

## For All New Patient's...

Before you come in to see me for your first acupuncture treatment, please if possible, do just 2 things:

- 1) Fill out all forms as completely as possible. This will save both of us time. If you have any questions, leave what you are working on blank and skip to the next part.
- 2) If you are coming in for any treatment and have not eaten anything in the past 5 hours prior to your scheduled visit, please eat a light snack or piece of fruit before you come in. I have found that this nearly completely eliminates any feelings of nausea that a very small percentage of people might experience. Food needs to be in the stomach so it will help ground you since we tend to move a lot of energy in the body during acupuncture.

***I greatly look forward to trying to help you and will make your acupuncture experience as pleasant as possible!!!***

Best in Health,

Justin Mandel, L.Ac Dipl.C.H.

# Wu-Wei Healing Arts

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

## Personal Information

Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Person responsible for your account \_\_\_\_\_

Medical Doctor's Name, address, phone \_\_\_\_\_

Date of last MD visit and diagnosis \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Sex:  Male  Female    Height \_\_\_\_\_    Weight \_\_\_\_\_    Birth date \_\_\_\_\_    Age \_\_\_\_\_

Marital Status:  Married     Single     Divorced     Widowed    Number of children \_\_\_\_\_

Have you received Acupuncture before?  Yes     No  
 When? \_\_\_\_\_ With whom? \_\_\_\_\_

Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had:

Illness	You	Relative	Date	Illness	You	Relative	Date
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug, Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sexually Transmitted Diseases:  AIDS     HPV     Herpes     Syphilis     Other    Date \_\_\_\_\_

List any medications and supplements you are currently taking:

Medicine	Dosage	Reason	How Long	Prescribed by

Please indicate the use and frequency of the following:

	Yes	No	How much	Yes	No	How much	Yes	No	How much		
Coffee/tea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	Water intake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Non-medical drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soda pop	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Personal Information (continued)**

What is the main health problem for which you are seeking treatment?

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What other forms of treatment have you sought?

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Serious Illnesses/ Injuries (please list date and outcome):

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Hospitalizations/ Surgeries (please list reason and outcome):

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Allergies (Food, Medications, etc...):

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Please state any concerns that you would like to discuss...

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**Thank you for taking the time to fill in this information as completely as possible.**  
**The reason that Wu-Wei Healing Arts uses such comprehensive forms is to help us provide you with the best health care possible.**

## For Women

Age of 1st period (menarche) \_\_\_\_\_ Are you pregnant?  Yes  No # of pregnancies \_\_\_\_\_

Age of Last period (menopause) \_\_\_\_\_ # of live births \_\_\_\_\_ # of Abortions \_\_\_\_\_ # of Miscarriages \_\_\_\_\_

Date of last: Gynecologic exam \_\_\_\_\_ Pap Smear \_\_\_\_\_ Mammogram \_\_\_\_\_ Bone Density Scan \_\_\_\_\_

Results \_\_\_\_\_

Number of days between periods \_\_\_\_\_ Number of days of flow \_\_\_\_\_ Color of flow \_\_\_\_\_

Clots?  Yes  No Color \_\_\_\_\_

Average number of pads used per day: 1st day \_\_\_\_ 2nd day \_\_\_\_ 3rd day \_\_\_\_ 4th day \_\_\_\_ + days \_\_\_\_

Have you been diagnosed with:  Fibroids  Endometriosis  Ovarian Cysts  PID  Fibrocystic Breasts  
 Other \_\_\_\_\_

Location of Pain:  Lower abdomen  Lower back  Thighs  Other \_\_\_\_\_

Nature of Pain (please indicate Before, During or After menses)

Cramping \_\_\_\_\_ Stabbing \_\_\_\_\_ Burning \_\_\_\_\_ Aching \_\_\_\_\_ Dull \_\_\_\_\_ Bloating \_\_\_\_\_

Consistent \_\_\_\_\_ Intermittent \_\_\_\_\_ Bearing down sensation \_\_\_\_\_

Other Symptoms related to menses:  Headache  Mood swings  Hot flashes  Night sweats  Insomnia

Nausea  Poor appetite  Ravenous appetite  Swollen breasts  Constipation  Diarrhea  Vaginal dryness

Discharge  Increased libido  Decreased libido

## For Men

Date of last prostate check up \_\_\_\_\_ PSA results \_\_\_\_\_ Manual prostate exam results \_\_\_\_\_

Frequency of Urination: daytime \_\_\_\_\_ nighttime \_\_\_\_\_ Color of urine:  clear  murky odor: \_\_\_\_\_

Symptoms:  Prostate problems  Delayed stream  Dribbling  Incontinence  Retention of urine

Rectal dysfunction  Increased libido  Decreased libido  Premature ejaculation  Impotence

Back pain  Groin pain  Testicular pain  Other \_\_\_\_\_

## Symptom Survey (For everyone)

Please indicate any of the following symptoms experienced in the last 3 months (+) Frequently (√) Sometimes

