LIZA POLLOCK
- ACUPUNCTURE -

Phone: 845-288-2617
Email: aculiza@gmail.com

We the undersigned, do affirm that _____
patient's printed name

in accordance with New York State law has been advised by his/her attending licensed acupuncturist Liza Pollock to consult a physician regarding the condition or conditions for which such patient seeks acupuncture/Chinese medical treatment.

_____ _____
patient or guardian signature date

_____ _____
licensed acupuncturist signature date

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Patient Informed Consent

I hereby authorize Liza Pollock, L.Ac. to perform the following procedures with any and each being explained before performing:

· **Acupuncture**: The insertion of pre-sterilized one-time use disposable needles through the skin at specific points on the surface of the body.
· **Acupressure, massage, and manual therapy**: The use of Traditional Chinese medical massage and therapeutic bodywork and exercises.
· **Infrared heat therapy**: Applying heat generated by an infrared lamp over the body.
· **Moxibustion**: Heated moxa stick or directly application over specific areas of the body.
· **Cupping and gua sha**: Glass cups placed on the skin with a vacuum created by heat or suction; the use of a ceramic spoon to create dermal friction
· **Liniments, Essential Oils, Plasters**: Herbal or medicinal formulas applied topically.
· **Electroacupuncture**: Using very small amounts of electricity to stimulate specific acupuncture points.
. **Herbal prescription:** From plant, animal, and mineral sources in bulk or tincture form

I recognize the potential benefits and risks of these procedures as described below:

· **Potential Benefits**: Relief of presenting symptoms and improved balance within the body that may lead to prevention, improvement or elimination of the presenting problem.
· **Potential Risks:** Minor: discomfort, pain, temporary bruising, swelling, bleeding, dizziness, drowsiness, minor burns with the use of moxa, possible temporary aggravation of symptoms existing prior to treatment, gastro-intestinal upset with the use of herbs. In *extremely rare* cases: infection at the site of the procedure, pnuemothorax, broken needle, fainting. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me regarding cure or improvement of my condition. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I understand that if I have any questions about this information, I should ask my acupuncturist.

I hereby release Liza Pollock from any and all liability, which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Cancellation Policy

In signing this form, I also understand and accept that $25 will be charged if cancellation or rescheduling is not done 24 hours prior to the date of the appointment with the exception of difficult circumstances.

Signature of patient or guardian_____Date_____

Printed name_____

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4 Deming St., Woodstock, NY
17 Glen Pond Dr., Red Hook, NY
303 5th Ave. Manhattan, NY

PERSONAL INFORMATION

Name_____Date of birth_____age_____

Address_____

Email_____

Phone #(s)_____

Referred by:_____

Emergency contact name: _____Phone:_____

If you have acupuncture benefit coverage:

Health Insurance _____ID #_____

Phone # for provider to check benefits_____

MAIN COMPLAINTS (What reason are you seeking acupuncture/herbs today?)

_____

_____

_____

_____

_____

Have you ever had acupuncture before? Yes/ No

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FAMILY HEALTH HISTORY — Please complete to the best of your knowledge.

Place and "X" in the appropriate boxes

	Self	mother	father	sibling	spouse	children
Cancers or Tumors						
Diabetes						
Blood or bleeding disorders/anemia						
Siezures						
High blood pressure/heart disease						
Allergies						
Stroke						
Drug abuse						
Depression or mental illness						
Age of death						
Hepatitis						
Kidney disorders						
Thyroid disorders						
Musculoskeletal disorders						
Blood transfusion (if before 1985)						

PERSONAL LIFESTYLE HABITS

How much per day or week:

Cigarettes (packs)_____ Coffee/Tea (cups)_____Alcohol_____

Marijuana_____ Other substances_____

Vitamins/herbs/supplements_____

_____

_____

Dietary Restrictions (anything you DO NOT eat)_____

_____

Food Cravings (circle) sweet, salty, sour, bitter, spicy, other _____

Exercise: type(s)_____

_____

how often_____

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Do you normally get enough sleep at night? Yes/ No - How many hours?_____

Do you wake up feeling rested/refreshed? Yes/ No - Rate your general energy level (1-10)_____

Do you have a lot of dreams? Yes/ No - If yes, do they disturb you? Yes/ No

Are you generally under a lot of stress? Yes/ No - If yes, how do you manage stress? _____

_____

Do you run hot or sensitive to heat? Yes/ No - If yes, when?_____

Do you feel cold or overly sensitive to cold? Yes/ No - If yes, when?_____

Do you have cold hand & feet? Yes/ No

Do you have a tendency to any of the following emotions (circle): anxiety, sadness, fear, anger, grief, excitation, worry, obsessive thoughts, over thinking/racing thoughts, irritability

MEDICINES:

Prescription drugs you are currently taking: For what condition?

_____ _____

_____ _____

_____ _____

Over-the-counter drugs you are currently taking: For what condition?

_____ _____

_____ _____

Allergies/Sensitivities_____

MAJOR HOSPITALIZATIONS: If you have ever been hospitalized for any serious medical illness or operation, indicate below. (Do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS

Bowel Movements (circle all that apply): every other day or less, 1x/day, 2x/day, more than 2x/day, irregular, loose/soft, hard, difficult, painful, burning, bleeding,

other_____

Urination- frequency per day: less than 2x/day, 3, 4, 5, 6, 7, more than 7x/day.

