Kenton Sefcik Acupuncture & Chinese Medicine

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Comprehensive Patient Profile for Chinese Medicine Visit

Please note that Chinese Medicine views the body as an intricate relationship between organs and systems. In order to fully understand your condition, it is important that you take the time to fill out this form.

Full Name: _____ Date of Birth (mm/dd/yy):_____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: _____ (Home) _____ (Work)

Occupation: _____ Marital Status: _____ Biological Sex: ____ (M/F)

Emergency Contact: _____ Phone Number: _____

How did you hear about the clinic? _____

Primary Health Concerns

Please list your primary health concerns/chief complaints:

1. _____
2. _____
3. _____
4. _____
5. _____

Of which of these concerns is the most important to you? _____
Do you have a pacemaker or hearing aid? (Y/N) *Are you pregnant?* (Y/N or N/A)

Allergies

Please list any allergies you may have: _____

_____

Medications

Please list all medications you are currently taking including vitamins, herbal and illicit:

_____

_____

Please list how often you smoke and/or use alcohol:

_____

Hospitalizations

Please list to the best of your ability the times you have been hospitalized:

Illness/Procedure	Date	Hospital

Blood Borne, Insect Borne and Sexually Transmitted Diseases

Due to the fact acupuncture is an invasive procedure, for your safety and others, please check if you are experiencing any of the following:

☐ HIV/Aids
☐ Hepatitis B
☐ Hepatitis C
☐ Chlamydia
☐ Encephalitis
☐ Genital Warts
☐ Gonorrhea
☐ Herpes
☐ Malaria
☐ Pelvic Inflammatory Disease
☐ Syphilis
☐ Trichomonas
☐ Tuberculosis
☐ Other: _____

Goals

What are some of your health goals? _____

_____

If your quality of health was improved, what would that allow you to do that you are currently unable to do? _____

_____

If there aren't any medications that interact, would you be open to trying Chinese herbs if it would speed your recovery?

_____

Release of Information to Physician

Medical Doctor's Name: _____

Address: _____

Phone number: _____

I authorize Kenton Sefcik to disclose the patient/client's health information enclosed to the individual identified above. I understand I may revoke this consent in writing at any time.

_____ _____ ____/____/____

Client Name *Client Signature* *MM DD YY*

Please read the following Informed Consent form and sign below.

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture if necessary, including but not limited to needling, moxibustion, cupping, electroacupuncture, tuina (massage), herbal recommendations, dietary recommendations, qigong (moving meditation), lifestyle suggestions and other techniques within the scope of practice of a Practitioner of Chinese Medicine.

I understand the nature and purpose of acupuncture, other procedures and alternative care. I further understand and am informed that, as in all health care, in the practice of acupuncture, even though the needles are pre-sterilized and once-use-only disposable, and all equipment is cleaned and disinfected after use there are some slight risks to treatment including, but not limited to temporary soreness, bruising, burning, nausea, fainting, bleeding, infection and shock. I do not expect the acupuncturist to be able to anticipate all risks and complications. I wish to rely on the acupuncturist to be able to exercise judgment during the course of the procedures which the acupuncturist feels at the time, based upon facts then known, are in my best interest.

I have read the above consent and have had the opportunity to ask questions if necessary. I intend this consent to cover the entire course of treatment for my present condition(s) and for any future condition(s) for which I seek treatment.

_____ _____ ____/____/____

Client Name *Client / Guardian Signature* *MM DD YYYY*

Time Guarantee

I value your time. I will call you if I am running more than 15 minutes late. I request that you call the clinic if you are running 15 minutes late, as well. I also require a 24-hour cancellation notice. Missed appointments or late cancellations will be billed for an amount of $30.00.

PLEASE INITIAL _____

End of Document

The Following is for Practitioner Use Only

Chills/Fever:

Perspiration:

Urinary System:

Bowel System:

Gastrointestinal/Digestion System:

Appetite:

Sleep Patterns:

Pain & Headaches:

Sexual Function & Drive:

Menstrual Patterns/Discomforts:

Pregnancies & Complications:

Motivations/Expectations:

Other Concerns:

Chinese Medicine Diagnosis:

Treatment Protocol/Notes: