CHIROBODY

DR. SUE - ACUPUNCTURE NEW PATIENT

PATIENT INFORMATION	CONTACT INFO.
Date: _____ Sex: ☐ M ☐ F	Cell: _____ Work: _____
Name: _____	Email: _____
Birth Date: _____ Age: _____	Address: _____
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	_____
Spouse's Name: _____ DOB:_____	City: _____ State: _____ Zip: _____
If under 18 years of age, list legal parents/guardians:	EMERGENCY CONTACT: _____
Name DOB Phone	Relationship: _____ Phone #: _____
Father: _____	Address: _____
Mother: _____	How did you hear about us?
Guardian: _____	☐ Friend/Family If so, who? _____
Who do you normally live with?	☐ Facebook ☐ Instagram ☐ Other _____
☐ Mother & Father ☐ Father ☐ Mother ☐ Guardian ☐ None	Do we have your expressed permission to send monthly educational and promotional content to your email? ☐ Yes ☐ No

Is this condition or injury due to an accident? ☐ Yes ☐ No

If yes, is this:

☐ Worker's compensation (L n I)

☐ Auto accident - Date of accident or injury: _____/_____/_____

☐ Other, please explain: _____

Cancellation policy: 24 hours noticed is appreciated. Please call or text us at (425) 338-5537 as soon as possible if you are unable to make your appointment.

Signature: _____ Date: _____/_____/_____

Printed Name: _____ DOB:_____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

Dr. Sue Yang-Eng, DAOM, LAc

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name: _____ **Sex:** M F	**Date of birth:** _____/_____/_____
Marital status: Single Partnered Married Separated Divorced Widowed	
Primary Care Doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	Tetanus	Pneumonia
	Hepatitis	Chickenpox
	Influenza	MMR Measles, Mumps, Rubella

List any medical problems that other doctors have diagnosed:

Surgeries:

Year	Reason	Hospital

Other hospitalizations:

Year	Reason	Hospital

Consent to Treatment Form

I the undersigned, hereby voluntarily consent to be treated with acupuncture and/or substances from Oriental Materia Medica by a licensed acupuncturist at Chirobody. I understand that acupuncturists practicing in the state of Washington 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 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, infection, minor bleeding, needle sickness, broken needle, pain or discomfort at the site of insertion or 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 treatment at any time.

Moxibustion: I understand that I may also have moxa performed that involves the burning of mugwort to enhance healing with acupuncture. I am aware the risks of moxibustion can include skin sensitivity, nausea/vomiting, and coughing from the smoke. I understand I may decline this treatment.

Acupressure/Tui-Na: I understand that I may also be given acupressure/tui-na 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 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.

Cupping/Gua Sha/Blasting: I understand that I may also be asked to have cupping/gua sha/blasting as part of my treatment to mobilize blood flow and promote healing. I am aware that certain side effects may result. These may include, but are not limited to: bruising, pain, discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may decline this treatment.

About Dr. Sue Yang-Eng: Dr. Yang-Eng received her training in acupuncture and Chinese herbal medicine from Bastyr University. She obtained a Masters of Science Degree in Acupuncture and Oriental Medicine and a Doctorate of Acupuncture and Oriental Medicine Degree in 2000 and 2009, respectively. She holds a current Acupuncture license from the state of Washington issued in December 2001, #AC00001849.

WA Scope of Practice: The "scope of practice" for an acupuncturist in the state of Washington includes but is not limited to the following list of techniques: Use of acupuncture needles to stimulate acupuncture points and meridians; Use of electrical, mechanical or magnetic devices to stimulate acupuncture points and meridians; Moxibustion; Acupressure/Tui Na; Cupping; Dermal friction technique (gua sha); Infra-red; Sonopuncture; Laserpuncture; Dietary advice based on traditional Chinese medical theory; and Point injection therapy (aquapuncture).

Patients that are pregnant or may be pregnant and patients that have severe bleeding disorders or pacemakers must inform the practitioner prior to treatment.

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.

Printed Name: _____

_____ _____

Signature of the patient (or guardian if under 18) Date