



Julie Magram Acupuncture LLC

Risks and Benefits of Acupuncture

The World Health Organization recognizes numerous conditions in which acupuncture is successful in treating. The goal of acupuncture is to balance the whole person: body, mind, and spirit. When the person is brought into balance, many conditions such as pain, sickness, and disease can be eliminated.

Acupuncture is quite safe. Acupuncturists are trained according to strict standards set by the National Commission for the Certification of Acupuncturists, and must abide by the criterion set by the Occupational Safety and Health Administration regarding hygiene, sterilization of equipment, disposal of hazardous materials, as well as precautions regarding blood borne pathogens and clean needle technique. I only use sterile and disposable needles.

The risks of acupuncture are low, and could include some pain in the area of treatment and fainting (which can be avoided by eating 1 to 2 hours before the treatment). Occasionally you may get a small hematoma (a small dime-sized bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern – it will go away in a few days. Slight bleeding may occur if the needle strikes a capillary. The risks of moxa could include a slight burn or scarring, which can be avoided by good technique and clear communication between practitioner and patient. The cupping technique may leave a mark that lasts up to several days. Sometimes after receiving an acupuncture treatment you may feel a little bit lightheaded. If that is the case, please sit for a while in the waiting room. In a few minutes you'll feel relaxed and clear headed.

You must advise your acupuncturist if you have a pacemaker, bleeding disorder, or if you are or may be pregnant. It is also very important to notify your acupuncturist if you have a contagious disease. Your acupuncturist needs to know any medications that you are taking, especially if you are taking blood thinners such as Coumadin/Warfarin. Herbal prescriptions are intended only for the person for whom they are prescribed. Do not give herbal formulas to anyone else.

If the patient has a serious disorder such as: cardiac pain/arrest, unexplained weight loss, fracture, respiratory distress, or a hemorrhagic disorder, they should go to the emergency room immediately.

CONSENT FOR ACUPUNCTURE TREATMENT

I, the undersigned, agree to undergo acupuncture treatment by Julie Magram, L.Ac. I am aware of both the benefits and risks of acupuncture and its conjunctive therapies (herbs, moxa, and cupping). I fully understand that there is no guarantee of success of a specific treatment. I do not expect the acupuncturist to be able to anticipate all risks and complications. I intend the consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment. I realize that acupuncture may or may not be covered by my insurance company and I accept full responsibility for payment of all services at the time they are rendered.

Printed Name: _____ Signature: _____ Date: _____

Parent or Guardian Signature (if under 18): _____ Date: _____





Symptom List

Circle any problem or disease you have now. Underline items that affected you in the past.

Head: Headaches Facial pain Head Injury Concussion

Eyes: Blurred vision Eye strain Eye pain Red Eyes Glaucoma Cataracts
Night Blindness Spots in Eyes Floaters Itchy Eyes

Mouth: Bleeding Gums Grinding Teeth TMJ Dry Mouth Excessive Saliva
Sores on lips/tongue Toothaches without cavities Unusual taste in mouth

Ear, Nose and Throat: Deafness Tinnitus (Ringing in ears) Ear Pain Frequent Ear Infections
Sinus Headaches Yellow Mucus Stuffy Nose Post Nasal Drip Dry Throat Itchy Throat
Difficulty swallowing Frequent colds Excessive Flem

Respiratory: Bronchitis Shortness of Breath Emphysema Wheezing Cough
Pneumonia

Cardiovascular: High Blood Pressure Low Blood Pressure Palpitations Irregular Heartbeat
Fast Pulse (over 100 beats / min) Slow Pulse (less than 60 beats / min) Feeling of pressure in the chest short of
breath Chest Pain Dizziness Migraines Headache with nausea Cold hands/feet
Flushed Face Fainting Anemia Blood Clots Heart Disease

Gastrointestinal: Diarrhea Constipation Stomach or abdominal pain Indigestion
Nausea Vomiting Heartburn Bloating /Intestinal gas Stomach Acid
Belching Ulcer Hemorrhoids Loose Tool Pancreatitis Irritable Bowel Intestinal cramping
Intestinal Parasites

Hormone Balance: Low Thyroid Overactive Thyroid Diabetes Hypoglycemia Blood sugar
Low Adrenals

Other Hormone Imbalance _____

Autoimmune & Inflammatory Conditions: Hashimoto's Disease Rheumatism Systematic Lupus
Colitis Crohn's Disease Fibromyalgia Myofacial Syndrome Arthritis

Skin and Hair: Eczema Rashes Hives Acne Ulceration Psoriasis Warts
Fungal Infection Dermatitis Moles Dry Skin Hair Loss

Neuropsychological: Numbness / Tingling Tics Tremors Seizures Nerve Pain
Sadness Lack of coordination Poor Memory Depression Anxiety Irritability
Anger Easily Stressed Seeing a therapist Other _____

Urination: Frequent Difficult Urgent Painful Burning Nighttime Incontinence
Bedwetting Kidney Stones

Woman: Menstrual Problems Cramping Heavy/light/irregular periods PMS
Emotional reactions Menopause symptoms Tubal ligation Infertility Low libido





Men: Impotence Premature ejaculation pPostate gland problems Vasectomy Ifertility

Other: _____

Thank you for taking the time to complete this form.

