



Niss Family Clinic

Acupuncture, Herbal, & Functional Medicine

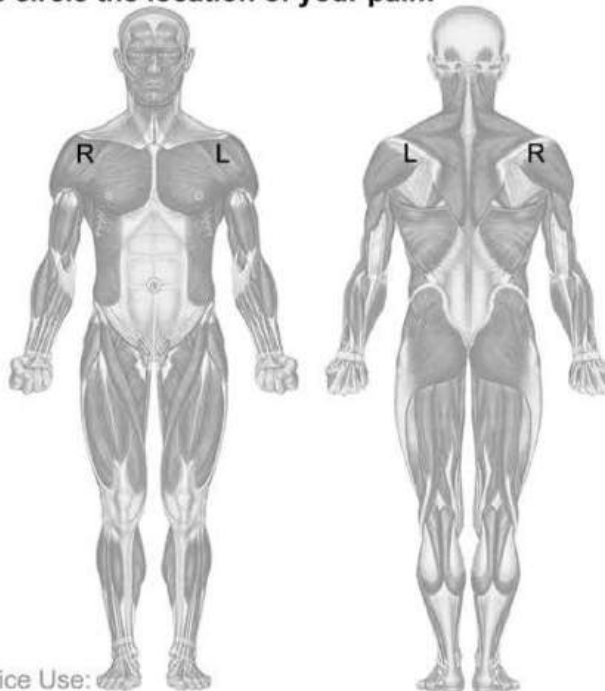
1616 W. Magnolia Blvd, Burbank, CA 91506. (323) 617-5027. mike@universalfamilyclinic.com

Name: _____ Appointment Date: _____ Time: _____
Age: _____ Date of Birth: ____/____/____ Gender: _____ Preferred Pronoun: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Email Address: _____
Referral Source: _____ Occupation: _____
Emergency Contact (if under 18 years old, name of legal guardian & relationship): _____ Phone: _____

Please briefly list your health concerns:

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

Please circle the location of your pain:



Diet & Lifestyle

How much water do you drink each day? _____ (oz)
If you drink coffee, how much? _____ (cups/ day)
If you drink alcohol, how much? _____ (drinks/ week)
Are there any foods you do not eat? If so please list them: _____

Do you drink soda or energy drinks? yes: _____ no: _____
Do you eat fast food? yes: _____ no: _____
Do you smoke cigarettes? yes: _____ no: _____

For Office Use:
Tongue: _____
Pulse: _____
TCM Dx: _____
Points: _____

Medical History & Medicines

Major illnesses: _____
Surgeries: _____
Significant Traumas: _____
List any infectious diseases: _____
Current prescriptions (& length of use): _____

Current supplements: _____

Allergies/ sensitivities: _____

Have you traveled internationally in the past 6 months? yes: _____ no: _____ If yes, where? _____

Have you had a fever in the past 30 days? yes: _____ no: _____ Are you pregnant? yes: _____ no: _____

Family Medical History

Mother: _____
Father: _____
Siblings: _____
Grandparents: _____

Symptom Checklist

- ☐ frequent or severe headaches
- ☐ neck pain
- ☐ neck lumps or swelling
- ☐ loss of balance
- ☐ dizzy spells
- ☐ blackouts/fainting
- ☐ blurry vision
- ☐ eyesight worsening
- ☐ see double
- ☐ see halos or lights
- ☐ eye pain or itching
- ☐ watering eyes
- ☐ hearing difficulties
- ☐ earaches
- ☐ discharge from ears
- ☐ noises in ears
- ☐ dental problems
- ☐ sore or bleeding gums
- ☐ sore tongue
- ☐ tongue coating
- ☐ wheezing or gasping
- ☐ frequent coughing
- ☐ cough up phlegm
- ☐ cough up blood
- ☐ chest colds
- ☐ rhinitis, sinusitis, or sneezing
- ☐ sore throat
- ☐ swollen glands
- ☐ rapid or skipped heartbeats
- ☐ chest pains
- ☐ shortness of breath
- ☐ swollen feet or ankles
- ☐ poor circulation
- ☐ bad breath
- ☐ stomach pain after eating
- ☐ heartburn
- ☐ antacids help
- ☐ sugar cravings
- ☐ fatigue after eating
- ☐ increased thirst & appetite
- ☐ salt cravings
- ☐ recurring indigestion
- ☐ frequent belching
- ☐ nausea
- ☐ vomiting
- ☐ pain in abdomen
- ☐ bloated abdomen
- ☐ foul smelling gas
- ☐ odorless gas
- ☐ gas after eating
- ☐ constipation
- ☐ hard dry or small stool
- ☐ loose bowels
- ☐ diarrhea
- ☐ not feeling empty after BM
- ☐ undigested food in stool
- ☐ alternating constipation diarrhea
- ☐ pain relieved by gas or BM
- ☐ black stools
- ☐ grey or whitish stools
- ☐ pain in rectum
- ☐ itching rectum
- ☐ blood in stool
- ☐ frequent urination
- ☐ involuntary escape of urine
- ☐ burning on urination
- ☐ brown black or bloody urine
- ☐ weak urine stream
- ☐ difficulty starting urine
- ☐ constant urge to urinate
- ☐ aching muscles or joints
- ☐ swollen joints
- ☐ back or shoulder pains
- ☐ weakness in arms or legs
- ☐ painful feet
- ☐ trembling
- ☐ numbness
- ☐ leg cramps
- ☐ joint pain worse w/weather
- ☐ better w/heat
- ☐ better w/cold
- ☐ skin problems
- ☐ scalp problems
- ☐ itching or burning skin
- ☐ bruise easily
- ☐ acne
- ☐ nervousness or anxiety
- ☐ difficulty making decisions
- ☐ lack of concentration
- ☐ absentminded/loss of memory
- ☐ lonely or depressed
- ☐ frequent crying
- ☐ hopeless outlook
- ☐ difficulty relaxing
- ☐ worrying a lot
- ☐ frightening dreams or thoughts
- ☐ feeling of desperation
- ☐ angered easily
- ☐ high stress at home
- ☐ high stress at work
- ☐ decrease in libido or sex function
- ☐ considered suicide
- ☐ sought psychiatric help
- ☐ loss or gain in weight
- ☐ feel warmer or colder than others
- ☐ loss of appetite
- ☐ always hungry
- ☐ swelling in armpits or groin
- ☐ unusual fatigue or weakness
- ☐ difficulty sleeping
- ☐ fever or chills
- ☐ excessive sweating
- ☐ night sweats
- ☐ hot flashes
- ☐ cannot stay asleep
- ☐ insomnia
- ☐ sweat easily
- ☐ genital burning, discharge, or pain
- ☐ lumps or swelling on testicles
- ☐ age of first period
- ☐ duration of period (days)
- ☐ date of last period
- ☐ # of pregnancies
- ☐ # of births
- ☐ missed period
- ☐ menstrual problems
- ☐ bleeding/spotting between periods
- ☐ tension or pain before periods
- ☐ heavy bleeding
- ☐ clots
- ☐ bearing down feeling
- ☐ vaginal discharge
- ☐ genital irritation
- ☐ yeast infection
- ☐ PMS
- ☐ pain w/intercourse
- ☐ swelling or lumps in breasts
- ☐ painful breasts
- ☐ scanty blood flow
- ☐ alternating cycle lengths
- ☐ facial hair growth
- ☐ hair loss/thinning
- ☐ menopause



Please use this section to further describe your health concerns.

1. _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

What other treatment have you tried? _____

Other important details: _____

Notes (For Office Use): _____

2. _____

When did this start? _____

What makes it better? _____

What makes it worse? _____

What other treatment have you tried? _____

Other important details: _____

Notes (For Office Use): _____

3. _____

4. _____

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 the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

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 be an unpleasant smell or taste. I will immediately notify a member of the clinical staff 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 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 I 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 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:

(Date)

PATIENT SIGNATURE

X

(Or Patient Representative)

(Indicate relationship if signing for patient)

