PATIENT INFORMATION FORM

Name:	
Date of Birth:	
Mailing Address	
Telephone Numbers (cell, work, or home):	Other (cell, work, home):
E-mail address	
Emergency Contact Name: Phone:	Relationship
Current Physician:	Phone/contact for physcian:

Have you had acupuncture before? YES NO

We have a minimum 48 hours cancellation policy. Please be aware that it is difficult to fill your appointment even with 48 hours notice. We appreciate as much notice as possible. We reserve your appointment time especially for you.

We do not double or triple book appointment times. This allows us to spend more time with each individual patient and manage our time effectively so as not to inconvenience you. Policies aside, we know that life often intervenes at the last moment and some situations cannot be avoided. We will work with you and appreciate your attentiveness to this matter.

We ask for payment to be made at the time of your visit. Our bank charges us a $15.00 fee for any bounced checks. Therefore, if you bounce a check, please be prepared to pay that fee.

Print:_____,

Signature:_____ Date:
(or patient representative) (Indicate relationship if signing)

Brookman Acupuncture LLC
Silver Spring MD • Washington DC • 301-648-8825

Integrative Oncology Intake Form

Name:	Date of Birth:
What type of cancer were you diagnosed with?	What stage? When were you diagnosed?
What is the current state of your cancer diagnosis?	
Who is your oncologist? Name: Phone: Center and/or address:	

What conventional therapies are you using for cancer treatment (answer all that apply)?

Chemotherapy: circle all that apply (Past-Current-Future)	Surgery: circle all that apply (Past-Current-Future)	Radiotherapy: circle all that apply (Past-Current-Future)	Other (hormone, immunotherapy, clinical trial, etc): circle all that apply (Past-Current-Future)
Start date: Which drugs or protocol? 1. 2. 3. 4. 5. How often? Last date or expected last date of therapy:	Date of procedure(s): Type of procedure(s):	Date(s): What type/where?	Details:

List and side effects you are experiencing from treatment:
What is most important for you in getting acupuncture treatment and Chinese medical treatment?

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HEALTH HISTORY

CONFIDENTIAL

Name (Last, First, Middle)	Date
Reason for treatment:	
How did this condition develop?	
How long has this condition persisted?	
Is there anything that makes it better?	
Is there anything that makes it worse?	
Have you ever received treatment for this condition?	If yes when?
Where?	By whom?
What was the diagnosis?	What kinds of treatment?
What were the results of treatment?	
List any substances you are allergic to:	

List any medication you are currently taking:

MEDICATION:	DOSE:	FOR WHAT CONDITION:	FOR HOW LONG:

List any major surgeries you have had:

DATE	PROBLEM/SURGERY

Significant trauma (auto accidents, falls, etc.)

DATE	

SIGNIFICANT ILLNESSES (PLEASE CHECK ALL THAT APPLY)

- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Aids/HIV
- ☐ Cancer
- ☐ Connective Tissue Disease
- ☐ Diabetes
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Stones
- ☐ Rheumatic Fever
- ☐ Ruptured Appedix
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Venereal Disease
- ☐ Other:

HEALTH HISTORY

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE):	DATE:

Please check any symptoms you currently have or have had in the past year

General
☐ Chills
☐ Low energy
☐ Dizziness
☐ Allergies
☐ Fatigue
☐ Fevers
☐ Excess thirst
☐ Insomnia
☐ Nervousness
☐ Numbness
☐ Sweat spontaneously
☐ Night sweating
☐ Lack of sweating
☐ Weight gain
☐ Weight loss
☐ Aversion to heat
☐ Aversion to cold

Sensory Orifices
☐ Blurred vision
☐ Heaviness in the head
☐ Headache
☐ Cataract
☐ Double vision
☐ Red/inflamed eye
☐ Eye pain/strain
☐ Corrected vision
☐ Earache
☐ Ear discharge
☐ Ringing in ears
☐ Hearing loss
☐ See Floaters
☐ Nasal obstruction
☐ Nasal discharge
☐ Loss of sense of smell
☐ Sinus problems
☐ Nosebleeds
☐ Recurrent sore throat
☐ Phlegm in throat
☐ Sores on lips/tongue
☐ Taste change
☐ Teeth problems

Respiratory
☐ Asthma
☐ Hay fever
☐ Persistent cough
☐ Coughing blood
☐ Shortness of breath
☐ Recurrent bronchitis
☐ Phlegm Production
☐ Difficulty inhaling
☐ Difficulty exhaling

Cardiovascular
☐ Chest pain
☐ High blood pressure
☐ Low blood pressure
☐ Irregular heart beat
☐ Poor circulation
☐ Swelling of ankles
☐ Varicose veins
☐ Lower ribcage pain
☐ Distention in the chest or beneath ribcage

