Olive Branch Healing

All information on this form is confidential. Please print.

Name: _____ Date: _____
Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____
Occupation: _____ Email: _____
Are you: ( ) Married/in a Partnership ( ) Single ( ) Divorced ( ) Widow/Widower

Date of Birth: _____ Place of Birth: _____

What would you like treated -- health conditions and goals?

Have you been given a diagnosis? Please explain. _____
_____

Indicate any accidents, surgeries, hospitalizations, etc. that you have had:

	Date or Age
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had or do you have a communicable disease?	Yes	No	If yes, when & how long
Mono	___	___	_____
Hepatitis A ____ B ____ C ____	___	___	_____
AIDS/HIV	___	___	_____
Tuberculosis	___	___	_____

Other Specify: _____

Current and Past Conditions

For any illness or condition, please mark "**C**" for Current; and/or "**P**" for a past condition.

_____ Anemia	_____ Allergies	_____ Alcoholism
_____ Arthritis	_____ Food Allergies	_____ Anxiety
_____ Bleeding Gums	_____ Brittle Nails	_____ Bladder Infection
_____ Bronchitis	_____ Bleeding Tendency	_____ Bruise Easily
_____ Cold Hands &/or Feet	_____ Cancer	_____ Lymph Nodes Removed
_____ High Cholesterol	_____ Frequent Colds	_____ Diabetes
_____ Dizziness	_____ Emphysema	_____ Depression
_____ Edema	_____ Forgetfulness	_____ Gallstones
_____ Epilepsy	_____ Goiter	_____ Insomnia
_____ Rheumatism	_____ Hay Fever	_____ Osteoporosis
_____ Grinding Teeth	_____ High Blood Pressure	_____ Reduced Sexual Energy
_____ Hearing Loss	_____ Tension/Stress	_____ Perspire Easily
_____ Herpes	_____ Frequent Colds	_____ Ringing in Ears/Tinnitus
_____ Hives or Rashes	_____ Migraines	_____ Pacemaker
_____ Kidney Stones	_____ Pericarditis	_____ Lyme Disease
_____ Asthma	_____ Thyroid Condition	_____ Shortness of Breath
_____ Night Sweats	_____ Irregular Heart Beat	_____ Sores in Mouth
_____ Palpitations	_____ TMJ	_____ Sinusitis
_____ Pneumonia	_____ Venereal Disease	_____ Reduced Energy

In your family is there a history of:

	Yes?	Relationship		Yes?	Relationship
Anxiety	____	_____	Heart Problems	____	_____
Alcoholism	____	_____	Stroke	____	_____
Cancer	____	_____	Tuberculosis	____	_____
Diabetes	____	_____	Depression	____	_____

List any medications (prescription or over-the-counter) you are currently taking:
_____
_____

What vitamins or supplements do you regularly take? _____
_____

Daily Consumption?

Liquor	_____	Red Meat	_____
Beer	_____	Fish	_____
Wine	_____	Fowl	_____
Coffee	_____	Dairy	_____
Decaf Coffee	_____	Eggs	_____
Tea	_____		
Soft Drinks	_____	Cigarettes	_____
Water	_____	Cigars or Pipe	_____

Gastrointestinal

For any illness or condition below, mark "**C**" for Current and/or "**P**" for Past condition.

_____ Anorexia	_____ Bulimia	_____ Obesity
_____ Overweight	_____ Belching	_____ Flatulence-gas
_____ Heartburn	_____ Abdominal Bloating	_____ Abdominal Pain
_____ Pain After Eating	_____ Pain Before Eating	_____ Tired after Eating
_____ Underweight	_____ Ulcer	_____ Rapid Weight Change
_____ Hypoglycemia	_____ Colitis	_____ Difficulty Swallowing
_____ Nausea	_____ Stomach Tension	_____ Irritable Before Eating
_____ Constipation	_____ Diarrhea	_____ Irregular Bowels
_____ Hemorrhoids	_____ Bleeding from Rectum	_____ Undigested food in stools
_____ Acid Reflux	_____ Hard Stools	_____ Irritable Bowel Syndrome
_____ Loose Stools	_____ Crohn's Disease	_____ Distress from fats (such as nausea,
	_____ Use laxatives	dizziness, headaches, etc.)