### General

- \_\_ Depression
- \_\_ Dizziness
- \_\_ Fainting
- \_\_ Fatigue
- \_\_ Forgetfulness
- \_\_ Headache
- \_\_ Irritability
- \_\_ Loss of sleep
- \_\_ Loss of weight
- \_\_ Migraines
- \_\_ Nervousness

### Gastrointestinal

- \_\_ Poor Appetite
- \_\_ Bloating
- \_\_ Constipation
- \_\_ Diarrhea
- \_\_ Excessive hunger
- \_\_ Excessive thirst
- \_\_ Hemorrhoids
- \_\_ Indigestion
- \_\_ Nausea, Vomiting
- \_\_ Rectal bleeding
- \_\_ Stomach pain

### Eyes, Ears, Nose, Throat

- \_\_ Bleeding gums
- \_\_ Blurred vision
- \_\_ Dry mouth, throat
- \_\_ Earaches
- \_\_ Frequent colds
- \_\_ Hay fever
- \_\_ Loss of hearing
- \_\_ Nosebleeds
- \_\_ Persistent cough
- \_\_ Ringing in ears
- \_\_ Shortness of breath
- \_\_ Sinus problems

### Muscles, Joints, Bones

- (Pain, weakness, numbness)
- \_\_ Arms
  - \_\_ Shoulders
  - \_\_ Elbows
  - \_\_ Wrists
  - \_\_ Hands
  - \_\_ Fingers
  - \_\_ Back
  - \_\_ TMJ
  - \_\_ Legs
  - \_\_ Hips
  - \_\_ Knees
  - \_\_ Ankles
  - \_\_ Feet
  - \_\_ Toes
  - \_\_ Neck
  - \_\_ Carpal Tunnel Syndrome

### Skin, Nails

- \_\_ Bruises easily
- \_\_ Eczema
- \_\_ Hives
- \_\_ Psoriasis
- \_\_ Dry Skin
- \_\_ Brittle Nails

### Cardiovascular

- \_\_ Chest pain
- \_\_ High cholesterol
- \_\_ Palpitations
- \_\_ Poor circulation
- \_\_ Swelling of the ankles
- \_\_ High Blood Pressure
- \_\_ Low Blood Pressure

**I. PATIENT ADVISORY TO CONSULT A PHYSICIAN**

Wu-Wei Healing Arts is committed to your health and well being. Justin Mandel, L.Ac Dipl. C.H. has a great deal to offer as an Acupuncturist, but he cannot totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160, Section 812 1.1 (b) of NYS Education Law we request that you read a sign the following statement:

WE, THE UNDERSIGNED, DO AFFIRM THAT \_\_\_\_\_

HAS BEEN ADVISED BY Justin Mandel, L.Ac Dipl.C.H.

TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH A PATIENT SEEKS ACUPUNCTURE TREATMENT.

\_\_\_\_\_  
Patient Signature Date  
\_\_\_\_\_  
Licensed Acupuncturist Signature Date

**II. INFORMED CONSENT FOR ACUPUNCTURE TREATMENT**

I consent to acupuncture treatments and other procedures associated with Chinese Medicine by Justin Mandel Licensed Acupuncturist. I have discussed the nature and purpose of my treatment with Justin Mandel, L.Ac Dipl. C.H.

I understand that methods of treatment may include but are not limited to: Acupuncture, Moxibustion, Cupping, Electrical Stimulation, and Tui Na (Chinese Massage).

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 for a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Justin Mandel, L.Ac Dipl.C.H. uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal, and mineral sources) which may be recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachaches, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify any member of Wu-Wei Healing Arts of any unanticipated or unpleasant effects associated with the consumption of the herbal teas.

I will notify Wu-Wei Healing Arts if I become pregnant.

I do not expect Justin Mandel, L.Ac, Dipl.C.H. to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on his judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interests.

**By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, 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 from to cover the entire course of treatment and for any future conditions) for which I seek treatment.**

To be completed by patient (or patient’s representative if the patient is a minor or is physically or legally incapacitated)

To be completed by Justin Mandel, L.Ac Dipl.C.H. providing information and obtaining consent

\_\_\_\_\_  
Date Consent Completed

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Print Name of Patient Representative

\_\_\_\_\_  
**Justin Mandel, L.Ac Dipl. C.H.**

## **24 Hour Cancellation Policy**

I understand that there is 24 hour cancellation policy to see Justin Mandel, L.Ac Dipl.C.H. for Acupuncture treatment.

In the event that I miss an appointment without 24 hours notice given, I will be charged the full amount for my scheduled visit through my credit card.

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(Name)

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(Signature)

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(Date)

Credit Card (Please Check):

Visa

Mastercard

Discover

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

3 Digit number on back of card: \_\_\_\_\_