Gastrointestinal
☐ Difficulty swallowing
☐ Abdominal pain
☐ Bloating
☐ Belching
☐ Poor appetite
☐ Nausea
☐ Heartburn/reflux
☐ Indigestion
☐ Vomiting
☐ Vomiting blood
☐ Stomachache
☐ Gas
☐ Constipation
☐ Diarrhea/loose stools
☐ Bloody stools
☐ Hemorrhoids

Diet/Lifestyle
☐ Vegetarian
☐ Healthy diet
☐ Eat much fried foods
☐ Eat much meat
☐ Eat a lot of sweats
☐ Drink Coffee
☐ Drink Alcohol
☐ Use drugs
☐ Take steroids
☐ Exercise regularly
☐ Exercise excessively

Weight
☐ Underweight
☐ Normal for height
☐ Overweight
☐ Very overweight

Genitourinary
☐ Dilute urine
☐ Dark urine
☐ Blood in urine
☐ Cloudy urine
☐ Burning urination
☐ Scanty urine
☐ Profuse urine
☐ Frequent urine
☐ poor bladder control
☐ Urgency to urinate

Musculoskeletal:
Pain, weakness, numbness in:
☐ Arms
☐ Feet
☐ Hands
☐ Joints
☐ Legs
☐ Knee(s)
☐ Hips
☐ Neck
☐ Shoulders
☐ Pain everywhere
☐ Cold limbs
☐ Low back
☐ Lack of strength
☐ Broken bones
☐ All over weakness

Skin
☐ Thick skin
☐ Thin Skin
☐ Dry skin
☐ Acne
☐ Broken blood vessels
☐ Blood not clotting
☐ Bruise easily
☐ Discoloration
☐ Dark circles around eyes
☐ Bags under eyes
☐ Lumps in groin
☐ Lumps in underarm
☐ Brittle nails
☐ Premature gray hair
☐ Dry/brittle hair
☐ Hair falling out

Neurological
☐ Fainting
☐ Convulsions
☐ Change in handwriting
☐ Paralysis
☐ Stroke
☐ Seizures
☐ Tremor
☐ Recent clumsiness
☐ Drowsiness
☐ Vertigo

Emotional
☐ Insomnia
☐ Irritability
☐ Often feel angry
☐ Troubling dreams
☐ Cry uncontrollably
☐ Feel sad a lot
☐ Forgetful
☐ Mind not clear
☐ Anxiety
☐ Much fear
☐ Mania/
☐ Terrors
☐ Difficultly expressing emotions

Men Only
☐ Genital pain
☐ Impotence
☐ Genital sores
☐ Lump in testicles
☐ Penis discharge
☐ Nocturnal emission
☐ Low libido

