ACUPUNCTUREWITH**STEVE**

Steven D. Kanovitz, L.Ac.
818.860.1735

Patient Information

Date_____
Name_____
Address_____
City State Zip_____
Age_____Birthdate_____
Occupation_____
Company Name_____
Primary Physician_____
Physician Phone Number_____
How did you hear about us?_____
_____

Contact Information

Home Phone_____
Work Phone_____
Other/Cell Phone_____
Email_____
Allow limited email contact from Acupuncture With Steve?
☐ Yes ☐ No

Emergency Contact_____
Relationship_____
Home Phone_____
Work Phone_____
Cell Phone_____

Health History

In order of importance, please list your primary concerns for coming in for treatment and indicate if you have seen any other specialists for these conditions (Yes or No/Name of Specialist):

1._____
_____
_____
2._____
_____
_____
3._____
_____
_____

How is your sleep?_____
_____
How is your digestion?_____
_____
List medications/food supplements you are taking_____
_____
List serious illnesses/accidents/surgeries_____
_____
_____

Check illnesses that have occurred in blood relatives:

□ Diabetes □ High Blood Pressure □ Cancer
□ Heart Disease □ Blood Disorder □ Seizures
□ Arthritis □ Stroke □ Kidney 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:

□ AIDS
□ Allergies
□ Anemia
□ Arthritis
□ Bleeding disorders
□ Breast lump
□ Cancer
□ Diabetes

When was your last complete medical exam?_____
_____

Does your blood clot normally? ☐ Yes ☐ No

Health History…continued

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 Hips
□ Back Legs
□ 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

FOR MEN ONLY
□ Erection difficulties
□ Penis discharge
□ Prostate trouble

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

Age of first period_____

Date of last period_____

Age of menopause_____

Are you, or could you be, pregnant now? □ Yes □ No

Signature

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

Signature_____ Date_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Steven D. Kanovitz, L.Ac. (Steve).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Steve of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Steve if I am or become pregnant.

While I do not expect Steve to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on Steve to exercise judgment during the course of treatment which he thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand Steve may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

ACUPUNCTURIST NAME: Steven D. Kanovitz (Date)

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)