Kim Silsby, L.Ac. at Los Gatos Chiropractic and Wellness Center

Confidential New Patient Forms

Name: _____ Date _____

Address: _____

City, State, Zip_____

Which phone # is best to reach you? _____

Email:_____ Date of birth: _____ Age: _____

Relationship status: _____ Emergency contact and phone number: _____

How were you referred to White Peony Acupuncture? _____

Fees for services

Initial Consult and Acupuncture: $190
Established client acupuncture: $110
Consult 30/60 minutes, no acupuncture: $50/$100
Missed appointment fee: $100

You are required to pay the provider for services at each visit. We are out of network with insurance.

Receipts are available upon request.

Please note we request a 24 hour cancellation of appointment by phone/email.

Missed appointment fee is $100.

I have read and understand my responsibility for payment of services.

_____ _____

Patient Signature Date

Reasons for starting acupuncture with us? _____

Health History –Please include approximate date(s):

Acne, Eczema, Psoriasis, Rosacea, other skin disorders
Addiction: Alcohol/Cigarette/Drug
AIDS, HIV Positive
Allergies/Ashma/ lung disorders
Arthritis/other joint concerns
Blood Pressure-High or Low
Blood clotting or any bleeding disorder
Cancer/Lymphoma
Depression, Anxiety, Mood Disorder
Diabetes/Hypoglycemia
Digestion/Stomach/Intestinal Disorder
Dizziness/Vertigo/Epilepsy
Fatigue, Lethargy
Fibromyalgia or Chronic Fatigue
Frequent Colds/Flus/ Low Immunity/Auto-immune Disorder
Headaches/Migraine
Heart Disorder
Kidney/ Urinary problems
Liver Disorder/Hepatitis/Cirrhosis
Neurological Disorder/Paralysis/Stroke
Pain
Sleep Disorder/Insomnia
Thyroid/Endocrine Disorder
Please list any other:

Please list the name(s) of your current health care providers:

Please list the **medications, vitamins, and supplements** you are currently taking:

Please list known **allergies** to environment, food, supplements, or medications:

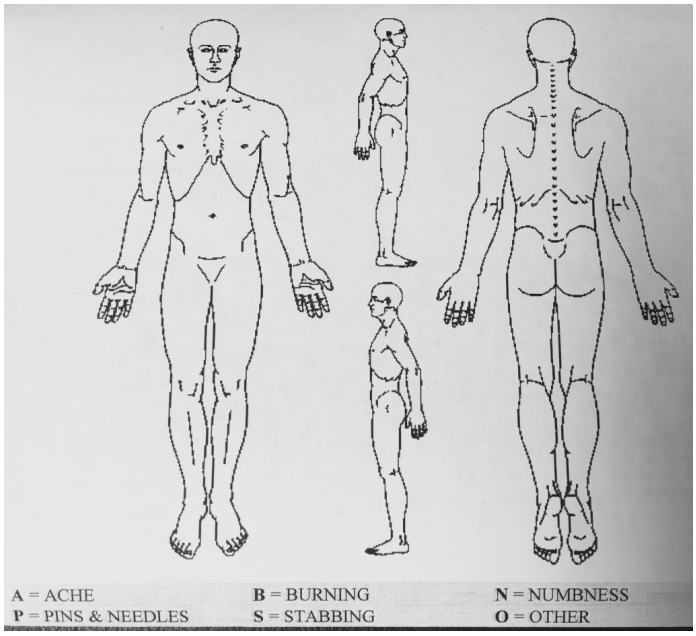
Please list **surgeries** you have had and the date(s):

Where would you rate your stress level on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

Where would you rate your energy level on a scale of 1-10? 1 2 3 4 5 6 7 8 9 10

Where do you experience pain? Please see illustration below and indicate your pain.

When did the pain begin, and was there an injury or an event which initiated it?



What is the severity of pain **today?** : 0 1 2 3 4 5 6 7 8 9 10

What is the severity of pain **usually?** 0 1 2 3 4 5 6 7 8 9 10

Please describe any digestion/elimination problem: _____

_____

Please describe any problems with sleep: _____

Do you experience hot flushing or sweating during the day/night? _____

Please describe your **typical diet below.** Are you **vegetarian/vegan/gluten free/omnivore?**

Female Reproductive History

Are you trying to conceive, and for how long? _____

Currently pregnant? _____ # weeks Are you currently breast-feeding? _____# of months.

Your child(s) age(s)? _____

Have you achieved pregnancy with any partner? _____

Have you had miscarriage(s) or termination(s)? _____

Menstruation: Age it began: _____ Are you in menopause, since when? _____

Is your cycle regular? _____ # days bleeding _____

How many days in cycle? (25-33) _____ Date of last menstrual cycle: _____

Blood color: _____ Blood consistency & Amount: _____

Do you spot before, between, or after periods?_____

During menses do you require pain medication?_____

Do you experience acne, breast tenderness, mood changes, low back or abdominal pain with your cycle?

_____

Do you ovulate? _____ On what day in your cycle?_____ How do you check for ovulation?_____

How is your libido? low, normal, high Do you experience pain with intercourse? _____

Do you have fibroids, cysts, polyps, PCOS, or endometriosis? _____

Do you get yeast, bladder, or kidney infections? _____

Ever had an abnormal pap? When? _____

Ever had a cervical biopsy? When? _____

Have you ever tested positive for: Chlamydia, Venereal Disease, HPV, or Herpes? _____

Have you had a Hysterosalpingogram (HSG) to check if fallopian tubes are open-When? _____

_____

Have you recently had any ultrasounds? Date(s): _____

_____

What fertility treatments have you already had (medications, insemination, in vitro fertilization, surrogacy, etc)?

_____

_____

Male Reproductive History

What health concerns are you experiencing? _____

Have you achieved pregnancy with any partner? _____Have you been evaluated by an

Urologist? Date and Result: _____

Date(s) of semen analysis and results: _____

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 Kim Silsby L.Ac.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, palpation or short 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 a member of the clinical staff of any unanticipated or unpleasant effect 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 includes 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 plan, 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 a clinical staff member who is caring for me if I am or become pregnant.

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

I understand the clinical and administrative staff 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 to form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature X

_____Date_____

(Indicate relationship if signing for patient)