What foods or tastes do you have cravings for? _____
_____

Do you prefer hot or cold drinks? ( ) Hot ( ) Cold ( ) No Preference
Do you yourself tend more toward being hot or cold? ( ) Hot ( ) Cold ( ) Neither

Energy and Exercise

How is your energy? ( ) Always High ( ) Pretty Good ( ) Just OK ( ) I Feel Tired Most of the Time
Do you fatigue easily? _____
What time of day is your energy: Highest _____ Lowest _____

Please describe the kind(s) of exercise you do, or your program of physical fitness. _____
_____
How often do you exercise? _____

Stress and Emotions

How long do you normally sleep? _____ hours per night

Please check all that apply. I have difficulties ...

( ) Falling asleep ( ) Staying asleep ( ) Disturbed sleep
( ) Nightmares ( ) Vivid dreams
( ) Waking up at about _____ am/pm, and not being able to fall asleep again.

Describe the levels of stress in your life. How does stress impact you and how do you deal with stress?

_____
_____

Which emotions seem to be predominant in your life? _____
_____

Is your marriage or current relationship stable? _____ Yes _____ No
How do you feel about your relationship? _____

Do you use any prescription or non-prescription substances? Anti-depressants _____ Sleeping Pills _____

For Women Only. (Men please skip this section and continue with the next.)

At what age did you start menstruating? _____ Number of days between cycles? _____
Number of days of flow: _____ Color of flow: _____

Symptoms of menopause: _____

Number of pregnancies? _____ Number of miscarriages? _____ Number of abortions? _____

Do you currently take birth control pills? _____ For how long? _____
Have you ever taken birth control pills? When and for how long? _____
Type of contraception now used? _____

Do you go to the gynecologist annually? When was your last visit? _____
_____

Please mark "**C**" for Current and/or "**P**" for a Past condition.

_____ Heavy Bleeding	_____ Cramping Before Period	_____ PMS
_____ Cramping with Period	_____ Clots with Period	_____ Ovarian Cyst
_____ Bleeding Between Periods	_____ Genital Herpes	_____ PID
_____ Vaginal Burning/Itching	_____ Urinary Tract Infection	_____ Breast Lumps
_____ Yeast Infection	_____ Vaginal Discharge	_____ Infertility
_____ Pain During Intercourse	_____ Bleeding After Intercourse	_____ Fibroids
_____ Hormone Imbalance	_____ Endometriosis	_____ Spotting Between Periods
_____ Light Menstrual Flow	_____ Breast distention	_____ Emotions before/during menses

For Men Only. (Women please skip this section and continue with the next.)

Please mark "**C**" for Current and/or "**P**" for Past conditions.

_____ Urine Stream Weak or Slow
_____ Frequent Urination with Small Amount
_____ Dribbling After Urination
_____ Burning Urination
_____ Waking at Night to Urinate
_____ Prostate Disorder
_____ Discharge from Penis
_____ Nocturnal Emission
_____ Loss of Sexual Activity
_____ Swelling or Lumps on Testicles

