rebecca cates, M.S., L.Ac.
acupuncture and herbal medicine

PERSONAL INFORMATION

Patient Name:	Last	First	Middle
Address:		City	Zip
Telephone:	Home ( )	Cell ( )	
Fax: ( )		Email	
Date of birth:		Gender:	
Status: ☐ Single	☐ Married/Domestic Partnership	☐ Divorced	☐ Widowed ☐ Other
Referred by:			
EMERGENCY CONTACT			
Name:		Telephone: ( )	Relationship:

EMPLOYMENT INFORMATION

Employment Status: ☐ Full-Time	☐ Part-time	☐ Self-Employed	☐ Retired	☐ Unemployed	☐ Student
Occupation:		Number of work/study hours per week:			
Employers name:		Employers telephone: ( )			
Employers address:					

PRIMARY HEALTHCARE PROVIDER

Physician name:	Physician telephone: ( )
Physician address: Telephone: ( )	Date of last visit:

CONFIDENTIALITY

Your patient records and information will be kept confidential and shared only when necessary to provide care and service, or by your authorization or when required or permitted by law. My office is HIPAA compliant.

ILLNESS AND TREATMENT INFORMATION

What health issue do you want treated? Please describe as fully as possible.

Have you been using other medical treatments for relief of this issue? Please describe.

☐ no ☐ yes

Have you ever had an acupuncture treatment? When and for what reason?

☐ no ☐ yes

Are you presently being treated for any other medical condition? Please describe.

☐ no ☐ yes

Do you suffer from any chronic pain? Please describe.

☐ no ☐ yes

Do you have any other health concerns? Please describe.

☐ no ☐ yes

Do you exercise regularly? Please describe.

☐ no ☐ yes

What are your goals for your health? Please describe.

What are the top priorities in your life? Please describe.

HABITS: please check any habits which apply to you now or in the past.

Coffee:	no	yes	cups per day/week	age started	age quit
Tobacco:	no	yes	cigarettes per day/week	age started	age quit
Alcohol:	no	yes	drinks per day/week	age started	age quit
Marijuana:	no	yes	use per day/week	age started	age quit
Crack/Cocaine:	no	yes	use per day/week	age started	age quit
Heroin:	no	yes	use per day/week	age started	age quit
Other:			use per day/week	age started	age quit
Other:			use per day/week	age started	age quit

TYPICAL DIET

Breakfast:	Morning Snack:
Lunch:	Afternoon Snack:
Dinner:	Evening Snack:
Please describe any restrictive diet you follow(ed) now or in the past:	
Do you have any particular food cravings? Please describe.	

FOOD ALLERGIES: please list

FAMILY HISTORY INFORMATION: please complete for each family member, placing an X in the appropriate box

	self	mother	father	sister	brother	spouse	child
allergies	☐	☐	☐	☐	☐	☐	☐
blood disorder/anemia	☐	☐	☐	☐	☐	☐	☐
diabetes	☐	☐	☐	☐	☐	☐	☐
cancer or tumors	☐	☐	☐	☐	☐	☐	☐
seizures	☐	☐	☐	☐	☐	☐	☐
high blood pressure	☐	☐	☐	☐	☐	☐	☐
kidney or bladder disorder	☐	☐	☐	☐	☐	☐	☐
stomach or intestinal disorder	☐	☐	☐	☐	☐	☐	☐
drug/alcohol abuse	☐	☐	☐	☐	☐	☐	☐
tuberculosis	☐	☐	☐	☐	☐	☐	☐
heart disease	☐	☐	☐	☐	☐	☐	☐
stroke	☐	☐	☐	☐	☐	☐	☐
depression/mental illness	☐	☐	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐
Age of death							

MAJOR HOSPITALIZATIONS: please list any hospitalizations or surgeries below.

