



SARAH KNAUP
Licensed Acupuncturist (L.Ac.)

NEW PATIENT PAPERWORK

1. GENERAL INFORMATION

Name _____ Date ____/____/____ Sex _____

Significant Other Name _____

DOB ____/____/____ Age _____ Height _____ Weight _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Fax: _____ Email: _____

Occupation: _____ Employer _____

Emergency Contact: Name _____ Phone: _____

Reason(s) you are coming to see us: _____

Have you had acupuncture before? Yes No

If yes, list condition(s) treated? _____

Referred by: _____

2. INSURANCE

Please present your insurance card at your initial visit

Insurance Company _____ Group Number _____

Insurance Plan Name _____ Insured ID's No _____

Insured Name _____ Insured DOB _____

3. MEDICAL ILLNESS

Do you have or have you had?

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rubella | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis/liver disorder | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Shingles | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Gall Bladder problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Serious injury | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Colitis/enteritis | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart Murmur | | | |

4. MEDICATIONS *List all prescriptions and over-the-counter drugs used during the past year*

Name	Dose and Frequency	Date(s)	Reason

5. OTHER HISTORY *Check all that apply and specify amount (Amt) per day*

- Cigarette Smoke Amt _____
 Alcohol Amt _____
 Caffeine Amt _____
 Exercise Amt _____
 Marijuana Amt _____
 Other drugs Amt _____

5. GENERAL HEALTH *Please put a Check by any condition you experience*

Emotional

- Anxiety
- Difficulty Making Decisions
- Nervousness
- Excessive Worry
- Stress

Energy and Immunity

- Fatigue
- Slow Wound Healing
- Chronic Fatigue Syndrome
- Chronic Infection
- Rashes
- Eczema/Hives

Head, Eye, Ear, Nose, and Throat

- Impaired Vision
- Eye Pain/Strain
- Glaucoma
- Glasses/Contacts
- Tearing/Dryness
- Impaired Hearing
- Ear Ringing
- Earaches
- Headaches
- Sinus Problems
- Nose Bleeds
- Frequent Sore Throats
- Teeth Grinding
- TMJ/Jaw Problems
- Hay Fever

Cardiovascular

- Swelling of Ankles
- Easily Bruise
- Chest Pain
- High Blood Pressure
- Palpitations/Fluttering
- Varicose Veins
- Heart Murmurs
- Cold Hands and Feet
- Anemia

Respiratory

- Difficulty Breathing
- Shortness of Breath
- Persistent Cough
- Frequent Common Colds

Sleep

- Insomnia
- Vivid Dreams
- Night Sweats
- Restless Leg Disorder

Gastrointestinal

- Abdominal Pain
- Epigastric Pain
- Changes in Appetite
- Nausea/Vomiting
- Flatulence
- Heart Burn
- Acid Regurgitation
- Hemorrhoids
- Belching

Genito-Urinary Tract

- Painful Urination
- Frequent UTI
- Frequent Urination
- Frequent Urination at Night
- Kidney Stones
- Impaired Urination
- Blood in Urine

Neurologic

- Vertigo/Dizziness
- Paralysis
- Numbness/Tingling
- Loss of Balance

Musculo-Skeletal

- Neck/Shoulder Pain
- Muscle Spasms/Cramps
- Arm/ Leg Pain
- Back Pain
- Joint Pain

6. FEMALE HISTORY

A. Reproductive/Breasts

- | | | |
|---|--|--|
| <input type="checkbox"/> Irregular Cycles | <input type="checkbox"/> Breast Lumps/Tenderness | <input type="checkbox"/> Nipple Discharge |
| <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Premenstrual Problems |
| <input type="checkbox"/> Light Flow | <input type="checkbox"/> Clotting | <input type="checkbox"/> Bleeding Between Cycles |
| <input type="checkbox"/> Bright Red Blood | <input type="checkbox"/> Dark Red Blood | <input type="checkbox"/> Brown Blood |
| <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Pre-Menopausal Symptoms | <input type="checkbox"/> Difficulty Conceiving |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Menopausal Symptoms | <input type="checkbox"/> Post Menopausal |

B. Menstrual/Birthing History:

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____
 2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births _____
 3. Length of Cycle: _____ 6. # of Miscarriages: _____ 9. # C sections _____

Dates of Last 2 menstrual cycles (if applicable):

1. From ____/____/____ to ____/____/____
 2. From ____/____/____ to ____/____/____

7. MALE HISTORY

- Sexual Difficulties
- Prostrate Problems
- Testicular Pain/Swelling
- Penile Discharge

Sarah Knaup, L.Ac.

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 a Sarah Knaup, L.Ac. at the Comprehensive Therapy Services.

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, 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 acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

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 bodily 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 the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Sarah Knaup, L.Ac. 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 certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or 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 carefully read and understand all of 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 give my permission and consent to treatment.

Signature: _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

FEES AND PAYMENT AGREEMENT

Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled with less than 24 hours notice you may be charged a \$35 fee.

The fees for office services are payable at the time of the visit. We gladly accept the following forms of payment: cash, check, Visa or Mastercard. A \$20 fee will be charged for all return checks.

Please indicate your understanding and acceptance of these policies by signing below.

Signature

Printed Name

Date