Michigan TCM Wellness Center
Consent to Treat ❍ Privacy Practices

Patient Name: _____

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

1. 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.
2. 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.
3. The treatment and therapies provided or recommended by this clinic may be different than those usually offered by other licensed health care providers.
4. The treatments for cancer are adjunctive and the patient needs to maintain a continuing relationship with a surgeon or an oncologist.
5. There have been no representations made regarding the likelihood of success of a treatment. Current research will be provided upon request.
6. 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.
7. 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.
8. I will notify the practitioner immediately of any unanticipated or unpleasant effects associated with the consumption of herbs or other products.
9. 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.
10. 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.
11. I will notify the acupuncturist if I become pregnant.
12. I understand that results are not guaranteed.
13. I understand that all 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

NEW PATIENT HEALTH HISTORY

Michigan TCM Wellness Center ❍ ACUPUNCTURE ❍ HERBAL MEDICINE ❍ WELLNESS

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: ☐ Male ☐ Female ☐ Trans ☐ FTM ☐ MTF

Street Address: City: State: Zip:

Home Phone: Cell Phone: Email Address:

May our office call and leave a message? ☐ YES ☐ NO
Please mark which number (s) you prefer to be contacted at.

We will never sell or transfer your information to third parties. May our office send you emails about clinic special events and offers? ☐ YES ☐ NO

Occupation: Employer:

Employer Address: Employer Phone:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ 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? ☐ YES ☐ NO Herbal Medicine? ☐ YES ☐ NO

Who should we thank for referring you:

FINANCIAL POLICY

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.

The office maintains a 24 hour cancellation policy. All appointments must be cancelled and/or rescheduled more than 24 hours before the appointment time or the full visit charge will be applied to the patient's account.

I understand and agree to the Financial Policy as stated above:

Printed Name_____ Date_____

Signature_____

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			
☐	☐ Tobacco Use:	If yes, # cigarettes per day_____		Age started_____
☐	☐ Alcohol Use:	If yes, # drinks per week_____		Age started_____
☐	☐ Recreational Drugs:	If yes, drug name_____	Use per day_____	Age started_____
☐	☐ Caffeine Use:	# sodas/day_____	# coffee/day_____	# tea / day_____
☐	☐ 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:

__Vomiting
__Nausea
__Abdominal Pain
__Digestive Problems
__Lack of Appetite
__Fatigue
__Poor Memory
__Heavy Limbs
__Constant Worry
__Abdominal Bloating
__Heartburn

__Easily Stressed
__Headaches
__Migraines
__Teeth Clenching
__Bad Temper
__Neck Pain
__High Blood Pressure
__Premenstrual Tension
__Floaters
__Anemia

__Dry Skin
__Hot Flashes
__Flushed Face
__Dry Mouth
__Night Sweats
__Loose Stools/Diarrhea
__Constipation
__Palpitations
__Vivid Dreams
__Anxiety
__Depression
__Manic Episodes
__Irregular Heartbeat

__Muscle Spasm/Twitching
__Eye Twitching
__Vertigo
__Seizures
__Dizziness
__Gallstones
__Difficulty digesting greasy foods
__Easily Startled

__Couqh
__Wheeze
__Shortness of breath
__Chest Pain
__Grief
__Catch colds easily

__Asthma
__Phlegm
Color_____
__Fainting
__Swollen limbs

__Hearing Loss
__Low Back Pain
__Ear Ringing
__Knee Pain
__Fertility Issues
__Low Libido
__Hair Loss
__Often Cold/Prefer warmth

__Preference for cold beverages
__Bad Breath
__Foul Smelling Stools
__Heat Intolerance
__Allergies
__Sinus Congestion

__Vaginal Discharge
__Frequent UTI's
__Acne
__Rashes
__Eczema
__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
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)_____

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

Are You Pregnant? ☐ YES ☐ NO
Expected Due Date_____

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	_____	☐ YES ☐ NO	_____	Pap Smear	_____	☐ YES ☐ NO	_____
Mammogram	_____	☐ YES ☐ NO	_____	Bone Density	_____	☐ YES ☐ NO	_____
Colonoscopy	_____	☐ YES ☐ NO	_____				

MALE HEALTH

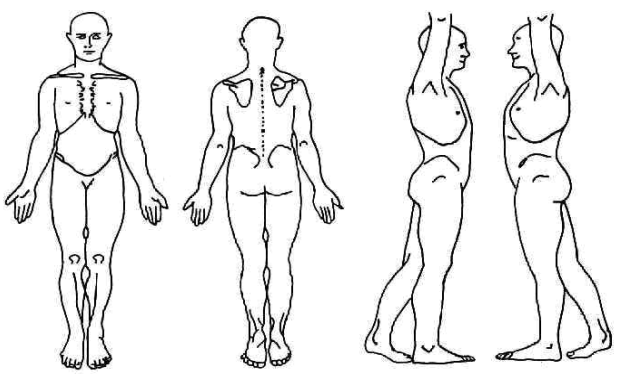
	Last Exam Date	**Normal**	**Abnormal**
Digital Rectal Exam	_____	☐ YES ☐ NO	_____
PSA Labs	_____	☐ YES ☐ NO	_____
Colonoscopy	_____	☐ YES ☐ NO	_____

Please mark all that apply:
__Frequent Urination __Nighttime Urination
__Increased Libido __Burning Urination
__Impotence __Groin Pain
__Prostate Problems __Genital Itching
__Genital Soreness __Penile Discharge
__Low Libido __Testicular Pain
__ 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: