Living Well Acupuncture
5031 Forest Dr, Suite A
New Albany, OH 43054
Phone: (740) 206-8705

Office Use Only	
DR: Michelle Sauberzweig	
Dxl	Dx2
Dx3	Dx4

Confidential Patient Information for Acupuncture

Patient's Full Name: _____ Date: ___/_____/_____
Home Phone: _____ Cell Phone: _____
Mailing Address: _____City:_____ State: _____ Zip: _____
E-Mail:_____ Male Female Age: _____
Date of Birth: _____/____/_____
Occupation: _____ Hours/Week____ Employer: _____ Business Phone: _____
Spouse's Name: _____ Employer: _____ Business Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
How did you hear about our office? _____ If referred, by whom? _____
Have you had previous Acupuncture care: Y / N If Yes, for what Problems: _____
_____
_____

How would you describe your discomfort? _____
Intensity: mild _____ moderate _____ severe _____ other_____
Duration: constant _____ intermittent _____ with certain motions _____

Please list any surgeries/hospitalizations and dates:
_____
_____
_____

Childhood Illness (Please circle any that you have had):
Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox
Other:_____

Please list any medications/supplements/vitamins:
_____
_____

Do you typically eat at least three meals a day? Y / N If no, how many? _____
Exercise Routine:_____
How many hours per night do you sleep?_____ Do you wake rested? Y / N
Do you smoke cigarettes? Y / N If yes, how long?_____ How much? _____
Do you consume alcohol? Y/ N If yes, what kind? _____ How often? _____
Do you use recreational drugs? Y / N If yes, what kind? _____ How often? _____
Do you drink caffeine? Y / N If yes, what kind?_____ How much? _____
Have you experienced any traumas? Y / N Explain:_____
How much water do you drink per day? _____
Females only: What age did you start menstruating? _____ How many days in your cycle? _____
How many days of bleeding? _____ Is your cycle regular? _____ When was your last period? _____

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Please place a check mark for **symptoms/diseases** you have had in the past. Circle the name of any **symptoms/diseases** that you are currently experiencing and write the frequency, intensity or duration.

GENERAL SYMPTOMS
__ Chills
__ Cold hands/feet
__ Confusion
__ Convulsions
__ Depression/Anxiety
__ Fainting/Dizziness/Vertigo
__ Fatigue
__ Fever
__ Forgetfulness
__ Headaches
__ Loss of sleep/Insomnia
__ Loss of weight
__ Migraines
__ Motion Sickness
__ Nervousness
__ Numbness
__ Paralysis
__ Sweating
__ Tremors
__ Other

EYES, EARS, NOSE, THROAT
__ Allergies
__ Asthma/Bronchitis/Pneumonia
__ Blurry vision
__ Cataracts
__ Color blindness
__ Cross eye
__ Deafness
__ Dental decay
__ Difficult speech
__ Difficult swallowing
__ Ear discharge
__ Ear noises/ringing
__ Earache
__ Enlarged/swelling glands
__ Eye inflammation
__ Eye pain or sensitivity
__ Eye strain
__ Failing vision
__ Frequent colds/flu
__ Glaucoma
__ Gum problems
__ Hay fever
__ Hoarseness
__ Loss of hearing
__ Loss of smell
__ Loss of taste/change in tastes
__ Nasal drainage
__ Nasal obstruction
__ Nose bleeds
__ Sinus infection
__ Sore throat
__ Spots/lines in vision
__ Tonsillitis
__ Thyroid problems

SKIN, HAIR, NAILS
__ Boils
__ Cuts heal slowly
__ Finger/Toenail problems
__ Hair problems
__ Hives or allergy
__ Moles/warts
__ Rashes
__ Sensitive skin
__ Skin eruptions
__ Other

RESPIRATORY
__ Chest pain
__ Chronic cough
__ Difficulty breathing
__ Spitting up blood
__ Spitting up phlegm
__ Wheezing
__ Other

CARDIOVASCULAR
__ Anemia
__ Hardening of arteries
__ Heart Disease
__ High blood pressure
__ High cholesterol
__ Irregular heat beat
__ Low blood pressure
__ Low cholesterol
__ Pacemaker
__ Pain over heart
__ Paralytic stroke
__ Poor circulation
__ Previous stroke
__ Rapid heart beat
__ Slow heart beat
__ Swelling of ankles
__ Varicose veins
__ Other

MUSCLE and JOINTS
__ Arthritis/osteoarthritis
__ Backache
__ Disc Problems
__ Faulty posture
__ Fibromyalgia
__ Finger, hand or wrist problems
__ Hernia
__ Pain between shoulders
__ Painful joints
__ Painful tailbone,
__ Sciatica
__ Sore muscles
__ Spinal curvature
__ Stiff joints
__ Stiff neck or neck pain
__ Walking problems
__ Weak muscles
__ Other

