New Client Questionnaire for Dr. Vadim Chalov, LAc

373 S. Monroe Street, Suite 103 San Jose, CA 95128

Name_____

Address_____

Phone #_____ Work #_____

Emergency Contact (name & #)_____

Birthdate_____ Age_____

Occupation/Employer_____

Email_____

Health Insurance Info:_____

_____

_____

Western medications currently taking:_____

_____

Nutritional supplements, vitamins, herbs, etc._____

_____

Allergies:_____

Do you exercise regularly?_____ What kind?_____

Health habits: Cigarettes?_____ How many?_____

Alcohol?_____ How much?_____

Caffeine? _____ How much?_____

Sweets?_____ How much?_____

Vegetarian, vegan, or carnivorous?_____

Late night or morning person?_____

Stress level of lifestyle high or low?_____

Height: _____ Weight: _____

What brings you to seek acupuncture today?_____

_____

_____

Have you had acupuncture before?_____

Have you taken Chinese herbs before?_____ If yes, what form?_____

Symptom checklist

Gastrointestinal:

( ) Poor appetite ( ) Excess appetite
( ) Weight loss ( ) Weight gain
( ) Nausea ( ) Vomiting
( ) Diarrhea ( ) Constipation
( ) Belching ( ) Flatulence
( ) Hiccups ( ) Bloating after meals
( ) Acid regurgitation ( ) Irritable bowel syndrome
( ) Other_____

General

( ) Fatigue ( ) Hyperactivity ( ) Dizziness/fainting
( ) Insomnia ( ) Sleeping too much ( ) Nightmares
( ) Feeling of heaviness ( ) Daytime sweating ( ) Night sweats
( ) Hot flashes ( ) Fevers ( ) Chills ( ) Cold hands/feet
( ) Muscle cramps ( ) Poor circulation
( ) Joint pain---where?_____
( ) Other_____

Head and Neck

( ) Eye pain ( ) Itchy/red eyes ( ) Blurred vision
( ) Floaters ( ) Poor night vision ( ) Glaucoma
( ) TMJ ( ) Swollen gums ( ) Mouth sores
( ) Dry mouth ( ) Toothache ( ) Sore throat
( ) Nosebleeds ( ) Stuffy nose ( )Sinusitis ( ) Allergies
( ) Poor hearing ( ) Ringing in ears ( ) Ear pain
( ) Stiff neck
( ) Headaches----------location:_____
frequency:_____
( ) Other_____

Respiratory

( ) Shortness of breath ( ) Asthma/wheezing
( ) Cough ( ) Excess phlegm production ( ) Blood in sputum
( ) Other_____

Cardiovascular

( ) Palpitations ( ) Chest pain ( ) High blood pressure
( ) Low blood pressure ( ) Rapid heart rate
( ) Irregular heart beat ( ) Other_____

Urinary ( ) Frequent urine ( ) Painful urine ( ) Urgent urine
( ) Difficult urine/incomplete urination ( ) Kidney stones
( ) Waking up at night to urinate---how many times?_____

Skin and Hair ( ) Rashes ( ) Acne ( ) Hives ( ) Eczema
( ) Psoriasis ( ) Dandruff ( ) Itching
( ) Hair loss ( ) Brittle hair
( ) Other_____

Neurological ( ) Seizures ( ) Numbness ( ) Tingling ( ) Muscle twitches
( ) Low back pain ( ) Shoulder pain ( ) Hip pain
( ) Leg pain ( ) Knee pain ( ) Ankle pain ( ) Foot pain
( ) Arm pain ( ) Elbow pain ( ) Hand pain ( ) Wrist pain

Emotional ( ) Irritability ( ) Excess anger ( ) Mood swings ( ) Depression
( ) Anxiety ( ) Suffered recent shock ( ) Stress
( ) Difficulty concentrating ( ) Poor memory

Gynecological ( ) PMS ( ) Painful periods ( ) Irregular cycle
( ) Heavy menstrual flow ( ) Scanty menstrual flow
( ) Amenorrhea---how long since last menses?_____
( ) Peri-menopause ( ) Post-menopause
( ) Breast tenderness ( ) Breast lumps
( ) Vaginal discharge ( ) Chronic yeast infection

Endocrine/Constitutional ( ) Diabetes Type I / II
( ) Hypothyroid ( ) Hyperthyroid
( ) Immune disorder _____
( ) Hepatitis _____
( ) Cancer_____

Other:_____
_____

INFORMED CONSENT FORM FOR ACUPUNCTURE PATIENTS

Please read this information carefully, and ask the practitioner to clarify any parts you do not understand.

Acupuncture and Chinese medical treatments are shown to be very effective for maintaining physical well-being and ameliorating many complaints. Though many patients undergo treatments without undesirable side effects, practitioners are required to advise patients of the possible risks of acupuncture.

Any of the following side effects can occur, though it is not possible to anticipate all of the complications which may arise in each individual case. If there are specific risks which apply in your case, the practitioner will discuss these with you.

Possible side effects of acupuncture include:

---Drowsiness may occur. If affected, one might wish to refrain from operating a motor vehicle. One might also ask for help getting down the stairs if dizziness occurs.

--- Fainting may occur during or after the treatment, especially in patients prone to fainting, and especially during the first treatment.

---Minor bleeding or bruising may occur at the sites of the acupuncture needles.

---In less than 3% of patients, symptoms may become initially worse before they improve for 1-2 days following the treatment. This is often a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.

Possible side effects of cupping:

---Bruising at the sites of the cups, in a circular shape, is very common, and it self-resolves in several days. The marks may be light or dark purple.

Regarding Chinese herbal supplements:

---The herbs, formulas, and nutritional supplements from plant, animal and mineral sources that have been recommended have been regarded as safe traditionally in the practice of Chinese medicine, although some may be toxic in large doses or inappropriate during pregnancy. If you are a vegetarian, only formulas from plant or mineral sources will be given.

Regarding electro-acupuncture:

---People with pacemakers or other electrical implants should not have electro-acupuncture. Please inform the practitioner if you have one.

Please let the practitioner know if:

---If you have ever experienced a fit, a faint, or other odd sensations
---If you have a pacemaker or other electrical implants
---If you are pregnant
---If you have hemophilia or a bleeding disorder
---If you are taking anti-coagulants (blood thinners) or other medications
---If you have damaged heart valves or any other particular risk of infection

STATEMENT OF CONSENT

I confirm that I have read and understood the above infromation, and I consent to having treatments and procedures from this clinic. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. ***I also understand that I can refuse treatment at any time.***

I wish to rely on my practitioner to exercise judgment during the course of the treatment which, based upon the facts known at that time, is in my best interests. I understand that the practitioner may request to review my medical records and lab reports, but that 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 this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had the opportunity to ask questions of the practitioner. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

_____Print name in full

_____Signature

_____Date

MISSED APPOINTMENT POLICY

Please call at least 24 hours in advance to cancel an appointment. Any no shows or late cancellations will be charged full price for the appointment.

I here by agree t opay for all missed appointments.

Signed_____ __Date_____