Childhood illnesses, surgery or accidents?

Age: _____
Age: _____

Adolescent illnesses, surgery or accidents?

Age: _____
Age: _____

Adulthood illnesses, surgery or accidents?

Age: _____
Age: _____
Age: _____
Age: _____
Age: _____

Family Medical History:

Please note all major illness in your *immediate family*, like diabetes, heart disease, blood pressure, neurological disorders, psychological disorders, blood disorders, orthopedic disorders, cancers, etc.

Past Medical History

- | | | |
|---|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Addiction (alcohol or drugs) | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> AIDS / HIV+ | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis _A_B_C | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Polio | |





Problems during you birth? _____

Any reactions to vaccinations? _____

Allergies? _____

Which of the following is part of your lifestyle?

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Tobacco smoking | <input type="checkbox"/> Exercise | <input type="checkbox"/> Coffee Drinking |
| <input type="checkbox"/> Relaxation/Meditation | <input type="checkbox"/> Special Diet | <input type="checkbox"/> Vitamins / Supplements |
| <input type="checkbox"/> Recreational Drugs | | <input type="checkbox"/> Birth Control Pills |
| <input type="checkbox"/> Alcohol Drinking | | |

General Symptoms

- | | | |
|--|---|---|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Bodily Heaviness | <input type="checkbox"/> Bleeds Easily |
| <input type="checkbox"/> Strong appetite | <input type="checkbox"/> Never Sweats | <input type="checkbox"/> Bruises easily |
| <input type="checkbox"/> Thirsts for cold drinks | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Thirsts for warm drink | <input type="checkbox"/> Muscle Cramps | |
| <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Chills | |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Lack of Strength | |
| <input type="checkbox"/> Fatigue | | |
| <input type="checkbox"/> Shortness of Breath | | |
| <input type="checkbox"/> Hot palms, soles, and chest | | |
| <input type="checkbox"/> Sweats Easily | | |
| <input type="checkbox"/> Dizziness | | |
| <input type="checkbox"/> Easily car / air / sea sick | | |





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Julie Magram Acupuncturist LLC
Mutual Understanding in the Therapeutic Relationship

Confidentiality

Matters regarding care will be kept confidential except in the following circumstances: you sign a release of information giving permission to release information to a specific individual or agency; child abuse; patient or client is in imminent danger to self or others; subpoena of records.

Cancellation and Missed Appointments

If you need to cancel an appointment, please give us a minimum of 24 hours notice. It is our policy to charge a **\$20 cancellation fee for less than 24 hour notification.**

Initials: _____

It is Agreed: I agree to hold harmless the practitioner of Julie Magram Acupuncture LLC or to present any issue or concern of medical malpractice by letter to the practitioner and if taken further, it will be decided by neutral arbitration; and therewith give up my right to jury or court trial should an issue arise. Because of the differences in human constitution and response, I understand that there is no way possible to warrant the outcome of such medical care and service.

Initials: _____

It is Also Agreed: I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment at the time of visit. If your insurance company covers acupuncture, I will give you a super bill to be sent to the company, and they will reimburse you after we have received your payment.

Initials: _____

Printed Name: _____ Signature: _____ Date: _____

Parent or Guardian Signature (if under 18): _____ Date: _____





Julie Magram Acupuncturist LLC

Welcome to Julie Magram Acupuncture LLC. Thank you for choosing our clinic for your healthcare needs. To provide you with the best possible care, please fill out this form as accurately as possible.

This information will remain confidential.

Please Print:

First name:	Last Name:	MI:	Age:
Social Security #: - -	Sex: __F__M	Birthdate: / /	
Street Address:			
City:	State:	Zip:	
Home Phone:	Work Phone:	Cell:	
Occupation:		Email:	
In case of emergency, contact:	Relationship:	Phone:	
How did you hear about us?			
Does your insurance cover acupuncture? Yes / No / I don't know		If Yes:	
Name of company:			
Policy Number:			
Please Describe your major health concern(s):			
Do you have a western medical diagnosis?			
Are you currently taking any prescription or herbal medicine? Please List.			