GENITOURINARY
__ Bed wetting
__ Bladder problems
__ Blood in urine
__ Discolored/cloudy urine
__ Foul smelling urine
__ Frequent urination
__ Inability to control urine
__ Kidney infection/stones
__ Painful urination
__ Pus in urine
__ Scanty urine
__ Urinary tract infections
__ Venereal disease
__ Other

GASTROINTESTINAL
__ Anal problems
__ Bad breath
__ Belching
__ Black stool
__ Blood in stool
__ Colitis
__ Colon problems
__ Constipation
__ Diarrhea
__ Difficult chewing
__ Distention/bloating
__ Eating disorder
__ Excessive hunger
__ Gallbladder problems/stones
__ Gas
__ Heartburn
__ Hemorrhoids
__ Indigestion
__ Intestinal worms
__ Jaundice
__ Liver problems
__ Mucous in stool
__ Nausea
__ Pain in abdominal area
__ Poor appetite
__ Ulcer/Gird
__ Undigested food in stool
__ Vomiting
__ Vomiting of blood
__ Weight problems
__ Other

FEMALE
__ Abnormal bleeding
__ Abnormal Pap test
__ Breast pain
__ Excessive flow
__ Irregular cycle
__ Lumps in breast
__ Menopausal symptoms
__ Painful menstrual periods
__ Period cramps or Backache
__ PMS
__ Pregnancy
__ Pregnancy complications
__ Previous miscarriage
__ Reduced sex drive
__ Vaginal discharge
__ Vaginal pain
__ Yeast infections
__ Other

MALE
__ Discharges
__ Genital pain or problems
__ Impotence
__ Premature ejaculation
__ Prostate problems
__ Reduced sex drive
__ Seminal emission
__ Other

OTHER
__ Alcoholism/substance abuse
__ Cancer
__ Diabetes
__ Edema Hepatitis
__ Hepatitis A/B/C
__ Herpes
__ HIV+/AIDS
__ Mental/Emotional disorder
__ TB Epilepsy

Consent to Treatment Form

By signing below I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by Michelle Sauberzweig, licensed acupuncturist. I understand that acupuncturists practicing in the state of Ohio are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

Acupuncture: I understand that acupuncture is performed by the insertion of needles at certain points on the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include but are not limited to local bruising, minor bleeding, fainting, pain or discomfort and the possible aggravation of symptoms existing prior to acupuncturist's treatment. I understand that no guarantees concerning its use and effects are given to me and that I am a free to stop acupuncture treatments at any time.

Fire Cupping/Guisha: I understand that cupping is performed by applying glass or plastic suction cups on the body and creating suction. Guisha is a method used for scraping the skin to improve blood flow and reduce muscular tension and pain. These modalities can result in bruising, burns, pain or discomfort as well as aggravation of symptoms existing prior to the treatment. I understand that I may stop the treatment at any time if it is too uncomfortable. I also understand that I may refuse this treatment.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat body dysfunction or diseases, to modify or prevent pain perception and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow 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. They could include, but are not limited to changes in bowel movements, abdominal pain or discomfort and possible aggravation of symptoms exiting prior to herbal treatment. Should I experience any problems that I associate with these substances, I should suspend taking them and call my herbalist/acupuncturist as soon as possible.

Acupressure/Tui-Na Massage: I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that aches and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include but are not limited to electrical shock, pain, or discomfort and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

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

I have read and understand all of the risks involved in regards to each treatment modality. I agree to the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I agree to accept all risks and release all liability from the practitioner. I give my permission and consent to treatment.

_____ X_____

Printed Name Date Patient's Signature Date

MANDATORY DISCLOSURE STATEMENT

Education and Experience

Michelle Sauberzweig earned her Master of Acupuncture and Oriental Medicine degree from Colorado School of Traditional Chinese Medicine in April of 2009. She was certified as a Diplomate in Acupuncture and Traditional Chinese Medicine by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in October 2009. This includes the certification Clean Needle Technique.

This clinic complies with the rules and regulations required by the Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule

Initial Consultation and Treatment	$125
Follow up Treatment	$90
Allergy Elimination Treatment	$50/allergy

Patients Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used and the duration of therapy if known.
- The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrants in the Department of Regulatory Agencies.

The Medical Board of Ohio regulates the practice of acupuncture. If you have any comments, questions or complaints, you may contact them at 30 East Broad Street, 3rd Floor, Columbus, Ohio 43215-6127. Telephone: (614) 466-3934

I have read and understand this document.

_____ _____

Patient's Signature **Date**