Alchemy Clinic
Acupuncture - Traditional Medicine - Health

HEALTH HISTORY FORM

Today's Date _____

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Best Phone Number:_____

Email:_____

Date of birth: _____/_____/_____ Age:_____ Weight:_____ Height_____

Birthplace:_____

Marital Status: Single_____ Married____ Partnered____ Widowed____ Divorced____

# of Children_____ Ages of Children_____

Employer:_____Occupation:_____

Primary Care Physician:_____

Emergency Contact Person:

Name:_____Phone#_____

_____

Chief health concern(s): (please list in order of concern)

_____

_____

How long ago did this/these problem(s) begin? _____

Have you been given a diagnosis for this problem?_____ If yes, what? _____

_____

*To what extent does this problem interfere with your daily activities?*_____

Therapies that you have tried in the past for this problem:

_____

Are you currently involved in any other therapies for this problem? If yes, which?

_____

Is this your first experience with acupuncture? Yes_____ No _____

Please list all Supplements and Vitamins currently taking:

_____

_____

Please list all Drugs or Medications below: (if needed attach a second sheet or list)

Drug or Medication	Reason for taking

Any significant past health crisis or conditions not already mentioned (injury, accidents, serious diseases, etc.):

_____

_____

_____

Any current (chronic or acute) health conditions not already mentioned:

_____

_____

_____

Please list three goals you would like to focus on during your time with Alchemy Clinic:

1. _____

2. _____

3._____

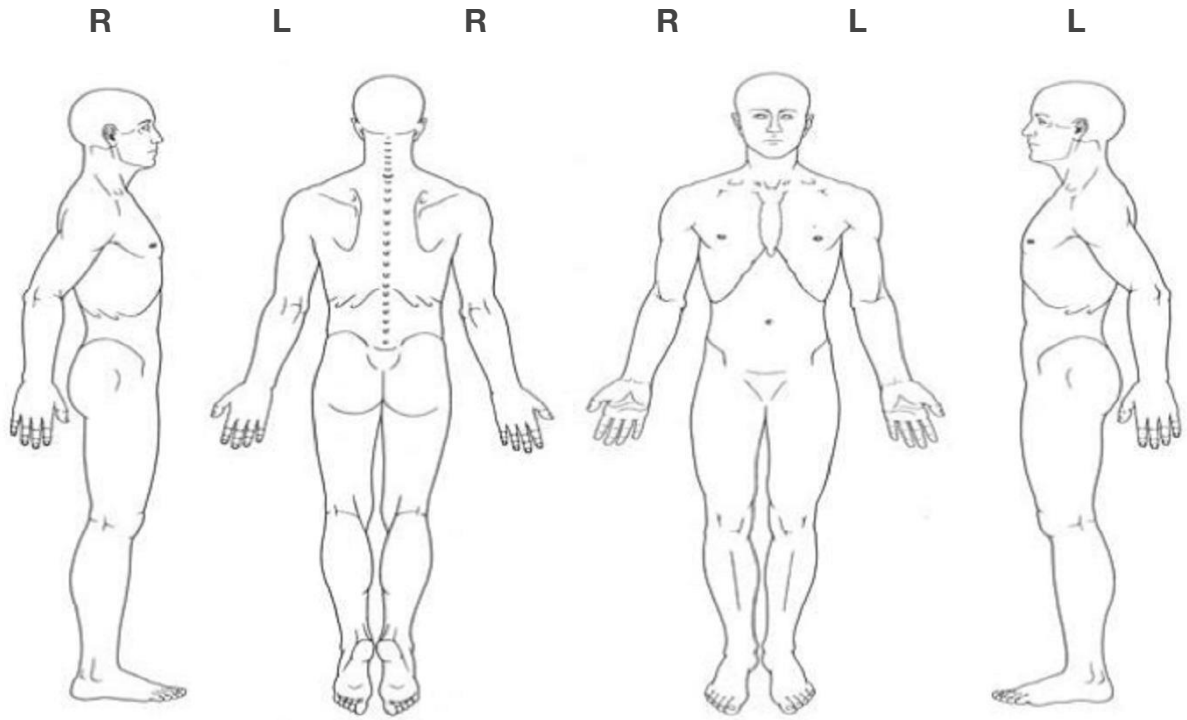
Pain Questionnaire

Do you ever experience pain or discomfort in your physical body? _____

If **yes**, please indicate the area and the intensity (ranging from1 mild to 10 extreme):

- *Area: _____ (mild) 1 2 3 4 5 6 7 8 9 10 (extreme)*
- *Area: _____ (mild) 1 2 3 4 5 6 7 8 9 10 (extreme)*
- *Area: _____ (mild) 1 2 3 4 5 6 7 8 9 10 (extreme)*

Please circle the area of the body where there is currently discomfort or pain:



Please circle the nature of the pain:

Sharp Distended Numbness/Tingling Dull/Achy

Pain in the Nerve Heavy Radiating (if so where?:_____)

Other (please explain): _____

Consent Form for Traditional Chinese Medicine Methods

I,_____ (full name) the undersigned, hereby authorize Maria "Montserrat" Gonzalez, L.Ac, to perform the following specific procedures as seen fit for my condition in order to get the best result:

Acupuncture: the insertion of special sterilized needles through the skin into underlying tissues, at specific points on the body.

Electroacupuncture: a form of acupuncture where a small electric current is passed between pairs of acupuncture needles. According to some acupuncturists, this practice augments the use of regular acupuncture, can restore health and well-being, and is particularly good for treating pain.

Fire Cupping: a technique to relieve symptoms in which cups made of glass, bamboo or other materials are placed on the skin with a vacuum created by heat or other device.

Gua Sha: rubbing on an area of the body with a blunt, round instrument. I recognize the potential risks and benefits of these procedures as described below:

Potential risks: discomfort, pain, infection or blistering at the site of the procedure; temporary discoloration of the skin; nausea, loose bowel movements, fainting, or aggravation of symptoms existing prior to the acupuncture treatment.

Potential benefits: drugless relief of presenting symptoms and improved balance of bodily energies, which may lead to prevention or elimination of the presenting problem, and strengthening the constitution.

Telemedicine Appointments: I understand my practitioner may suggest an online session if deemed appropriate, using HIPAA approved technology, if a live session is not possible.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Montserrat Gonzalez, L.Ac, regarding cure or improvement of my condition.

I hereby release Montserrat Gonzalez, L.AC, from any and liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care.

I understand I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Maria Montserrat Gonzalez, L.Ac. Missouri State License #2014004061, NCCAOM Diplomate

PATIENT SIGNATURE: _____ TODAY'S DATE: _____