Year	operation or illness	name of hospital	city and state
Year	operation or illness	name of hospital	city and state
Year	operation or illness	name of hospital	city and state
Year	operation or illness	name of hospital	city and state

PREVIOUS PREGNANCIES:

Total pregnancies	living	ectopic	miscarriages	induced abortions

MEDICINES / HERBS / SUPPLEMENTS : please mark an X in the box next to any of the following that you are currently taking

☐ aspirin	☐ ibuprofen	☐ acetaminophen(Tylenol)	
☐ antacids	☐ laxatives	☐ fiber supplements	☐ vitamins:_____
☐ diet pills	☐ tranquilizers	☐ sleeping pills	
☐ cold tablets	☐ allergy medication	☐ oral contraceptives	☐ herbs:_____
☐ blood pressure pills	☐ blood thinning pills	☐ insulin, diabetes medication	
☐ anti-depressants			☐ other:_____

DRUG ALLERGIES: please list

HEALTH: check all that apply

GENERAL

Past	Current	Condition
☐	☐	poor appetite
☐	☐	excessive appetite
☐	☐	change in appetite
☐	☐	insomnia
☐	☐	fatigue / low energy
☐	☐	poor concentration
☐	☐	poor memory
☐	☐	fever
☐	☐	chills
☐	☐	night sweats
☐	☐	sweat easily
☐	☐	tend to feel colder than others
☐	☐	tend to feel warmer than others
☐	☐	frequent or strong thirst
☐	☐	decreased sense of taste or smell
☐	☐	other:_____

SKIN & HAIR

Past	Current	Condition
☐	☐	rashes
☐	☐	hives
☐	☐	itching
☐	☐	eczema
☐	☐	psoriasis
☐	☐	acne
☐	☐	dryness
☐	☐	tumors, lumps
☐	☐	other:_____

HEAD & NECK

Past	Current	Condition
☐	☐	dizziness
☐	☐	fainting
☐	☐	neck stiffness
☐	☐	enlarged lymph glands
☐	☐	headaches
☐	☐	migraines
☐	☐	concussions
☐	☐	other:_____

EARS

Past	Current	Condition
☐	☐	infection
☐	☐	ringing
☐	☐	decreased hearing
☐	☐	other:_____

EYES

Past	Current	Condition
☐	☐	blurred vision
☐	☐	visual changes
☐	☐	poor night vision
☐	☐	floaters / spots in visual field
☐	☐	cataracts
☐	☐	glasses / contacts
☐	☐	eye inflammation
☐	☐	dry eyes
☐	☐	red eyes
☐	☐	other:_____

NOSE, THROAT, MOUTH

Past	Current	Condition
☐	☐	nose bleeds
☐	☐	sinus infections
☐	☐	hay fever or allergies
☐	☐	recurring sore throats
☐	☐	laryngitis / hoarse voice
☐	☐	grinding teeth
☐	☐	difficulty swallowing
☐	☐	other:_____

HEALTH: check all that apply

CARDIOVASCULAR

Past	Current	Condition
☐	☐	high blood pressure
☐	☐	low blood pressure
☐	☐	blood clotting disorders
☐	☐	palpitations
☐	☐	phlebitis
☐	☐	chest pain or pressure
☐	☐	irregular heart beat
☐	☐	cold hands / feet
☐	☐	swelling of hands / feet
☐	☐	other: _____

RESPIRATORY

Past	Current	Condition
☐	☐	asthma
☐	☐	bronchitis
☐	☐	frequent colds
☐	☐	chronic obstructive pulmonary disease
☐	☐	pneumonia
☐	☐	cough
☐	☐	cough with blood
☐	☐	excess phlegm production
☐	☐	other: _____

GASTRO-INTESTINAL

Past	Current	Condition
☐	☐	nausea
☐	☐	vomiting
☐	☐	diarrhea
☐	☐	constipation
☐	☐	belching
☐	☐	gas / abdominal bloating
☐	☐	blood in stools / black stools
☐	☐	bad breath
☐	☐	rectal pain
☐	☐	hemorrhoids
☐	☐	abdominal pain or cramps
☐	☐	indigestion
☐	☐	heartburn
☐	☐	ulcers
☐	☐	gallbladder disorder
☐	☐	other: _____

