CROW HEART

ACUPUNCTURE + CHINESE HERBS

6536 Telegraph Avenue, Suite 201A, Oakland CA 94609
838 Pomona Avenue, Albany CA 94706

PATIENT INFORMATION

How should I prepare for my appointment?
Because the tongue is routinely examined as part of Chinese diagnosis, please do not brush your tongue prior to your appointment (brushing your teeth is fine, though!). For best results from your acupuncture treatment, eat moderately within three hours of your treatment. Please do not come on an empty stomach or overly full. It is easiest to relax on the treatment table if you have not had caffeine or sugar immediately prior to the appointment.

What should I wear?
Loose clothing is best, especially with pants. If it is necessary to remove constrictive clothing, sheets/towels are available for coverage.

Should I avoid anything after acupuncture?
Avoid strenuous activity, baths, hot tubs and preferably any strong substances such as nicotine or alcohol for three hours after the treatment. Soup or a warm cup of tea is very good after a treatment.

FEES:

Initial Visit $120 - Subsequent visits - $90 / Cash, check, and credit cards are accepted. If fees are prohibitive, please inquire about financial hardship rates which can be made available pending an agreement.
(Herbal medicine is not included in the above prices.)

CANCELLATION POLICY:

LESS THAN 24 HOURS NOTICE will be billed at 50% of the acupuncture fee the first time and 100% thereafter. Your appointment time is reserved. If you miss your appointment, others who desire that appointment time cannot be served. Please be on time. Call or text if you are running late so that we can make every effort to reschedule you for a later time.

Crow Heart Acupuncture & Chinese Herbs
Sandra “Frances” Wocicki
510-919-5689
CrowHeartAcupuncture@gmail.com
CA AC License #15792

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PATIENT REGISTRATION FORM

Date of first visit: _____

Name: _____

Address: _____

_____

Phone: _____

Email: _____

Date of Birth:_____Age Today: _____

Occupation: _____

Employer:_____

Emergency contact: _____

Relationship: _____

Phone: _____

How did you hear about this clinic?_____

<u>ALLERGIES**</u> Please use the space below to list any foods, medications, or environmental allergies that you have and describe symptoms and severity and treatment (if any):**

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INFORMED CONSENT

I hereby request and consent to the performance of acupuncture treatments (and other procedures within the scope of the practice of acupuncture) on me by Sandra "Frances" Wocicki.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases. I am aware that certain adverse side effects may result which could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. The risk of infection is small as all needles used are single-use and sterile.

Herbs: I understand that substances from the Oriental Materia Medica and Western nutritional supplements may be recommended to me to treat bodily dysfunction or diseases, and to normalize the body's physiological functions. 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. I am aware that certain adverse side effects may result from taking these substances. *Should I experience any problems, I should suspend taking them and call my practitioner as soon as possible.*

Acupressure and Medical Qi Gong: I understand that I may also be given acupressure and Medical Qi Gong as part of my treatment to modify/ prevent pain perception and to normalize the body's physiological functions. I am aware that adverse side effects may result from this treatment, which could include, but are not limited to: sore muscles/ aches, and possible aggravation of symptoms. I understand that I may stop the treatment at any time.

Electro-Acupuncture: I understand that electro-acupuncture may be administered with the acupuncture in order to speed up the healing process. I am aware that certain adverse side effects may result. These may include, but are not limited to: pain or discomfort, and the possible aggravation of symptoms. I understand that I may refuse this treatment.

Cupping & Scraping "Gua Sha": I understand that cupping and scraping are commonly used during an acupuncture treatment. I am aware that these treatments create a temporary petichia (discoloration) on the skin's surface where the procedure is being performed, which may last 1-5 days. Occasionally, bruising, blistering, or bleeding may occur as a result of the pressure of cupping or gua sha.

I understand that there may be other treatment alternatives, including treatment by a licensed physician.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment to choose the procedures and treatments that are in my best interest, based on the current diagnosis and the facts known at the time of treatment.

I will notify the acupuncturist if I am or become pregnant, and also of any allergies I currently have.

I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content. By signing below I agree to the above-named procedures. 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. I understand the results are not guaranteed.

Printed Name:_____

Signature:_____ Date:_____

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COMPREHENSIVE ACUPUNCTURE EXAMINATION

Note: this a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

NAME:_____

Height:_____Weight:_____

Major Complaints: _____

_____

_____

Date of onset (when did you first notice the problem?): _____

Pain is: ❒ Minimal ❒ Slight ❒ Moderate ❒ Severe

How long have you had this condition? _____

Have you had this in the past?_____If so, when? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ❒ Getting worse ❒ Constant ❒ Comes and Goes

Medications / Drugs / Herbs you are currently taking:

_____

_____

Operations / Surgeries you have had, and dates:

_____

_____

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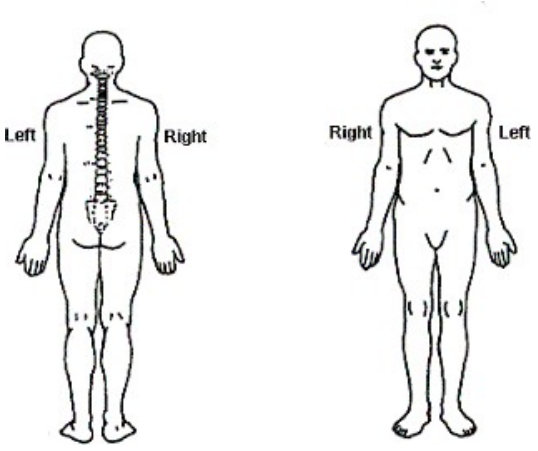
Medical History (Do you have or have you ever have...):

