Blue Heron Acupuncture

31 Hayward Street
Suite C-2
Franklin, MA 02038
(401) 528-9980
www.BlueHeron-Acupuncture.com

REGISTRATION FORM

Name: _____ Gender: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home)_____ (Cell)_____ (Work)_____

Email Address: _____

Employed? Yes: ___ No: ___ Occupation: _____

Primary Care Physician: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Have you ever been treated with Acupuncture before? Yes: ___ No: ___

Is it okay if we contact you/leave messages by: Phone? Yes: ___ No: ___ Email? Yes: ___ No: ___

How did you hear about Blue Heron Acupuncture (Please circle all that apply)?

Printed Advertisement Website Internet search Doctor Referral Friend Other:_____

Please let us know if someone referred you. We would like to thank them!

Referred by: _____

Signature: _____ Date: _____
(If under 18 years of age a parent or legal guardian must sign)

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Late Cancellation/No Show Policy:

We at Blue Heron Acupuncture value your health and your time. It is important that our patients keep to their prescribed treatment plan and come regularly to their appointments. Missed appointments decrease the effectiveness of treatment and lengthen the overall time required for patients to feel better.

In the event that you need to cancel or reschedule an appointment, kindly provide us with a minimum of 24 hours notice by phone or email so that we may offer your appointment time to other patients.

Unless otherwise agreed upon in advance or in the case of inclement weather, patients who cancel last minute or miss an appointment with no notice will be subject to a charge of $50.00. Appointments that are rescheduled to a later date with less than 24 hours notice will also incur a $50.00 charge. You will be required to pay this fee at the beginning of your next treatment. Appointments that are rescheduled to a different time on the same day will not be subject to this charge.

There will be a $30.00 processing fee for any returned check.

I, the undersigned, have read and understand the Blue Heron Acupuncture Cancellation and No-Show Policy.

Signature: _____ **Date:** _____
(If under 18 years of age a parent or legal guardian must sign.)

Acknowledgement of Notice of Privacy Practices:

I have been presented with a copy of The Notice of Privacy Policies for the office of Blue Heron Acupuncture. I understand how this clinic may use or disclose my health information. I understand when this medical office may not use or disclose my health information. I understand my health information rights and understand that this office reserves the right to change this notice of privacy practices. I also understand how to place a complaint regarding this notice and have also been provided the opportunity to review and question the privacy policies of this clinic.

Signature: _____ **Date:** _____
(If under 18 years of age a parent or legal guardian must sign.)

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CONSENT TO TREATMENT

By signing below, I do hereby voluntarily consent to the performance of acupuncture on me (or on the patient named below, for whom I am legally responsible) by a licensed acupuncturist at Blue Heron Acupuncture. This includes those who may now or in the future treat me while associated with or serving as back-up for the clinic named above, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to: acupuncture, Chinese herbal medicine, nutritional counseling, cupping, heat lamp, moxibustion, electrical stimulation, Gua Sha and Tiu-Na (Chinese massage). I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is recommended by this clinic.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including: local bruising, minor bleeding, dizziness or fainting, numbness or discomfort near the needling sites and possible aggravation of symptoms existing prior to acupuncture treatment. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Bruising is a common result of cupping and gua sha. Burns are a potential risk of moxibustion and heat lamps. Unusual and rare risks of acupuncture include spontaneous miscarriage, nerve damage or organ puncture including pneumothorax. I understand that while this document describes the major risks of treatment, other side effect and risks may occur.

The herbs (substances from the Oriental Materia Medica from plant, animal and mineral sources) that may be 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. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do decide to take them. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will stop taking the herbs and immediately notify a member of the clinical staff if there are any unanticipated or unpleasant effects associated with the consumption of herbs. I will notify a clinical staff member 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 is thought, based upon the facts then known, to be in my best interest. 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, all of the above information and am fully aware of what I am signing. I understand the nature, risks and possible unexpected complications of treatment and that I may ask my practitioner for a more detailed explanation. I understand that I am free to refuse or stop treatment at any time and that no guarantee can be made regarding the results of treatment. I understand that there may be other treatment options, including treatment offered by a licensed physician. I intend this consent form to cover the entire course of treatment for current and future conditions and give my consent to treatment.

Signature: _____ **Date:** _____
(If under 18 years of age a parent or legal guardian must sign.)

Printed Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Blue Heron Acupuncture Health History Form

MAIN COMPLAINTS
Please list up to 3 main health concerns that you would like help with in order of importance to you.

#1_____

How does this affect you?_____
_____
When did this start?_____
What makes it better? _____
What makes it worse?_____
Have you seen a doctor for this?_____

#2_____

How does this affect you?_____
_____
When did this start?_____
What makes it better? _____
What makes it worse?_____
Have you seen a doctor for this?_____

#3_____

How does this affect you?_____
_____
When did this start?_____
What makes it better? _____
What makes it worse?_____
Have you seen a doctor for this?_____

PAST PERSONAL MEDICAL HISTORY
Please check off any that apply to you

Anemia
Asthma
Auto-immune Disorder
Cancer
Chemical Dependency
Diabetes
Glaucoma
Heart Disease
Herpes
Hepatitis/Liver Disease
High Blood Pressure
HIV/Aids
Kidney Disease
Mental Illness
Osteoporosis
Pacemaker
Rheumatic Fever
Seizures
STD
Stroke
Thyroid Disorder
Allergies: please list
_____
_____
_____
Other: please list
_____
_____

CURRENT MEDICATIONS
Please list anything taken within the past 2 months including prescriptions, vitamins, supplements, etc.

