STREAM POINT Wellness

Andrea Johnston, Dipl OM, LAc.
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Name: _____ DOB: _____ Age: _____ Gender _____

Ht: _____ Wt: _____ Occupation: _____ Marital Status:_____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact/Relation: _____ Phone: _____

Primary Care Physician (Name, Phone): _____

Who may we thank for the referral? _____Have you received acupuncture? Y N

What are the main health issues that bring you here? _____

Medical History

Mark the box if any of the following are true today:

☐ Concussion or loss of consciousness	☐ Current/possible fracture	☐ Recent stroke
☐ Severe acute pain _____	☐ Drastic weight change	☐ Current/possible infection
☐ Acute respiratory distress	☐ Current/possible pregnancy	☐ Psychiatric _____
☐ Cancer (type): _____	☐ Heart Condition _____	☐ Pacemaker
☐ Diabetes (Type 1) (Type 2)	☐ Seizures or Epilepsy	☐ Using Wafarin or similar drug

Do any of the above conditions run in your family? _____

Please indicate any diagnoses given by a qualified physician _____

Allergies (seasonal, food, medicine etc)? _____

History of serious illness, injuries, surgeries etc _____

Current medicines and supplements _____

Dietary Habits:_____

Cigarettes ___ Coffee ___ Tea___ Alcohol ___ Tobacco ___ Drugs ___ Sugar ___ Salt ___ Soda/Pop ___

How do you FEEL about the following areas in your life

Self _____	Family _____	Partner _____
Sex _____	Social Life _____	Work _____
Diet _____	Exercise _____	Spirituality _____

For the next portion, please indicate if you are currently or have a significant history of any of the following conditions or symptoms:

General

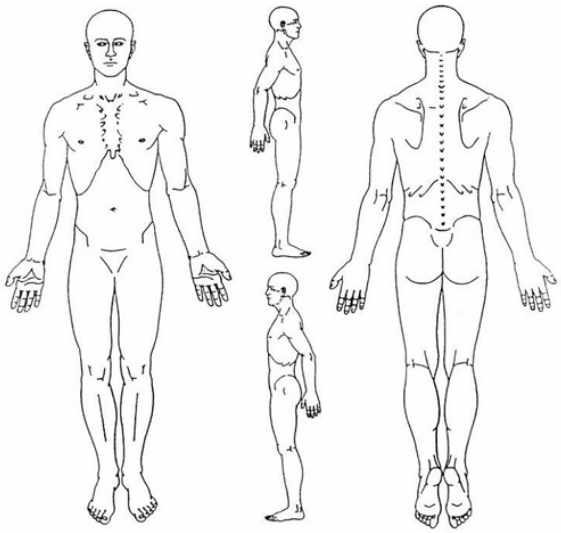
☐Easily Stressed ☐Insomnia ☐Fatigue ☐Poor Immunity
☐Changes in Weight ☐Changes in Appetite ☐Cravings ☐Dizziness
☐Fever/Chills ☐Abnormal Sweat ☐Cold Hands & Feet Other_____

Musculoskeletal

☐Headache ☐Pain ☐Injury
☐Arthritis ☐Stiffness ☐Numbness/Tingling

Please indicate on the diagram the locations, severity (1-10), and quality of pain you are experiencing (i.e. dull, achey, sharp, stabling, throbbing, burning, electric)

_____
_____
_____
_____
_____
_____
_____



Skin, Hair, EENT

☐Acne/Pimples ☐Skin Condition _____ ☐Hair Loss/Gray
☐Change in hair, skin texture _____ ☐Tumors or Lumps _____
☐Poor Vision ☐Eye Strain/Pain ☐Cataracts ☐Glaucoma
☐Ringing in Ears (Tinnitus) ☐Hearing Loss ☐Earaches ☐Sinus Problem
☐ Nosebleed ☐ Runny Nose ☐ Loss of Smell/Bad Smell ☐ Dry Mouth
☐ Copious Saliva ☐ TMJ/Teeth Grinding ☐ Toothache ☐ Other _____

Respiratory:

☐ Asthma ☐ Shortness of Breath ☐ Cough ☐ Cough Blood
☐ Bronchitis ☐ Emphysema ☐ Pneumonia ☐ COPD
☐ Tuberculosis Other: _____
Production of phlegm: Amt./Freq.: _____ Color: _____ Consistency: _____

