Dancing Crane Center of Chinese Medicine

Greg B. Johnston, L. Ac., MOM
11 Library Square, Salem, Virginia 24153 540.444.1053

Personal Data

Name:_____
First Middle Last

Address:_____
Street City State Zip

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Date of Birth:_____ Age:_____ Gender:_____ Marital Status: S/M/D/W/Cohabitating

Emergency Contact:_____ Relation:_____ Contact Phone:_____

Personal Health History

Circle any that apply:
Implants/ Pacemaker/ Pregnant/ Cancer/ HIV/ Hepatitis/ Hearing Aids/ Osteoporosis/ Diabetes
Allergies (food/drug)/ Asthma/ Thyroid/ High Blood Pressure/ Stroke/ Seizures/ Tuberculosis

Hospitalizations/Surgeries:
Reason Date Outcome

_____

_____

Height:_____ Current Weight:_____ Past Maximum:_____ When:_____

What is the main reason for today's visit?

_____

Have you received past treatment for this condition? If yes, what was the treatment and the outcome of the treatment?

_____

_____

Dancing Crane Center of Chinese Medicine

11 Library Square Salem, Virginia 24153 540.444.1053

Female Reproductive

Are you currently pregnant? Yes/ No
Number of live births?_____ Number of pregnancies?_____
Number of miscarriages?_____ Number of Abortions?_____
Did you or do you have trouble with conceiving, pregnancy or delivery? _____

Medications

Please list any medications or supplements you are currently taking?

_____

_____

Please list any medication or food allergies you may have?

_____

_____

Do you have a family history of any of the following? Please circle any that apply to you.

Allergies/ Blood disorders/ Diabetes/ Cancer/Tumors/ Seizures/ High Blood Pressure/ Kidney/ Bladder Prostate/ Stomach/ Intestinal/ Drug or alcohol Abuse/ Heart Disease/ Stroke/ Other

Do you now or have you in the past used:

Alcohol Cigarettes Caffeine

Do you currently see any other Doctors or Physicians? Yes No

If yes, please list.

_____

_____

Have you experienced any major traumas? ie. Deaths, divorce, injury, abuse etc.

_____

_____

Dancing Crane Center of Chinese Medicine
11 Library Square Salem, Virginia 24153 540.444.1053

Do you currently engage in any type of exercise? Yes/ No
If yes, what type of exercise do you engage in?

_____

Do you have any long term health goals that you would like to accomplish? If so, what are they?

_____

What is prohibiting you from accomplishing these goals?

_____

How did you hear about us?

_____

I have filled out the above information accurately and to the best of my ability.

_____ _____
Signature Date

Dancing Crane Center of Chinese Medicine

Greg B. Johnston, L. Ac., MOM

11 Library Square Salem, Virginia 24153 540.444.1053

Informed Consent to Acupuncture and Oriental Medical Treatment

I consent to acupuncture, herbal treatments and other procedures associated with Chinese medicine. I understand that treatment may include, but not limited to acupuncture, moxibustion, cupping, electrical stimulation, herbal medicine and nutritional counseling.

I understand there are risks associated with any medical treatment. Most people experience a sense of relaxation and well being during treatment. Although there is a possibility of slight bruising, tingling or numbness around the site of needle insertion. Dizziness or fainting may also occur, although this is a very rare event. With any form of heat treatment there is always a risk of burning. Herbal treatments may cause stomach discomfort or bowel changes. Bruising is also a possible side effect of cupping. I understand that while this document describes the major risks involved, other side effects may occur.

I will notify the acupuncturist if I become pregnant or if there are any significant changes in my medical condition.

I will expect the acupuncturist to exercise good judgment based on the available information given, and that they will act according to my best interest.

I understand that all of my medical records will be confidential. Any information used for publication or research purposes will omit any identifying information.

By voluntarily signing below, I show that I have read or have had read to me this consent form and that I have given my consent for treatment. This document pertains to treatment for my present condition and any other condition in the future for which I seek treatment.

_____ _____

Please print name Date

_____

Signature