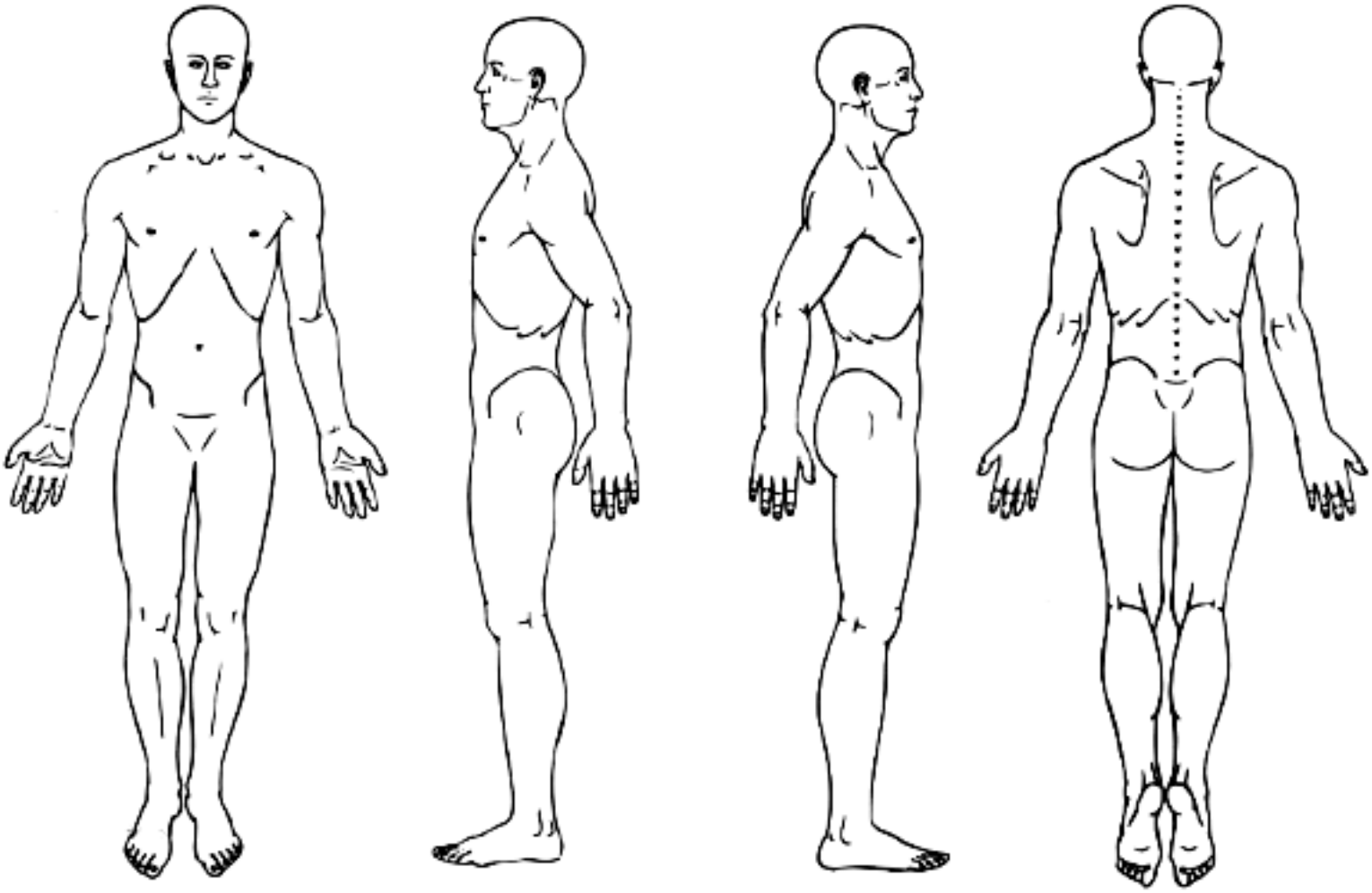
Women Only
☐ May be pregnant
☐ Abnormal pap smear
☐ Bleed between periods
☐ Irregular periods
☐ Heavy Periods
☐ Premenstrual tension
☐ < 25 day cycle
☐ > 35 day cycle
☐ Contraceptives
☐ Menopausal
☐ Low libido
☐ Vaginal discharges
☐ Uterine prolapse
☐ Endometriosis
☐ Facial hair
☐ Loss of head hair

PAIN ASSESSMENT

Name	Date:

1. ☐ Initial Visit ☐ Follow-up Visit

2. Please mark or shade the areas of your body where you feel pain on the diagrams below



3. Next to each area marked above, please note the intesity of pain

No Pain	Minimal		Tolerable but hinders activities		High - 50% of activities impaired		Extreme - most activities impaired		Unbearable
0	1	2	3	4	5	6	7	8	9

BROOKMAN ACUPUNCTURE LLC
CONSENT TO SERVICES

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 on the patient named below, for whom I am legally responsible) by Matthew Brookman and/or other licensed acupuncturist who now or in the future treat me while employed by, working or associated with or serving as back-up for Matthew Brookman, including those working at the clinic or office listed or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, gua sha, cupping, electrical stimulation, tui-na (Chinese massage), Chinese herbs and nutritional counseling.

I have been informed that acupuncture is a generally 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 dew days, and rarely dizziness or fainting. Very rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable single-use needles and maintains a clean and safe environment.

Burns and/or scarring are a potential risk of heat treatments using Artemesia vulgaris (moxibustion, "moxa") or a conventional heat lamp. The heat generated from the moxa treatments may involve slight discomfort or leave a blister or scar on the skin. With any type of heat, there is always a risk of a burn.

Bruise-like marks are common side effect of cupping and gua sha. Cupping and a massage technique called "gua sha" leaves redness, or red/purple marks on the skin that can last for 1-5 days, in rare cases cupping marks take more then 3 weeks to fade. Slight bruising and tenderness may persist after the treatment.

The herbs and/or nutritional supplements that have been recommended are traditionally considered safe, although some may be toxic is large doses. I understand that the herbs and supplements may need to be prepared and the teas consumed according to the instructions provided orally in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs or nutritional supplements.

I understand that this document describes the major risks of treatment, other side effect and risks may occur. I will notify a clinical staff member who is caring for me 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 the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that the results are not guaranteed.

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, the above consent to treatment, I have been told the risks and 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 condition(s) for which I seek treatment.

Print:_____,

Signature:_____ Date:
(or patient representative) (Indicate relationship if signing for patient)