Cardiovascular & Blood:

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Chest Pain ☐ Angina
☐ Irregular Heart Beat ☐ Palpitations ☐ Swelling/Edema ☐ Heart Attack
☐ Heart Disease _____ ☐ Anemia ☐ Clotting Disorder
☐ Bleeding Disorder ☐ Bruise Easily ☐ Other_____

Digestive:

☐ Nausea/Sensitivity ☐ Indigestion/Heart Burn ☐ Belching ☐ Vomiting
☐ Bad breath/taste ☐ Bloating/Distension ☐ Stomach Pain ☐ Acid Reflux
☐ Ulcer _____ ☐ Constipation ☐ Diarrhea ☐ Jaundice
☐ Irritable Bowel ☐ Food Allergies _____ ☐Other _____
Bowel (Freq, Color, Odor, Pus/Blood, Pain) _____

Neurological/Hormonal/Emotional:

☐ Fainting ☐ Concussion ☐ Tremors ☐ Stroke/TIA
☐ Poor Coordination ☐ Parkinson's ☐ Alzheimer's ☐ Seizures
☐ Anxiety/Depression ☐ Mood Swings ☐ Poor Memory ☐ Addiction
☐ Thyroid ☐ Hypoglycemia ☐ Diabetes ☐ Hot Flashes

Uro-Genital:

☐ Painful Urination ☐ Urinary Urgency ☐ Urinary Incontinence ☐ Urinary Dribble
☐ UTI ☐ Bladder Infection ☐ Kidney Infection ☐ STD
☐ Prostate (Describe) ☐ Erectile Dysfunction ☐ Libido Change ☐ Other: _____
Urine: Frequency _____ Stream _____ Color: _____ Odor:_____

OB/GYN:

Age of First Period _____ Cycle (How Often & Duration) _____ Menopause _____
Pregnancies _____ # Births _____ #Premature _____ #Miscarriage _____
Last Menses _____ Last PAP (date/result) _____ Last Mammogram_____
Changes Prior to Menstruation (PMS): _____
Period Flow (Color, Consistency, Quantity, Pain) _____
_____
Birth Control (Type/Duration) _____
☐ Irregular Periods ☐ Painful Periods ☐ Vaginal Discharge ☐ Clots
☐ Breast Lump ☐ Ovarian Cyst/PCOS ☐ Uterine Fibroids Other _____

Anything else you'd like us to know about you? _____
_____

Informed Consent For Acupuncture Treatment

You have the right as a patient to be informed about your condition, acupuncture treatment, and any other treatment you may receive that's within the scope of practice of Andrea Johnston, CAc, including the risks and benefits of treatments. This is so you may make an informed decision regarding your consent to receive or withhold treatment.

I hereby consent that Andrea Johnston, LAc may provide acupuncture and any other treatments within her scope of practice. I have had the opportunity to discuss my diagnosis, the nature, and purpose of acupuncture and other procedures and alternatives. Complications from acupuncture are very rare, but risks may include:

- Minor pain with needle insertion and manipulation, with or without electrical stimulation
- Minor bleeding or bruising after needle withdrawal, cupping, or gua sha treatment
- Minor burns after moxibustion treatment
- Lightheadedness, dizziness, fainting after needle insertion

I understand that Andrea Johnston, LAc will take the appropriate steps to control the above risks, or will contact emergency medical authorities in the case of an emergency. I do not expect Andrea Johnston, LAc to be able to anticipate and explain all risks and complications. I consent that he/she may exercise his/her medical judgment during the course of my treatment, and trust that his/her judgment is in my best interest.

MEDICAL REFERRALS: I understand I may be referred to a medical provider in the case of a medical condition that is outside the scope of practice of Andrea Johnston, LAc. In such circumstances, she will arrange a consultation, emergency transfer, and/or a referral to appropriate healthcare facilities or to an appropriate health-care practitioner. He/She will provide me with a written notification form that I have received the referral information, that he/she will be contacting the referred medical provider, and that I will take the appropriate steps to contact the referred medical provider for a consultation.

I have read, or have had read to me, the above consent. I have had the opportunity to ask any and all my questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to receive treatment from Andrea Johnston, LAc. I 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.

To be completed by the patient and/or patient's legal representative:

_____ _____ _____
Print Patient Name Patient or Representative Signature Date