Condition	✔ if you have	✔ if family history	Condition	✔ if you have	✔ if family history
Diabetes			High Blood Pressure		
High Cholesterol			Hypothyroidism		
Pneumonia			Pulmonary embolism		
Asthma			Goiter		
Emphysema			Cancer		
Stroke			Leukemia		
Epilepsy / Seizures			Psoriasis		
Eczema			Cataracts		
Angina			Heart Problems		
Kidney stones			Gallstones		
Hepatitis			Jaundice		
Hyperthyroidism			Arthritis		

Physical Injuries - please mark areas of pain and describe injuries:



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SYSTEMS REVIEW

General: ❑ Recent weight gain ❑ Recent weight loss ❑ Fatigue ❑ Weakness ❑ Fever	Sweating: ❑ Night sweats ❑ Excess daytime sweats ❑ Rarely sweats	Circulation: ❑ Often feel cold ❑ Often feel too hot ❑ Cold hands and feet
Skin: ❑ Dry / Itchy ❑ Moist / Clammy ❑ Burning ❑ Changing Moles or lumps ❑ Frequent skin rashes ❑ Acne ❑ Easily bruised ❑ Other	Sleep: Average number of hours you sleep each night: _____ ❑ Trouble falling asleep ❑ Trouble staying asleep ❑ Waking too early ❑ Excess dreaming / nightmare ❑ Snoring ❑ Sleep apnea ❑ Wake without feeling rested	Head: ❑ Headaches ❑ Migraines ❑ Dizziness ❑ Memory Loss ❑ Loss of balance ❑ Trouble concentrating
Eyes: ❑ Eye Pain ❑ Dry Eyes ❑ Blurry Vision	Nose: ❑ Frequent nose bleeds ❑ Sinus trouble ❑ Frequent colds	Throat: ❑ Sore throat ❑ Hoarseness ❑ Difficulty Swallowing ❑ Teeth / gum problems
Chest: ❑ Hard to breathe ❑ Wheezing ❑ Shortness of breath ❑ Trouble breathing at night ❑ Persistent cough ❑ Mucus rattles when breathing ❑ Pain / Pressure in chest ❑ Coughing phlegm	Blood Pressure: ❑ High ❑ Low ❑ Don't Know ❑ Controlled by medication ❑ On meds, but BP still high	Bowels: ❑ Diarrhea ❑ Constipation ❑ Diarrhea and constipation ❑ Difficult bowel movements ❑ Gas and bloating ❑ Foul odor ❑ Hemorrhoids ❑ Blood in Stools

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Urine:	Musculoskeletal:	Neurological:
❑ Frequent UTIs ❑ Dark color ❑ Difficult ❑ Burning / painful ❑ Frequent urination (day) ❑ Frequent urination (night) ❑ Blood in urine	Pain in: ❑ neck ❑ shoulder ❑ upper back ❑ mid back ❑ low back ❑ arms / hands ❑ fingers ❑ loss of grip ❑ feet / toes ❑ tingling in feet ❑ legs ❑ leg cramps at night ❑ weak legs ❑ weak ankles ❑ all over stiffness ❑ Other: _____	❑ Depressed ❑ Anxious ❑ Nervous ❑ Easily Irritated ❑ Frequent Crying ❑ Worry ❑ Mood Swings ❑ Memory / Confusion ❑ Suicidal ❑ Tremors ❑ Numbness / tingling limbs ❑ Poor coordination ❑ Muscle weakness ❑ Seizures ❑ Shingles ❑ Feel Weak / Shaky

WOMEN:

Pregnant? ❑ Yes ❑ No If yes, how many weeks? _____	Birth Control: ❑ None ❑ Pill ❑ IUD ❑ Other
Start date of last monthly period:	Age of Menarche:
Date of last PAP test:	Age of Menopause:
Operations: ❑ Cervix ❑ Uterus ❑ Ovaries	Hormone therapy? ❑ yes ❑ no

Menstrual Symptoms:

❑ Pain / Cramps ❑ Low back ache ❑ Water retention ❑ Mood changes ❑ Missed Periods
❑ Painful breasts ❑ Irregular cycles ❑ Clots ❑ Heavy bleeding ❑ Light / scanty bleeding
❑ Hot flashes ❑ Low / no libido Discharge: ❑ yellow ❑ thick ❑ white ❑ odor ❑ itching
❑ Bleeding between periods

Pregnancies:

Number of pregnancies:_____Number of Deliveries:_____Number of Miscarriages:_____
Number of cesareans:_____Number of Abortions: _____

MEN:

❑ Low / no libido	❑ erectile dysfunction	❑ premature ejaculation
❑ discharge	❑ pain / burning while urinating	❑ prostate trouble
❑ other:	❑ mood swings	Hormone therapy? ❑ yes ❑ no

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DIET / EXERCISE / LIFESTYLE

Appetite: ❑ Excessive ❑ Poor ❑ Grumpy / weak if a meal is missed ❑ Excess thirst ❑ Lack of thirst ❑ cravings:_____	**Diet**: ❑ vegetarian ❑ vegan ❑ omnivore ❑ pescatarian ❑ paleo diet ❑ crash diets ❑ food allergies: ❑ food sensitivities: ❑ Eat breakfast daily ❑ tend to eat with emotional upset ❑ I feel happy with my current dietary habits ❑ I wish to make dietary changes
Exercise: Please describe type and frequency of your weekly exercise routine: ❑ I feel happy with my weekly exercise routine ❑ I wish to make changes in my exercise routine	**Drug / Alcohol Use**: Amount of Alcohol consumed per week:_____ Type of alcohol:_____ Cigarettes per day:_____ How many years:_____ Marijuana frequency:_____ Other recreational drugs: _____ ❑ I feel comfortable with my current use habits ❑ I wish to make changes in my use of substances

Other symptoms, comments or questions: