

**Michigan TCM Wellness Center**  
**Acupuncture Informed Consent to Treat**

Patient Name: \_\_\_\_\_

**This is to acknowledge that I have been informed and understand that:**

- Any treatment or advice provided to me as a patient of Emily Liburdi, Dipl. O.M. is not mutually exclusive from any treatment or advice that I may be receiving now, in the future or from another health care provider.
- I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider. Emily Liburdi also encourages you to maintain established care with your primary care provider.
- The treatment and therapies provided or recommended by this clinic may be different than those usually offered by other licensed health care providers.
- The treatments for cancer are adjunctive and the patient needs to maintain a continuing relationship with a surgeon or an oncologist.
- I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Emily Liburdi, Dipl. O.M.
- I understand the methods of treatment may include, but are not limited to; acupuncture, Moxibustion, cupping, electrical stimulation, tui-na (traditional Chinese Medical Massage), gua sha (Chinese therapeutic scraping), Chinese herbal prescriptions, and nutritional and lifestyle counseling.
- I will notify the practitioner immediately of any unanticipated or unpleasant effects associated with the consumption of herbs or other products.
- I will keep the practitioner informed of any pharmaceutical drug or nutritional supplement, which I am taking, in order to allow proper timing and dosage of Chinese Herbal prescriptions, western herbs or other nutritional supplementation.
- 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 needling sites that may last several days and dizziness or fainting. Bruising is a common side effect of gua sha or cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the practitioner uses sterile, single-use, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a possible risk of Moxibustion and cupping. I understand that while this document describes the major risks of treatment, other risks may be present and other side effects may occur. The herbs and nutritional supplements (which are from plant, mineral and occasionally animal sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in extreme doses. I understand some herbs may be inappropriate in 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 the acupuncturist if I 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 my review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I request and consent to the performance of acupuncture and Oriental Medicine procedures at this clinic. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature on this form indicates that I have read and understand the information provided regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I hereby release the practitioner from any and all liability that may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I hereby authorize and consent to treatment and 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 from Emily Liburdi, Dipl. O.M.

\_\_\_\_\_  
Patient or Guardian's Signature

\_\_\_\_\_  
Date

## **Financial Arrangements and Insurance**

We are committed to providing you with the best possible care. If you have insurance, we are willing to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. We emphasize, then, as health care providers; our relationship is with YOU, not your insurance company. It is necessary for you to be aware of your benefits.

Payments, including copays, are due at the time services are rendered. We accept cash, checks, MasterCard, Visa or American Express. Returned checks will be subject to a \$30 fee.

I authorize Michigan TCM Wellness Center to release any medical information necessary to process my insurance claim and I authorize payment of medical benefits to be made to the provider listed above for the services rendered.

If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you.

I hereby authorize payment directly to Michigan TCM Wellness Center LLC. for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges if insurance does not cover them. I authorize Michigan TCM Wellness Center LLC. to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Submission to insurance companies is not a guarantee of payment. I also understand that the full fee will be charged if I miss an appointment giving less than 48 hours notice. I understand that this missed appointment fee will not be covered by insurance and that I will be responsible for payment.

**Patient/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Patient Name** \_\_\_\_\_ **Patient DOB** \_\_\_\_\_

Notice of Privacy Practices I have been offered and/or received a copy of Michigan TCM Wellness Center Notice of Privacy Practices. Additional copies are available at any time at our front desk or on our website. We will be happy to answer any questions or discuss any component of these rights and responsibilities.

X \_\_\_\_\_ / /

Signature (Patient, Parent, Guardian)

Date

**To best serve you, appointment slots are not double-booked. The office reserves the appointment time for only your visit. I understand that there is a 48-hour cancellation policy. I understand that I will be charged the full cost of the treatment if I have a missed appointment or a late cancellation. Please initial here: \_\_\_\_\_**

# Michigan TCM Wellness Center

## NEW PATIENT HEALTH HISTORY

All information is treated as confidential and will not be released without consent. All information obtained from this history will help in both your assessment and assist you in achieving your wellness goals.

**Date:** \_\_\_\_\_

PATIENT CONTACT INFORMATION			
Patient's Last Name:	First:	Middle:	Name Preference:
Date of Birth:	Age:	Height:	Weight:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans <input type="checkbox"/> FTM <input type="checkbox"/> MTF			
Street Address:		City:	State:                      Zip:
Home Phone:	Cell Phone:		Email Address:
May our office call and leave a message? <input type="checkbox"/> YES <input type="checkbox"/> NO Please mark which number (s) you prefer to be contacted at.			We will <b>never sell or transfer</b> your information to third parties. May our office send you emails about clinic special events and offers? <input type="checkbox"/> YES <input type="checkbox"/> NO
Occupation:	Employer:		
Employer Address:			Employer Phone:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership			
EMERGENCY CONTACT			
Emergency Contact Name:		Relationship:	Phone:
PRIMARY CARE PROVIDER			
Doctor's Name:		Phone:	Date of Last Visit:
OTHER			
Have you tried Acupuncture before? <input type="checkbox"/> YES <input type="checkbox"/> NO      Herbal Medicine? <input type="checkbox"/> YES <input type="checkbox"/> NO			Who should we thank for referring you:
FINANCIAL POLICY			
<p>The provider has informed me that it does not participate with my insurance. I have been informed that I will be billed for all items and services received, and that it is my responsibility to be compensated by my insurance. I understand and assume financial responsibility for any and all services and items received.</p> <p><b>To best serve you, appointment slots are not double-booked. The office reserves the appointment time for only your visit. I understand that there is a 48-hour cancellation policy. I understand that I will be charged the full cost of the treatment if I have a missed appointment or a late cancellation.</b></p> <p>I understand and agree to the Financial Policy as stated above:</p> <p>Printed Name _____ Date _____</p> <p>Signature _____</p>			

**GENERAL HEALTH**

**Purpose of the visit:** What is the primary concern associated with your visit today?

How long have you had this/these issues?

What forms of treatment have you had for this condition, if any?

Does anything make the condition better?  YES  NO If yes, what?

Does anything make the condition worse?  YES  NO If yes, what?

Are there any other issues or health concerns you are hoping to work on?

Please list all surgeries, hospitalizations & serious illnesses (Include dates):

**HABITS**

Past      Current

- |                          |  |   |                   |
|--------------------------|--|---|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Tobacco Use:        | If yes, # cigarettes per day _____        | Age started _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Alcohol Use:        | If yes, # drinks per week _____           | Age started _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Recreational Drugs: | If yes, drug name _____ Use per day _____ | Age started _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Caffeine Use:       | # sodas/day _____ # coffee/day _____      | # tea / day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Other:              | If yes, use per day _____                 |                   |

Food Cravings \_\_\_\_\_ Salty    Sweet    Sour    Bitter    Fats/Greasy  
 Food Sensitivities \_\_\_\_\_ Mark any dietary choices that apply: Vegan Vegetarian Other \_\_\_\_\_

Do you sleep well? Yes    No    Average Hours/night \_\_\_\_\_ How is your energy level? Low Medium High  
 Bowel frequency \_\_\_\_\_ #Times/day    Difficulty Yes No    Urinary frequency \_\_\_\_\_ #Times/day    Difficulty Yes No

**Please mark the list of symptoms you experience:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Dry Skin                          | <input type="checkbox"/> Cough               | <input type="checkbox"/> Hearing Loss                  |
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Hot Flashes                       | <input type="checkbox"/> Wheeze              | <input type="checkbox"/> Low Back Pain                 |
| <input type="checkbox"/> Abdominal Pain       | <input type="checkbox"/> Flushed Face                      | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Ear Ringing                   |
| <input type="checkbox"/> Digestive Problems   | <input type="checkbox"/> Dry Mouth                         | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Knee Pain                     |
| <input type="checkbox"/> Lack of Appetite     | <input type="checkbox"/> Night Sweats                      | <input type="checkbox"/> Grief               | <input type="checkbox"/> Fertility Issues              |
| <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Loose Stools/Diarrhea             | <input type="checkbox"/> Catch colds easily  | <input type="checkbox"/> Low Libido                    |
| <input type="checkbox"/> Poor Memory          | <input type="checkbox"/> Constipation                      | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Hair Loss                     |
| <input type="checkbox"/> Heavy Limbs          | <input type="checkbox"/> Palpitations                      | <input type="checkbox"/> Phlegm              | <input type="checkbox"/> Often Cold/Prefer warmth      |
| <input type="checkbox"/> Constant Worry       | <input type="checkbox"/> Vivid Dreams                      | Color _____                                  | <input type="checkbox"/> Preference for cold beverages |
| <input type="checkbox"/> Abdominal Bloating   | <input type="checkbox"/> Anxiety                           | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Bad Breath                    |
| <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Depression                        | <input type="checkbox"/> Swollen limbs       | <input type="checkbox"/> Foul Smelling Stools          |
| <input type="checkbox"/> Easily Stressed      | <input type="checkbox"/> Manic Episodes                    |  | <input type="checkbox"/> Heat Intolerance              |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Irregular Heartbeat               |  | <input type="checkbox"/> Allergies                     |
| <input type="checkbox"/> Migraines            |  |  | <input type="checkbox"/> Sinus Congestion              |
| <input type="checkbox"/> Teeth Clenching      | <input type="checkbox"/> Muscle Spasm/Twitching            |  |  |
| <input type="checkbox"/> Bad Temper           | <input type="checkbox"/> Eye Twitching                     |  |  |
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Vertigo                           |  | <input type="checkbox"/> Vaginal Discharge             |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Seizures                          |  | <input type="checkbox"/> Frequent UTI's                |
| <input type="checkbox"/> Premenstrual Tension | <input type="checkbox"/> Dizziness                         |  | <input type="checkbox"/> Acne                          |
| <input type="checkbox"/> Floaters             | <input type="checkbox"/> Gallstones                        |  | <input type="checkbox"/> Rashes                        |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Difficulty digesting greasy foods |  | <input type="checkbox"/> Eczema                        |
|   | <input type="checkbox"/> Easily Startled                   |  | <input type="checkbox"/> Psoriasis                     |

**MEDICATIONS**

**Are you allergic to anything?**    YES    NO   **Please list all known allergies to medications, food or other:**

I have a pacemaker    I am taking a blood thinner (Coumadin/Warfarin/Heparin)    I am taking anti-seizure meds    I am pregnant

Please list all medications, both prescription and over-the-counter that you are currently taking:

Medication	Reason for taking	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❖ Please continue on back of sheet if more space needed.

Please list all herbal formulas, supplements and vitamins you are taking:

**FAMILY MEDICAL HISTORY**

	You	Relative	Year		You	Relative	Year
Cancer (Type)				Tuberculosis			
Stomach/Intestinal Disorder				Autoimmune Disease (Type)			
High Blood Pressure				HIV/AIDS			
High Cholesterol				COPD/Emphysema			
Diabetes				Heart Disease			
Stroke				Seizures			
Asthma				Hepatitis			
Neurological Disease				Thyroid Disorder			
Emotional Disorders				Alzheimer's			
Infectious Disease				Other:			

Sexually Transmitted Diseases:    Herpes    HPV    Gonorrhea    Syphilis    Chlamydia   Date \_\_\_\_\_

**SELF**

How do you feel about the following: (please circle)

	FAIR			GREAT		COMMENTS
	1	2	3	4	5	
Your Life	1	2	3	4	5	_____
Your Health	1	2	3	4	5	_____
Your Significant Other	1	2	3	4	5	_____
Your Family	1	2	3	4	5	_____
Your Profession	1	2	3	4	5	_____

**FEMALE HEALTH**

Date Last Menstrual Period \_\_\_\_\_ Age of First Period \_\_\_\_\_  
 Age of Last Period (Menopause) \_\_\_\_\_

Are You Pregnant?  YES  NO  
 Expected Due Date \_\_\_\_\_

Number of Days in Between Periods \_\_\_\_\_  
 Number of Days of Flow \_\_\_\_\_  Heavy  Light  
 Color:  Pink  Red  Bright Red  Brown  Black  
 Clots:  Small  Medium  Large  
 Average number of pads/tampons used per day \_\_\_\_\_  
 Cramps  YES  NO Location? \_\_\_\_\_  
 Dull  Stabbing  Consistent  Intermittent

No. of Pregnancies \_\_\_\_\_  
 No. of Live Births \_\_\_\_\_  
 No. of Abortions \_\_\_\_\_  
 No. of Miscarriages \_\_\_\_\_  
 Are you taking birth control?  YES  NO  
 Name of Birth Control \_\_\_\_\_ How long? \_\_\_\_\_  
 Are you on hormone replacement therapy?  YES  NO

Last Exam Date	Normal	Abnormal	Last Exam Date	Normal	Abnormal
Gynecologic Exam _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	Pap Smear _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____
Mammogram _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____	Bone Density _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____
Colonoscopy _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____			

**MALE HEALTH**

<b>Last Exam Date</b>	<b>Normal</b>	<b>Abnormal</b>
Digital Rectal Exam _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____
PSA Labs _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____
Colonoscopy _____	<input type="checkbox"/> YES <input type="checkbox"/> NO _____	_____

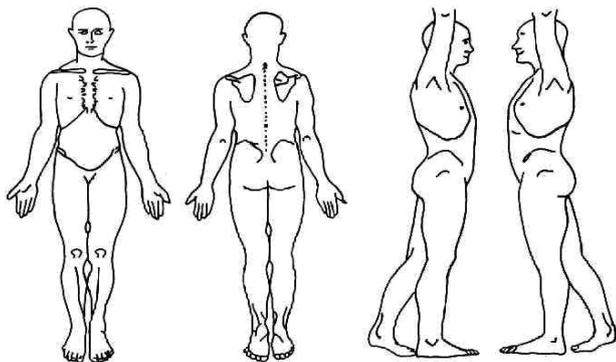
Please mark all that apply:

<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nighttime Urination
<input type="checkbox"/> Increased Libido	<input type="checkbox"/> Burning Urination
<input type="checkbox"/> Impotence	<input type="checkbox"/> Groin Pain
<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Genital Itching
<input type="checkbox"/> Genital Soreness	<input type="checkbox"/> Penile Discharge
<input type="checkbox"/> Low Libido	<input type="checkbox"/> Testicular Pain
<input type="checkbox"/> Urination Difficulty/Dribbling	

**PAIN HISTORY**

**Please mark the area of your pain below:**

**Right      Left**



Do you have chronic pain?  Yes  No  
 Do you have acute pain?  Yes  No

**Initial Onset (Date/Year)** \_\_\_\_\_

**Due to:**  Injury/Stress  Auto Accident  Work Related  
 Repetitive Stress  Other \_\_\_\_\_

Characteristics:  Dull/Ache  Sharp/Stabbing  Tingling  Localized  Moves Around  Constant  Comes & goes

What activities make the pain worse?

\_\_\_\_\_

\_\_\_\_\_

What makes it better?

\_\_\_\_\_

\_\_\_\_\_

The above information is accurate and true to the best of my knowledge. I understand that an acupuncture appointment could include acupuncture, cupping, guasha, moxabustion, dietary or nutritional counseling, flower essences, herbal formulas, Qi Gong or other breathing exercises, stretching, therapeutic massage and bodywork. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. If I have questions or concerns before, during, or after treatment, I will bring them to the attention of my practitioner, Emily Liburdi, Dipl. O.M.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_