Stonegate Wellness
Justin Phillips, LAc., MSTCM
512-673-0617
stonegatewellness@yahoo.com
www.stonegatewellness.com

Name_____ **Date**_____
Last **First** **Middle**

Address_____

City, State, Zip_____

Home Phone_____ **Alt Phone**_____

Email_____ **Best Method/Time**_____

Sex __M __F **Birth Date**_____ **Marital Status**_____

Parent/Guardian(if under 18)_____

Employer/Occupation_____ **Work Phone**_____

Emergency Contact_____ **Phone**_____

Primary Physician_____ **Phone**_____

How did you hear about Stonegate Wellness_____

Have you ever had acupuncture before __Y __N Where_____

I _____, as a patient of Stonegate Wellness recognize that although acupuncture is beneficial for many things it does not replace regular check-ups by my primary care physician. Regular check-ups and physicals are an important part of maintaining good health and I recognize that it is my responsibility to see my primary care physician for these check-ups.

_____ _____
Patient Date

_____ _____

Parent/Guardian(if under 18) Date

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Health History

Name_____ Date of Birth _____

Today's Date_____

Personal/Family Health History: Please indicate the appropriate boxes below

	Self	Mother	Father	Sibling	Spouse	Child	Other
Allergies							
Blood Disorder							
Diabetes							
Cancer/Tumors							
Seizures							
High Blood Pressure							
Kidney/Bladder Disorder							
Stomach/Intestinal Disorder							
Drug Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Mental Illness							
Obesity							
Asthma/Emphysema							
Eye Disease, Glaucoma							
Arthritis							
Auto Immune Disease							
Gall Bladder/Liver Disease							
Age at Death							
Other							

Please List any Medications/Herbs (over the counter or perscription) you are taking
List doses if you know them

_____ _____
_
_____ _____
_

_____ _____
_
_____ _____
_
_____ _____
_
_____ _____
_
_____ _____
_

Are you allergic to any medications, foods, or latex? Please list

_____ _____
_
_____ _____
_
_____ _____
_

Have you been hospitalized or had a major surgury? Please list illness and appr. Year

_____ _____
_
_____ _____
_
_____ _____
_

Habits: Please answer any that apply

Coffee __y __n Cups per day/week___ age started___ age quit___
Tobacco __y __n Uses per day/week___ age started___ age quit___
Marijuana __y __n Uses per day/week___ age started___ age quit___
Alcohol __y __n Uses per day/week___ age started___ age quit___
Other narcotics __y __n Uses per day/week___ age started___ age quit___
Others_____

Typical Daily Diet(please include drinks)

Breakfast_____

Lunch_____

Dinner_____

Snacks_____ When_____

Is there anything else we should know about your health?

_____
_____
_____
_____

Digestive Health

How often are your bowel movements?

Are the difficult, hard, or loose?

Are the difficult, hard, or loose?

Any bloating after eating?

Fatigue after eating?

Acid reflux?

Respiratory Health
Do you have shortness of breath? How often?

Cough?

Sinus congestion?

Nasal discharge? What color? Is it thick or thin?

Cardiovascular Health
Do you have palpitations? (You can feel your heart beat in your chest)

Chest pain?

Cold hands and feet?

Diziness?

Energy and Sleep
How is your energy level? When is it best during the day? When is it worst?

Do you get to sleep easily? Do you sleep through the night?

Do you wake up feeling rested?

Do you dream frequently? Calm or disturbing dreams?

Urinary Health
How frequently do you urinate?

What is the consistency of your urine? What color?

Do you have to get up at night to urinate?

Do you have any dribbling or urinary incontinence?

Any discomfort with urination?

Informed Consent for Acupuncture Treatment

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures, including various modes of physiotherapy on me (or 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 working or associated with, or serving as a back-up for the acupuncturist named below, including those working at this or any other office, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping & gua sha, electrical stimulation, breathing techniques, exercise therapy Tui-Na (Chinese massage), Chinese or western herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects,

I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not make significant movements while the needles are being inserted, retained, or removed. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, mineral, and animal sources) that have been recommended are traditionally considered safe in the practice of Chinese 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 understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

Patients Name	Acupuncturists Name
Patient Signature	Acupuncturist Signature
Parent or Guardian Name	Parent or Guardian Signature
Date	