GENITO-URINARY

Past	Current	Condition
☐	☐	kidney stones
☐	☐	painful urination
☐	☐	frequent urination
☐	☐	blood in urine
☐	☐	urgency to urinate
☐	☐	urinary or bowel incontinence
☐	☐	other: _____

NEUROLOGICAL

Past	Current	Condition
☐	☐	seizures
☐	☐	tremors
☐	☐	numbness / tingling of limbs
☐	☐	burning pain
☐	☐	localized weakness
☐	☐	paralysis
☐	☐	other: _____

PSYCHOLOGICAL

Past	Current	Condition
☐	☐	depression
☐	☐	anxiety
☐	☐	stress
☐	☐	irritability
☐	☐	often feel afraid
☐	☐	often feel pensive / thoughtful
☐	☐	often feel sad
☐	☐	often feel angry
☐	☐	treated for emotional or psychological issues
☐	☐	other: _____

MALE

Past	Current	Condition
☐	☐	pain / itching of genitalia
☐	☐	genital lesions / discharge
☐	☐	impotence
☐	☐	weak urinary stream
☐	☐	prostatitis
☐	☐	lumps in testicles
☐	☐	decreased libido
☐	☐	other: _____

FEMALE

Past	Current	Condition
☐	☐	pain / itching of genitalia
☐	☐	genital lesions / discharge
☐	☐	frequent urinary tract infections
☐	☐	frequent vaginal infections
☐	☐	pelvic inflammatory disease
☐	☐	abnormal pap smear
☐	☐	irregular menstrual periods
☐	☐	painful menstrual periods
☐	☐	premenstrual syndrome
☐	☐	abnormal bleeding
☐	☐	menopausal syndrome
☐	☐	breast lumps
☐	☐	decreased libido
☐	☐	other: _____

INFECTION SCREENING

Positive	Condition
☐	HIV
☐	TB
☐	Hepatitis
☐	Gonorrhea
☐	Chlamydia
☐	Syphilis
☐	Genital Warts
☐	Herpes: Oral
☐	Herpes : Genital

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Informed Consent to Treatment

I request and consent to acupuncture treatments and other procedures associated with Traditional Chinese Medicine by Rebecca Cates, M.S. L.Ac. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, herbal medicine and nutritional counseling.

I understand that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites, that may last a few days, dizziness and/or fainting. Infection is another possible risk, although this clinic only uses sterile disposable single-use needles and maintains a clean and safe environment. Bruising is a common side effect of cupping. Burns and scarring are potential risks of moxibustion. Sometimes an aggravation of pre-existing symptoms may occur following treatment. Some possible side effects of taking herbs are nausea, indigestion, diarrhea and tingling of the tongue. I will immediately notify Rebecca Cates of any unanticipated or unpleasant effects associated with the consumption of the herbal medicine.

I understand that some herbs and acupuncture points may be inappropriate during pregnancy. I will immediately inform Rebecca Cates if I suspect that I am pregnant.

I have had the opportunity to discuss with Rebecca Cates the nature and purpose of my treatment with her. I do not expect Rebecca Cates to be able to anticipate and explain all possible risks and complications, and I wish to rely on Rebecca Cates to exercise her judgment during the course of my treatment and, based upon the facts then known, to proceed in a manner she determines is in my best interests.

By voluntarily signing below, I show that I have read, or have had read to me, this consent to treatment, and have had an opportunity to ask questions regarding its content. 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.

_____ Rebecca Cates, M.S., L.Ac.
print name of patient (or representative) print name of practitioner

_____ _____
signature of patient (or representative) signature of practitioner

Missed Appointment Policy
Your appointment time has been reserved for your care. If you need to change or cancel your appointment, please do so with at least 24 hours notice. Less than 24 hours notice will result in your being charged up to the full fee for your appointment.

_____ I understand the missed appointment policy.