Hillary Jaynes, L.Ac.

54445 N. Circle Drive, Suite A, Idyllwild, CA 92549
951-659-2500

Personal Information

Name ______________________ Date ______________

Home Address ______________________________

City ______________________ State _____ Zip ____________

Home Phone ______________ Work Phone ______________

Occupation ____________ Person Responsible for your account ____________

Employer ______________________________

How were you referred to this office? ______________________

Sex: Male Female Height _______ Weight _______ Birthdate _________ Age ______

Marital Status: Married Single Divorced Widowed Number of children: ________

Have you had acupuncture before? Yes No Date and with whom?______________

Please indicate any significant illnesses you or a blood relative have had:

ILLNESS	You	Your Relative	Date	ILLNESS	You	Your Relative	Date
Allergies			_____	Hepatitis			_____
Alcoholism			_____	High Bld Press.			_____
Asthma			_____	Infectious Diseases			_____
Cancer			_____	Seizures			_____
Diabetes			_____	Stroke			_____
Emotional Disorders			_____	Tuberculosis			_____
Heart Disease			_____	Other (please list)			____________

Sexually Transmitted Diseases: AIDS Herpes HPV Syphilis Date

Please indicate the amounts used of the following:

Coffee/black tea ____________ Tobacco ____________ Alcohol ____________
Non-medical drugs ____________ Soda pop ____________ Water ____________
Do you have any food cravings? ______________________________

Medication	Dosage	Reason	Duration	Prescribed by

Please list the main health problems you are seeking treatment for: ________________________________
____
____

What other forms of treatment have you sought?
____
____
____

List any other health problems you now have:
____
____
____

List any accidents, surgeries, or hospitalizations (include dates) ____________________________
____
____
____
____

Lab results: _______________________________
____
____

List any allergies or food sensitivities:
____
____

Symptom Survey

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

no mark ( ) = never experience **check mark (✓)** = sometimes experience **plus (+)** = always experience

__ lack of appetite
__ excessive appetite
__ loose stool or diarrhea
__ digestive problems, indigestion
__ vomiting
__ belching, burping
__ heartburn/reflux
__ feeling of the retention of food in the stomach
__ tendency to become obsessive in work, relationships...

__ feeling of claustrophobia
__ insomnia, difficulty sleeping
__ heart palpitations
__ cold hands and feet
__ nightmares

__ mentally restless
__ laughing for no apparent reason
__ angina pains
__ abdominal pain
__ chest pain
__ sciatic pain
__ headaches
__ pain or coldness in the genital region

__ cough
__ shortness of breath
__ nasal problems
__ decreased sense of smell
__ bronchitis
__ colitis or diverticulitis
__ constipation
__ hemorrhoids
__ recent use of antibiotics

__ eye problems
__ gallstones
__ jaundice (yellowish eyes or skin)
__ difficulty digesting oily foods
__ light colored stool
__ soft or brittle nails
__ easily angered or agitated
__ difficulty in making plans or decisions
__ spasms or twitching of muscles

__ low back pain
__ knee problems
__ hearing impairment
__ ear ringing
__ kidney stones
__ decreased sex drive
__ hair loss

__ urinary problems
__ fatigue
__ edema
__ blood in stool
__ black tarry stool
__ easily bruised
__ difficult to stop bleeding
__ asthma
__ tendency to catch colds easily
__ intolerance to weather changes
__ allergies
__ hay fever
__ dizziness
__ tendency to faint easily
__ high cholesterol levels
__ sudden weight loss

Women:

Age of 1st period _____________
Age of last period _____________
# of days between periods ______
# of days of flow _____________
PMS? ______________________

Date of last gyn. exam _________
Date of last mammogram _______
Results _____________________
Breast lumps ________________
Vaginal discharge? ___________

Are you pregnant? Yes No
Number of pregnancies ________
Number of births _____________
Birth control? _______________
Are you trying to get pregnant? __

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Idyllwild Community Acupuncture 54445 N. Circle Drive, Suite A Idyllwild, CA 92549
(951) 659-2500 (619) 990-7426

Informed Consent

Patient Name ____ **Date**____________

Address ____

City ______________________________ **State** ____________ **Zip** ___________

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 the patient named above, for whom I am legally responsible).

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine and nutritional counseling.

I have been informed that acupuncture is a 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 and fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. 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 Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify the acupuncturist if I am or become pregnant. I will also immediately notify the acupuncturist if there are any unpleasant effects associated with the consumption of the herbs.

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 the 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 conditions for which I seek treatment.

Patient Signature___________________________________ **Date**_______________
(or Patient Representative—indicate relationship if signing for patient)

Office Signature____________________________________ **Date**______________

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Financial Policy

Idyllwild Community Acupuncture is a community-supported business offering effective, affordable acupuncture and Chinese herbal medicine. Our goal is to make acupuncture and herbs accessible to as many people as possible, at the most affordable rates.

Our fee structure:

First Visit paperwork fee	$10
Acupuncture treatment	$20 - $40 sliding scale
Multiple acupuncture treatments per week	$15 – $40 sliding scale
Herbal consultations	$20 - $40 sliding scale

How sliding scale works: You decide what you can afford to pay within the scale in order to get the frequency of care that you need. No income verification of any kind is required.

We ask for a minimum of 24 hours advance notice for a change or cancellation of appointment.

There will be a $15 charge for any appointment that is missed, rescheduled or cancelled with less than 24 hours advance notice. If appointments have been purchased in a package, the missed, cancelled, or rescheduled appointment will be deducted from the number of remaining appointments in that package.

Please indicate that you have read and understood this page:

SIGNATURE ____

PRINTED NAME ____

DATE ______ / ______ / _______