



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, pneumothorax, 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 _____



LIZA POLLOCK
- ACUPUNCTURE -

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Kingston, 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



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						
Siezuers						
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 _____



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, excitement, 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 _____



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? _____



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 _____