_____
_____
_____
_____

HOSPITALIZATIONS, SURGERIES, INJURIES
(please include dates)

_____
_____
_____
_____

LIFESTYLE

Do you follow any special diet (vegetarian, vegan, raw, macrobiotic, medically prescribed, etc.)?
_____
How often do you eat every day?_____
Do you have a regular exercise program?
Yes___ No___ If yes, please describe:
_____

How much of the following do you drink per day:
Alcoholic beverages _____
Caffeinated beverages_____
Water (8 oz cups) _____

Do you smoke? Yes___ No___
If so, how many cigarettes per day? _____

SLEEP

of hours of sleep per night _____
Restless or light sleep
Difficulty falling asleep
Difficulty staying asleep
Waking _____ x/night at _____ pm/am
Wake to urinate_____ x/night
Disturbing dreams
Unrested upon waking

EMOTIONS

Have you been treated for emotional issues?YES NO
Have you ever considered suicide? YES NO

Which emotion(s) dominate your experience?

anger	irritability	depression
anxiety	worry	sadness/grief
joy	indecision	mood swings
fear	happiness	obsessive thoughts

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING, PARTICUARLY IN THE PAST 3 MONTHS

HEAD, EYES, EARS, NOSE & THROAT:

Eye strain/pain	Poor/blurry vision	Glaucoma/cataracts	Tearing/Dryness	Spots in vision
Red/itchy eyes	Ringing in ears	Ear aches	Poor hearing	Headaches
Migraines	Sinus problems	Nose bleeds	TMJ/jaw problems	Grinding teeth
Frequent sore throats	Facial pain	Lip or mouth sores	Tooth/Gum problems	Dizziness
Concussion	Other_____			

SKIN:

Dry skin/hair	Rashes	Eczema	Acne	Hives	Itchy skin	Recent moles
Psoriasis	Dermatitis	Dandruff	Oily skin	Recent changes in skin or hair texture		
Hair loss	Dry/brittle nails		Other _____			

RESPIRATORY:

Cough	Pneumonia	Coughing blood	Asthma /Bronchitis	Pain with deep breath
Shortness of breath		Chest tightness	Wheezing	Difficulty breathing while laying down
Frequent colds		Phlegm (what color)_____		Other _____

CARDIOVASCULAR:

Chest pain	Irregular heartbeat	High/Low blood pressure		Cold hands/feet
Swelling/Edema	Blood clots	Fainting	Varicose veins	Blocked arteries
Heart disease	Palpitations	Stroke	Heart murmur	Other_____

GASTROINTESTINAL:

How frequently do you have a bowel movement? _____x/day?

Ulcers	Nausea /Vomiting	Acid reflux	Heartburn	Excessive gas	Abdominal pain
Belching	Bloating	Colitis	Hernia	Indigestion	Bleeding gums
Diarrhea	Constipation	Rectal pain	Hemorrhoids	Blood in stool	IBS/Crohn's disease
Bad breath	Chronic laxative use	Slow digestion		Other_____	

URINARY:

Frequent urination	Urgent urination	Pain with urination	Blood in urine	Unable to hold urine
Kidney stones	Burning sensation	Cloudy urine	Decreased/interrupted flow	
Waking to urinate	Urination frequency _____x/day?		Urinary/Kidney infections	
Scanty urination	Excessive amount of urine		Other_____	

GENERAL:

Weight gain/loss	Poor or excessive appetite	Cravings for _____	Peculiar tastes/smells
Fevers/Chills	Night sweats	Bleeding or bruising easily	Fatigue
Sudden energy drop at _____time of day		Unusual sweating	Hot flashes
Strong thirst for: hot or cold drinks		Thirst but no desire to drink	Cold hands/feet

FEMALE REPRODUCTIVE:

Are you currently sexually active? YES NO
Are you or could you be pregnant right now? YES NO
Are you using birth control? YES NO

Age of first period_____	Date of last period ____	Period duration ____ days	Days between periods____
Heavy/scanty periods	Painful periods	Irregular periods	Menstrual clots PMS
Mid-cycle bleeding	Endometriosis	Ovarian cysts	Uterine fibroids
Difficulty getting pregnant	Western infertility treatment	Genital sores	Yeast infections
# of pregnancies _____	# of live births ____	# of miscarriages _____	# of abortions _____
Breast lumps	Vaginal dryness	Vaginal discharge	Polycystic ovarian disease
Hysterectomy	Menopause	Low libido	Other_____

MALE REPRODUCTIVE:

Are you sexually active? YES NO
Do you practice birth control? YES NO

Prostate problems	Testicular problems	Erectile difficulties	Penile discharge	Premature ejaculation
Low libido	Vasectomy	Low sperm count/motility	Other_____	

MUSCULOSKELETAL:

Neck pain	Shoulder pain	Hand/wrist pain	Hip pain	Knee pain	Foot/ankle pain
Muscle pain	Bursitis	Muscle weakness	Sciatica	Muscle spasm	Tendonitis
Sprains	Strains	Carpal tunnel	Arthritis	Osteoporosis	Fibromyalgia
Back Pain: Low___ Middle___ Upper___			Numbness	Other_____	

Please indicate any painful or distressed areas by circling the affected areas on the picture below.