

Patient Consent Form
for
Jamin A Nichols, AP MAON

Please Print,
Fill Out,
and
Bring to your first appointment.

Thank you.

Jamin A. Nichols, AP MAOM
Acupuncture Physician

PATIENT INFORMATION			
Name:			Date:
Home Address:			
City:	State:	Zip:	Email Address:
Phone:	Work Phone:	Cell:	
Business Address:			
City:		State:	Zip:
Occupation:			
Place of Birth:		Date of Birth:	Time of Birth: <input type="checkbox"/> AM <input type="checkbox"/> PM
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height:	Weight:	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Life Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
In Case of Emergency Notify			Relationship:
Phone:			
How did you hear of this office?			
Have you ever before tried acupuncture or Chinese herbal medicine? <input type="checkbox"/> Y <input type="checkbox"/> N			
CHIEF COMPLAINT			
What is the primary reason why you are seeking treatment?			
Please rate the extent to which your current complaint affects your daily life (1 = minor; 10 = major)			
Please rate your commitment to resolving this problem (1 = minor; 10 = major)			
What other forms of treatment have you sought?			
MEDICAL HISTORY (past and present)			
<input type="checkbox"/> Accidents	<input type="checkbox"/> Allergies	<input type="checkbox"/> Birth Trauma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Childhood Illnesses	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Medications	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Seizures
<input type="checkbox"/> Significant Trauma	<input type="checkbox"/> Surgeries	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Vaccinations
<input type="checkbox"/> Venereal Disease			
<input type="checkbox"/> Other (please specify)			
FAMILY HISTORY (check all which apply and specify which blood related)			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Emotional Disorder	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Infectious Disease	
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Other (please specify)			
LIFESTYLE (please indicate the use and frequency of the following)			
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Black Tea		
<input type="checkbox"/> Caffeinated Beverages	<input type="checkbox"/> Coffee		
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Exercise (please specify type)		
<input type="checkbox"/> Recreational Drug			

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MEDICATIONS

Please list any medications and/or supplements you are currently taking.

GENERAL HEALTH (please check all that apply)

<input type="checkbox"/> Bruise/Bleed Easily	<input type="checkbox"/> Catch Colds Easily	<input type="checkbox"/> Chills	<input type="checkbox"/> Cold Abdomen
<input type="checkbox"/> Cold Hand and Feet	<input type="checkbox"/> Cravings	<input type="checkbox"/> Disturbed Sleep	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fevers	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Large Appetite	<input type="checkbox"/> Localized Weakness
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Poor Coordination
<input type="checkbox"/> Soft/Brittle Nails	<input type="checkbox"/> Strong Thirst	<input type="checkbox"/> Sudden Energy Drop	<input type="checkbox"/> Sweat Easily
<input type="checkbox"/> Tremor	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	
<input type="checkbox"/> Other (please specify)			

SKIN AND HAIR

<input type="checkbox"/> Dandruff	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Hives
<input type="checkbox"/> Itching	<input type="checkbox"/> Pimples	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Rashes
<input type="checkbox"/> Recent Moles	<input type="checkbox"/> Redness	<input type="checkbox"/> Ulcerations	
<input type="checkbox"/> Other (please specify)			

HEAD, EYES, EARS, NOSE, THROAT

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Dry Mouth/Throat
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Earaches	<input type="checkbox"/> Headaches	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Floaters	<input type="checkbox"/> Jaw Clicking	<input type="checkbox"/> Migraines	<input type="checkbox"/> Night Blindness
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Recurrent Sore Throats	<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Sores on Lips/Tongue	<input type="checkbox"/> Toothaches		
<input type="checkbox"/> Other (please specify)			

CARDIOVASCULAR

<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cold Hands/Feet	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Fainting	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling of Hands/Feet		
<input type="checkbox"/> Other (please specify)			

