Verona Spine & Wellness Center
80 Pompton Ave., 3rd Floor
Verona, NJ 07044 | 973-857-1119

INITIAL ACUPUNCTURE REPORT

Name:_____ Visit Date:_____
Address:_____
Date of Birth:___/___/___/ Age:____ SSN:___-___-_____
Marital Status (Circle) Married Single Divorced Widowed
Home Phone# ( )_____-_____
Work Phone# ( )_____-_____
Cell Phone#_____-_____
E-mail:_____
Patient's Employer:_____
Employer's Address_____
EMERGENCY CONTACT: Phone#_____
Relationship to You:_____
Chief Complaint(s):



Onset, Duration, Intensity (mild/intermediate/severe), frequency (occasional/frequent/constant), Location and radiation (head/ neck/ shoulder/ arm/ hand/ back/ hip/ leg/ knee/ foot) exacerbated by moving/ standing/ sitting/ walking/ bending; Relieved by nothing/medication/ treatment/ rest

Mechanism of trauma, if trauma related: You were brought to:_____ Hospital/home.
You were: belted/ unbelted driver/ front/ rear seat passenger; Pedestrian/ motorcyclist/bicyclist
Your car was hit from: Head on/ right/ left front side; R/L middle side; R/L rear side; rear-end
You experienced: State of confusion/ vomiting/ dizziness/ headache/ bleeding/ unconsciousness

The treatments you have received: Acupuncture/ Massage/ Physical Therapy/ Chiropractic/ Herbs/
Results: the same/ somewhat/ much better/ temporary relief/ worse

List any Hospitalizations and Surgeries **Date** **Place**
_____
_____

List any medications being taken (include doses)
_____
_____

Family History (please include relation)
__ Migraines _____
__ Heart Disease _____
__ Allergies _____
__ Asthma _____
__ Arthritis _____
__ Diabetes _____
__ Glaucoma _____
__ Stroke _____
__ High Blood Pressure _____
__ Mental Illness _____
__ Gall Stones _____
__ Cancer _____
__ Thyroid Disease _____
__ Epilepsy _____

Are you allergic to any of the following? If yes, please specify
( ) Medicine ( ) Food ( ) Herbs ( ) Others:

Do you have or are you any of the following?
( ) Pacemaker ( ) Surgical Implants ( ) Bleeding Disorders ( ) HIV + ( ) Hepatitis A/B/C
( ) Pregnant

Verona Spine & Wellness Center
80 Pompton Ave., 3rd Floor
Verona, NJ 07044 | 973-857-1119

INITIAL ACUPUNCTURE REPORT

Please check if you have (please write "P", if you had it three months ago):

Constitutional:
__ Chills
__ Fever
__ Drowsiness
__ Spontaneously sweat
__ Night sweats
__ Over/under weight

Eyes/Vision:
__ Dry eyes
__ Blurred Vision
__ Excessive tearing
__ Double Vision
__ Glaucoma
__ Eyes Itching

Ears, Nose & Throat
__ Bleeding
__ Difficulty Swallowing
__ Discharge
__ Dizziness
__ Fainting
__ Ear Drainage
__ Ear Infection
__ Hearing Loss
__ Hoarseness
__ Loss of Smell
__ Nasal Congestion
__ White discharge
__ Yellow discharge
__ Sinus Infections
__ Snoring
__ Sore Throats
__ Ringing in ears
__ TMJ Disorder

Respiration:
__ Asthma
__ Cough
__ Shortness of Breath
__ White/Yellow Sputum
__ Wheezing

Cardiovascular:
__ Chest pain
__ Murmur
__ Palpitations
__ Shortness Breath
__ Swelling of legs
__ Ulcers
__ Varicose Veins

Gastrointestinal:
__ Poor appetite
__ Indigestion
__ Nausea
__ Vomiting
__ Belching
__ Heartburn
__ Sweat/bitter/sour
__ Black-Tarry Stools
__ Abdominal Pain
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Jaundice

Genitourinary:
__ Pregnancy
__ Burning Urine
__ Frequent Urine
__ Urine Retention
__ Breast Lumps/Pain
__ Early/delay menstruation
__ Irregular menstruation
__ Amenorrhea
__ Dysmenorrhea
__ Vaginal Bleeding
__ Vaginal Discharge
__ Erectile Dysfunction
__ Prostate Problems

Endocrine:
__ Cold Intolerance
__ Heat Intolerance
__ Diabetes
__ Excessive Appetite
__ Excessive Hunger
__ Excessive Thirst
__ Goiter
__ Prefer cold/hot water
__ Low libido

Skin & Nerve:
__ Hair Loss
__ Hives
__ Itching
__ Numbness/tingling
__ Rash
__ Skin Lesions or Ulcers
__ Limb Weakness
__ Loss of Memory
__ Loss of balance
__ Seizures
__ Sleep Disturbance
__ Slurred Speech
__ Stress
__ Strokes

The following will be filled by Acupuncturist:
Face: normal/ red / pale/ yellow/ green/ blue/ dark/ jaundice/ cloudy/ dry/ moist/ deep / shallow
Tongue: color: pale / light red / bright red / reddened / deep-red / purple / black
Tongue Shape: normal / swollen/ thin/ small/ prickled/ fissured/ tooth printed/ deviated/ shivering
Tongue fur: white/ yellow/ gray/ blue/ black/ thin/ thick/ dry/ moist/ greasy/ putrid/ exfoliating/ mirror-like
Pulse: floating/ sunken/ powerful/ weak/ slippery/ astringent/ string/ tense/ flood/ thread/ hollow/ irregular

Diagnosis:
R51.0 Headache; M54.2 Neck pain; M25.511/2 Shoulder pain; M25.521/2 Elbow; M25.541/2 Hand; M54.4 Thoracic spine pain; M54.5 lumbosacral sprain; M54.6 Sciatic; M25.551/2 Hip; M25.561/2 Knee; M79.671/2 Foot; G47.30 Insomnia; J30.89 Seasonal Allergy; G50.0 Trigeminal Neuralgia; R11.10 Nausea with Vomiting; F19.10 Substance Abuse; Z71.6 Stop Smoking.

Treatment: [ ] Acup. w/o elect. Stim 1st 15 min; [ ] Acup. w/o elect. Reinsert needles & stim add. 15 min;
[ ] Acup. w/ elect. Stim 1st 15 min; [ ] Acup. w/ elect. Reinsert needles & stim add. 15 min;
[ ] Infrared Therapy; [ ] Moxibustion; [ ] Cupping; [ ] Gua Sha; [ ] Tui Na

Provider's Name: _____ Signature: _____ Date: _____

Verona Spine & Wellness Center
80 Pompton Ave., 3rd Floor
Verona, NJ 07044 | 973-857-1119

INFORMED CONSENT

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 the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment, may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental Massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

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 the needling sites that may last 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 the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while 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) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in larges doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed. I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing this document, I show that I have read, or have had read to me, the above 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 for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature or
Patient Representative:_____ Date:_____
Relationship to Patient: _____

Office Signature :_____ Date: _____