Kristen Cady, M.S., LAc. **(301) 456-3079**
Harmony Acupuncture
10903 Indian Head Hwy, Ste 303
Fort Washington, MD 20744

Patient Profile

Date: _____

Name: _____ Age: ____ Birthdate:_____ Sex:_____
Mailing address: _____ City: _____
State:_____ Zip:_____ Occupation:_____
Phone: (home)_____ (alternate)_____
Name of emergency contact: _____ Phone: _____
How did you hear about this practice?_____

Please complete this questionnaire as thoroughly as possible in order to aid in your diagnosis and treatment. This is a confidential record of your medical treatment and will not be released unless you provide written request to do so. Thank you!

PRESENT HEALTH CONCERNS AND DURATION: (in order of *decreasing* significance.)

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

MAIN PROBLEM (S) YOU WOULD LIKE ADDRESSED TODAY:

_____

When did this problem begin?

_____

What makes it better?

_____

What makes it worse?

_____

To what extent does it interfere with your daily activities?

_____

What other treatments have you tried?

_____

Have you been given a diagnosis?_____ If so, what? _____
By whom? _____

WHAT GOALS DO YOU HAVE FOR YOUR VISIT TODAY?

Primary goal: _____
Other goals: _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, WITH DOSES:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PLEASE LIST VITAMINS, MINERALS, HERBS OR HOMEOPATHICS, WITH DOSES:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PLEASE LIST ANY KNOWN ALLERGIES TO THE FOLLOWING:

Drugs:

_____

Foods:

_____

Environmental (grasses, pollens, pets, etc.):

_____

PAST MEDICAL HISTORY:

Hospitalizations (please indicate reasons and dates):

_____

_____

Serious illnesses and injuries/significant traumas (and dates):

_____

_____

For women: Date of last PAP smear: _____
Results: _____

FAMILY HISTORY: Please check the "yes" box next to each condition that applies to you or one of your family members. Please mark a "**C**" for **current** or "**P**" for **past** conditions:

	Yes	RELATION	Current/Past		Yes	RELATION	Current/Past
Alcoholism				Headaches			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				High Blood Pressure			
Asthma				Kidney Disease			
Cancer				Mental Illness			
Diabetes				Stroke			
Eczema				Tuberculosis			
Epilepsy				Other			

Please describe your average daily diet:

morning:_____
afternoon:_____
evening:_____

How many packs of cigarettes do you smoke a day, if any?
_____
How much alcohol do you consume each week, if any?
_____

DO YOU HAVE ANY QUESTIONS ABOUT ACUPUNCTURE AND ORIENTAL MEDICINE BEFORE WE BEGIN?

_____

(Please turn over and sign consent form!)

Acupuncture and Oriental Medicine Informed Consent for Treatment:

I, _____, hereby authorize Kristen Cady, M.S., L.Ac. to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:
Acupuncture: the insertion of special sterile disposable needles through the skin into underlying tissues at specific points on the surface of the body.
Electro-acupuncture: acupuncture in combination with mild electrical stimulation.
Cupping: a technique in which glass or bamboo cups are placed on the skin with a vacuum created by heat or suction.
Gua Sha: rubbing an area of the body with a blunt, round object such as a ceramic spoon.
Moxibustion: direct or indirect burning on an acupuncture point using a stick or ball of moxa (Artemisia Vulgaris herb).
Tuina: an ancient massage therapy used to treat a wide variety of common disharmonies.
Dietary Advice: individualized and based on the theory of Traditional Chinese Medicine.
Herbs: given in the form of pills or tinctures.

I recognize the potential risks and benefits of these procedures as described below:
Potential risks: discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, abdominal cramping, headache, lightheadedness, low energy or aggravation of symptoms existing prior to the acupuncture treatment.
Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem and the strengthening of the overall constitution.

Notice to pregnant women: All female patients must alert the practitioner if they know or suspect they are pregnant. Treatments can be rendered on pregnant women, however no labor-inducing regimens will be performed.
Notice to patients with severe bleeding disorders or pacemakers: For your health and safety, you must inform the practitioner if you have either one of these conditions.

With this knowledge, I voluntarily consent to the above procedures, realizing that Kristen Cady, M.S., L.Ac, has given no guarantees to me regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by my representative or myself or if the law requires it. A records release form must be signed by me in order to share my records with another health care provider. I understand that I may look at my medical record and can request a copy of it by paying the $5.00 fee. I understand that my medical record will be kept no more than ten years after the date of my last treatment. I understand that my practitioner will answer any questions that I have.

_____ _____ _____

Signature of Patient or Guardian Date Witness

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