Painful, urgent, other_____

Color of urine: clear, pale yellow, golden, dark yellow, reddish-yellow, other_____

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Women only-- GYNECOLOGY

Age of first menses_____ Date of last menstrual period_____

# of days you bleed_____

# of days in your cycle (a typical cycle is 28 days; day 1= 1st day of bleeding) _____

Clots with bleeding? Yes/ No - If yes, how big? dime size or smaller/ nickel size / quarter size

Color of menstrual blood: pale, bright red, brown-red, dark brown, purple

other_____

Consistency of menstrual blood: watery, thin, normal, thick, sticky

Pain: yes/ no/ when_____

Irregular periods (describe): _____

PMS (describe):_____

Are you on the birth control pill? Yes/ no; were you in the past? Yes/ no/ for how long?_____

Are you currently pregnant? Yes/ No number of pregnancies:_____ number of live births:_____

Number of miscarriages:_____ number of abortions:_____

Breast (lumps, cysts, tenderness, other)_____

Urinary tract infections: presently? Yes/ No - Past: yes/ no/ how frequently_____

Vaginal infections: presently Yes/ No - Past: yes/ no/ how frequently _____

Vaginal pain or itching? Yes/ No - Uterine fibroids? Yes/ No - Endometriosis? Yes/ No

Menopause (date of onset)_____ Symptoms_____

Are you on Hormone Replacement Therapy (HRT)? Yes/ No - If yes, how long?_____

Side effects?_____

Anything else you would like to share? _____

_____

_____

_____

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Please put a "C" if the condition is current or a "P" if you had it in the past

General
___ Insomnia
___ Dreams/ nightmares
___ Irritability
___ Depression
___ Mood swings
___ Fatigue
___ Poor memory
___ Strongly like cold drinks
___ Strongly like hot drinks
___ Recent weight loss/ gain
___ Chills
___ Fever

Head & Neck
___ Headaches
___ Migraines
___ Stiff neck
___ Dizziness
___ Fainting
___ Swollen glands

Ears
___ Ringing
___ Hearing loss
___ Infections
___ Earache
___ Hearing aids
___ Vertigo

Eyes
___ Glasses/ contact lenses
___ Blurred vision
___ Dryness
___ Spots or floaters
___ Eye inflammation
___ Double vision
___ Glaucoma
___ Cataracts

Nose, Throat, & Mouth
___ Sinus infection
___ hay fever/ allergies
___ Frequent sore throat
___ Difficulty swallowing
___ Mouth and tongue ulcers
___ frequent colds
___ Nosebleed
___ dry nose
___ Nasal congestion
___ Loss of voice
___ Thirst
___ Excessive phlegm
___ TMJ
___ Facial pain
___ Gum problems
___ Dry Mouth

Skin
___ Hives
___ Rashes
___ Eczema
___ Psoriasis
___ Night sweating
___ Excess sweating
___ Dry skin
___ Easy bruising
___ Changes in moles, lumps
___ Itching

Respiratory
___ Difficulty Breathing
___ Difficulty breathing when lying down
___ Wheezing
___ Asthma
___ Chronic cough
___ Wet cough
___ Dry cough
___ Coughing up phlegm
___ Coughing up blood
___ Shortness of breath
___ Tight chest
___ Pneumonia

Cardiovascular
___ High blood pressure
___ Low blood pressure
___ Chest pain or tightness
___ Palpitation
___ Rapid heart beat
___ Irregular heart beat
___ Poor circulation
___ Swollen ankles
___ Phlebitis
___ Anemia
___ History of heart attack

Gastrointestinal
___ Nausea
___ Vomiting
___ Stomach pain
___ Diarrhea
___ Constipation
___ Poor appetite
___ Excessive hunger
___ sweet taste in mouth
___ metallic taste in mouth
___ Gas
___ Bloating
___ Hiccups
___ Burping
___ Acid regurgitation
___ Bad breath
___ Bloody stool
___ Mucus in stool
___ Hemorrhoids
___ Gallbladder disorder

Musculoskeletal
___ Joint pain/disorder
___ Sore muscles
___ Weak muscles
___ Difficulty walking
___ Neck/shoulder pain
___ Upper Back pain
___ Low back pain
___ Rib pain
___ Limited range of motion
___ Other (Describe)

Neurological
___ Seizures
___ Tremors
___ Numbness or tingling
___ Pain
___ Paralysis
___ Poor circulation
___ Other (Describe)

Genito-urinary
___ Pain on urination
___ Frequent urination
___ Urgent urination
___ Blood in urine
___ Unable to hold urine
___ Incomplete urination
___ Bedwetting
___ Wake to urinate
___ Increased libido
___ Decreased libido
___ Kidney stones
___ Impotence
___ Nocturnal emission
___ Pain/itching of genitalia

Male only
___ Lumps in testicles
___ Pain in testicles
___ Prostate disease
___ Hernias
___ Other (describe)

Infection Screening
___ HIV risks: self or partner
___ TB: self or household
___ Hepatitis risk: self or partner
___ History of STD: self or partner

Other_____
_____
_____
_____
_____
_____
_____