age_____ Birthdate _____

Gender Identity_____Preferred pronoun_____

Occupation _____

Company name _____

Primary physician _____

Have you had acupuncture before?_____

CONTACT INFORMATION

Primary Phone _____

Other phone _____

Email _____

How did you hear about us?

_____

Another person we may contact if needed:

Name _____

Relationship_____

Phone _____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- _____

2 - _____

3 - _____

How is your sleep? _____

_____

How is your digestion? _____

_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Circle illnesses that have occurred in blood relatives.
Diabetes Stroke Cancer Heart disease Lung disease Kidney disease Autoimmune disease

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ HIV/AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

□ Tremors or Cramps
□ Swollen joints

Pain, weakness, numbness in:

□ Arms or legs
□ Back or hips
□ Feet
□ Neck
□ Hands
□ Shoulders
□ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

□ Asthma/wheezing
□ Blurred or failing vision
□ Difficulty breathing
□ Earache
□ Enlarged glands
□ Eye pain
□ Frequent colds
□ Hay fever
□ Hoarseness
□ Gum trouble
□ Nose bleeds
□ Loss of hearing
□ Persistent cough
□ Ringing in ears
□ Sinus problems

SKIN

□ Boils
□ Bruise easily
□ Dry skin
□ Itching/rash
□ Sensitive skin
□ Sore won't heal
□ Sweats

GENITO/URINARY

□ Blood/pus in urine
□ Frequent urination
□ Inability to control urine
□ Kidney infection/stones
□ Lowered libido

CARDIOVASCULAR

□ Chest pain
□ Hardening of arteries
□ High or low blood pressure
□ Pain over heart
□ Poor circulation
□ Previous heart attack
□ Rapid/irregular heart beat
□ Swelling of ankles

GASTROINTESTINAL

□ Belching, gas or bloating
□ Colon trouble
□ Constipation
□ Diarrhea
□ Difficulty swallowing
□ Distention of abdomen
□ Excessive hunger
□ Gall bladder trouble
□ Hemorrhoids (piles)
□ Indigestion
□ Nausea
□ Pain over stomach
□ Poor appetite
□ Vomiting

REPRODUCTIVE HEALTH

□ Erection difficulties
□ Penis discharge
□ Prostate trouble

GYNECOLOGY

□ Bleeding between periods
□ Clots in menses
□ Excessive menstrual flow
□ Extreme menstrual pain
□ Irregular cycle
□ Menopausal symptoms
□ PMS
□ Previous miscarriage
□ Scanty menstrual flow

Could you be pregnant?_____

SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature_____ Date _____

Informed Consent for
Sloth Around Community Acupuncture & Wellness
10223 17th Ave SW • Seattle, WA • 98146

In accordance with WAC 246-82-120, we bring the following to your attention:
1. Practitioner's Qualifications:
Lynn Bondi, EAMP, American College of Traditional Chinese Medicine, MA, 2002, WA DOH, license # AC60302380.
My Nhung Kolb, EAMP, Bastyr University, MA, 2016, WA DOH, license # AC60739081
2. Scope of Practice: The scope of practice for an acupuncturist in the state of Washington includes but is not limited to, use of acupuncture needles to stimulate acupuncture points and meridians and dietary advice based on traditional Chinese medical theory.
3. Side effects such as local bruising, needle sickness, broken needles, pain at site of insertion, infection, pneumothorax, temporary aggravation of symptoms that existed prior to treatment are rare but possible.
4. Patients with severe bleeding disorders or pace makers should inform practitioner prior to any treatment. Please inform us if you are pregnant.
5. Please turn off your cell phone before entering the treatment area. Thank You.
6.To reduce the possibility of infection, all needles are pre-sterilized, one-time-use-only, made of surgical stainless steel. In accordance with WAC 246-802-110: If you are affected by any of the following conditions, we are required to request that you consult with a physician and provide a written diagnosis from him/her, or have the physician call us: Cardiac conditions including uncontrolled hypertension, Acute abdominal symptoms, Acute undiagnosed, neurological changes, Unexplained weight loss or gain in excess of fifteen percent body weight within a three month period, Suspected fracture or dislocation; Suspected systemic infection; Any serious undiagnosed hemorrhagic (bleeding) disorder; and Acute respiratory distress without previous history or diagnosis.
7. I understand that acupuncture is practiced in a group setting at Sloth Around . I understand that my conversations in the group room may be overheard by others sitting nearby. I understand that if I need to have a private conversation with the acupuncturist, it is best to do so by telephone or by scheduling an appointment to talk privately. I understand that Sloth Around may document in writing medical and other information concerning my treatment. I understand that Sloth Around abides by federal regulations regarding patient privacy and will keep my information confidential. I understand that my information may be shared if required by law or if I have given express written permission.

8. I understand that there is a $20 fee for missed appointments or appointments that are not cancelled 24 hours before the appointment time.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Sloth Around Community Acupuncture regarding cure or improvement of my condition. I hereby release Sloth Around Community Acupuncture from any and all liability which may occur in connection with the above mentioned procedures. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

_____
Name (Please print)

_____ _____
Signature of patient date