RESPIRATORY

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing Blood
<input type="checkbox"/> Coughing Phlegm	<input type="checkbox"/> Difficulty Breathing When Laying Down		<input type="checkbox"/> Nasal Congestion
<input type="checkbox"/> Pain With Deep Breath	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shortness of Breath	
<input type="checkbox"/> Other (please specify)			

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GASTROINTESTINAL			
<input type="checkbox"/> Abdominal Pain/Cramps	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Belching	<input type="checkbox"/> Black Stools
<input type="checkbox"/> Bloating	<input type="checkbox"/> Blood in Stools	<input type="checkbox"/> Chronic Laxative Use	<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> Excessive Appetite	<input type="checkbox"/> Heartburn/Reflux	<input type="checkbox"/> Haemorrhoids
<input type="checkbox"/> Gas	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Lack of Appetite	<input type="checkbox"/> Nausea
<input type="checkbox"/> Rectal Pain	<input type="checkbox"/> Retention of Food in Stomach	<input type="checkbox"/> Sensitive Abdomen	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Other (please specify)			
GENITO-URINARY			
<input type="checkbox"/> Pain In Urination	<input type="checkbox"/> Frequent Urinations	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Urgency to Urinate
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Decrease in Urine Flow	<input type="checkbox"/> Impotence
<input type="checkbox"/> Sore on Genitals	<input type="checkbox"/> Nocturia (wake to urinate)		
<input type="checkbox"/> Other (please specify)			
REPRODUCTIVE/GYNECOLOGICAL			
<input type="checkbox"/> Age of 1 st Period	<input type="checkbox"/> Age at Menopause	<input type="checkbox"/> # of Pregnancies	<input type="checkbox"/> # of Live Births
<input type="checkbox"/> # of Premature Births	<input type="checkbox"/> # of Miscarriages/Abortions	<input type="checkbox"/> # of Days Between Periods	<input type="checkbox"/> # of Days of Flow
<input type="checkbox"/> Breast Lumps/Swelling	<input type="checkbox"/> Color of Blood	<input type="checkbox"/> Clots (Color)	<input type="checkbox"/> Decrease Sex Drive
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Fibroids	<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Hot Flashes
<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Painful Periods	<input type="checkbox"/> Positive Mammogram/Pap Smear	<input type="checkbox"/> Premenstrual Symptoms
<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Strong Menstrual Odor	<input type="checkbox"/> Vaginal Discharge	<input type="checkbox"/> Vaginal Dryness
<input type="checkbox"/> Vaginal Odor	<input type="checkbox"/> Urinary Tract Infection		
<input type="checkbox"/> Other (please specify)			
MUSCULO-SKELETAL			
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Muscle Pain
<input type="checkbox"/> Foot/Ankle Pain	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Hand/Wrist Pain
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Muscle Weakness		
<input type="checkbox"/> Other (please specify)			
NEURO-PHYCHOLOGICAL			
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Areas of Numbness	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Bad Temper
<input type="checkbox"/> Concussion	<input type="checkbox"/> Depression	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Easily Stressed
<input type="checkbox"/> Lack of Coordination	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Poor Memory	<input type="checkbox"/> Seizures
<input type="checkbox"/> Treated for Emotional Problems			
<input type="checkbox"/> Other (please specify)			

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I, _____, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the Florida Acupuncture Practice Act on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below 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, cupping, electrical stimulation, tui-na and shiatsu (oriental massage), oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 few days, and dizziness or fainting. Bruising is a common side effect of cupping. 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 needles and maintains a clean and safe environment. Burns, bruises 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 effect 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. 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 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, have been told about 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.

For purpose of confidentiality, I give permission for my practitioner, Jamin Nichols, AP, MAOM, to leave a phone message at the following phone numbers.

1: () _____ - _____, 2: () _____ - _____, 3: () _____ - _____

PATIENT SIGNATURE _____ **DATE** ___/___/___

(or Parent/Guardian) - Relationship if signing for patient: _____