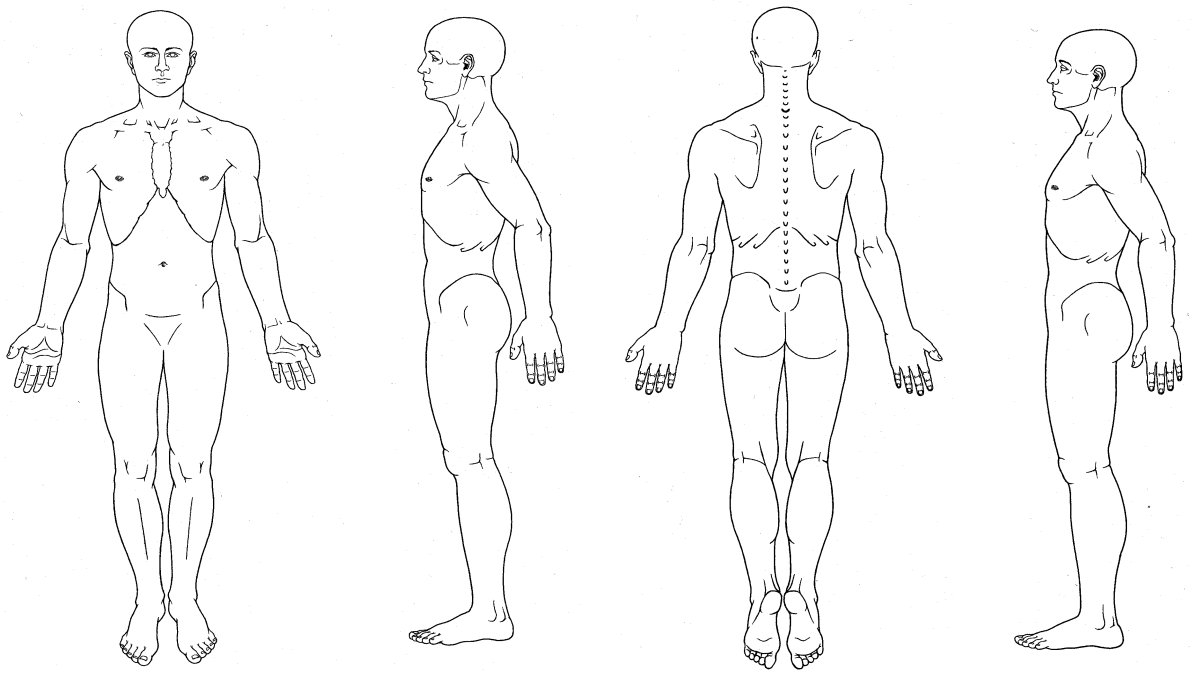
_____ Genital Burning
_____ Urinary Tract Infection
_____ Yeast Infection
_____ Genital Itching
_____ Infertility
_____ Genital Herpes
_____ Pain during Intercourse
_____ Premature Ejaculation
_____ Hernia
_____ Painful Testicles or Penis

Type of contraception used: _____

Have you ever had a prostate examination? If so, when. _____
_____

Muscles, Joints and Bones

On the drawings below, please shade in the areas of your body where you experience pain or discomfort.



Do you currently have any: Pain _____ Tightness _____ Stiffness _____

What is the level of your pain? (circle one) Least 1---2---3---4---5---6---7---8---9---10 Most

The pain feels: (circle all that apply) Sharp Dull Aching Numb/Tingly Burning Deep
Superficial Worse with cold Better with cold Worse with heat Better with heat Worse with rest

Better with rest Worse with pressure Better with pressure Better in AM Better in PM

Physician Advisory

While Chinese medicine has a great deal to offer as a health care system, it cannot replace the resources available through medical physicians. It is recommended that you consult a physician regarding any condition for which you are seeking acupuncture treatment.

I, (Print Name) _____ have been advised by Jessie Shaw, L.Ac., to consult a physician regarding the conditions for which I am seeking treatment.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Signature of practitioner Date

Informed Consent

I consent to acupuncture treatments and related procedures associated with Chinese medicine by Jessie Shaw, L.Ac. I have discussed the nature and purpose of my treatment with her and I understand that the methods of treatment may not be limited to acupuncture, but may also include moxibustion, cupping, gua sha, electrical stimulation and bloodletting.

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. Although extremely rare, some people experience dizziness, nausea, a cold sweat, or fainting. If any of these symptoms occur please let the practitioner know immediately so that the needles can be removed. These symptoms go away immediately after the needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. This office uses sterile, disposable needles and maintains a clean and safe environment. Burns and scarring are potential risks of using moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The possible benefits of acupuncture treatment are an increased feeling of well being, total or partial abatement of symptoms, improvement of bodily energies that may lead to enhanced health. Everyone responds to treatment differently. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several treatments have been taken. Please let the practitioner know how you responded to the previous treatment at the time of your follow up visit, so your treatment plan can be adjusted accordingly if necessary.

I understand that the practitioner and administrative staff may review my medical records and reports, but all of my records will be kept confidential and will not be released without my written consent. I will notify the acupuncturist who is caring for me if I become pregnant.

By voluntarily signing below, I show that I have read or have had read to me this consent to treatment. I 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 conditions for which I seek treatment.

_____

Printed name of patient or patient's representative

_____ _____

Signature of patient or patient's representative Date

This office has a firm 24 hour cancellation policy. Payment in full will be due for all sessions cancelled less than 24 hours prior to the scheduled appointment.