PATIENT INFORMATION

How should I prepare for my appointment?

The tongue is routinely examined as part of Chinese diagnosis; please do not brush your tongue prior to your appointment (brushing your teeth is fine). For best results, please do not come on an empty stomach or overly full. It is easiest to relax on the treatment table if you have not had caffeine or sugar immediately prior to the appointment.

What should I wear?

Loose clothing is best, especially with pants. If it is necessary to remove constrictive clothing, sheets/towels are available for coverage.

Should I avoid anything after acupuncture?

Avoid strenuous activity, baths, hot tubs and preferably any strong substances such as nicotine or alcohol for three hours after the treatment. Soup or a warm cup of tea is very good after a treatment.

FEES:

Initial Visit $216; Subsequent visits $108. Return Visit if I haven't seen you for 12+ months: $144. (Herbal medicine is additional.)

Cash or check are preferred (payable to "Frances Wocicki"); I can also email an invoice payable via credit card online.

CANCELLATION POLICY: The full cost of the appointment will be charged if you cancel with less than 24 hours notice or do not show up for you appointment. If you miss your appointment, others who desire that appointment time cannot be served. Please be on time. Call or text if you are running late.

Sandra "Frances" Wocicki, LAc, #15792
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PATIENT REGISTRATION FORM

Date of first visit: _____

Name: _____

Address: _____

_____

Phone: _____Email:_____

Age Today: _____

Male: ____Female:___ Intersex:___ Transgender:____

Preferred Pronoun:_____

Date of Birth: _____ Time of birth (if known):_____

Place of Birth (city, state, country): _____

Occupation & Employer: _____

Emergency contact:_____

Relationship: _____Phone:_____

How did you hear about this clinic? _____

****ALLERGIES**** Please use the space below or back of page to list any foods, medications, or environmental allergies that you have and describe symptoms / severity / treatment (if any):

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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 by Sandra "Frances" Wocicki.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases. I am aware that certain adverse side effects may result which could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. The risk of infection is small as all needles used are single-use and sterile.

Herbs: I understand that substances from the Oriental Materia Medica and Western nutritional supplements may be recommended to me to treat bodily dysfunction or diseases, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. *Should I experience any problems, I should suspend taking them and contact my practitioner as soon as possible.*

Acupressure and Medical Qi Gong: I understand that I may also be given acupressure and Medical Qi Gong as part of my treatment to modify/ prevent pain perception and to normalize the body's physiological functions. I am aware that adverse side effects may result from this treatment, which could include, but are not limited to: sore muscles/ aches, and possible aggravation of symptoms. I understand that I may stop the treatment at any time.

Electro-Acupuncture: I understand that electro-acupuncture may be administered with the acupuncture in order to speed up the healing process. I am aware that certain adverse side effects may result. These may include, but are not limited to: pain or discomfort, and the possible aggravation of symptoms. I understand that I may refuse this treatment.

Cupping & Scraping "Gua Sha": I understand that cupping and scraping are commonly used during an acupuncture treatment. I am aware that these treatments create a temporary petichia (discoloration) on the skin's surface where the procedure is being performed, which may last 1-5 days. Occasionally, bruising, blistering, or bleeding may occur as a result of the pressure of cupping or gua sha.

I understand that there may be other treatment alternatives, including treatment by a licensed physician.

I do not expect the acupuncturist to be able to anticipate and explain all risks and complications. I wish to rely on the acupuncturist to exercise judgment to choose the procedures and treatments that are in my best interest, based on the current diagnosis and the facts known at the time of treatment.

I will notify the acupuncturist if I am or become pregnant, and also of any allergies I currently have.

I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content. By signing below I agree to the above-named procedures. 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. I understand the results are not guaranteed.

Printed Name:_____

Signature: _____ Date: _____

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HEALTH HISTORY

Note: this a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person without your authorization.

NAME: _____

Height:_____Weight:_____

Areas in need of healing/ support / change / adjustment:

_____

_____

_____

Date of onset (when did you first notice the problem(s)?):_____

Have you had this in the past? _____If so, when?_____

Pain/discomfort is: ❒ Minimal ❒ Slight ❒ Moderate ❒ Severe

What makes it better?_____

What makes it worse?_____

Treatments/therapies you have tried (e.g. chiropractic, medications, etc.)?_____

_____

Is your condition: ❒ Getting worse ❒ Getting Better ❒ Comes and Goes ❒ Not changing

(use back of page if necessary for the following questions):

Medications / Herbs / Supplements you are currently taking:

Surgeries you have had, and approximate dates:

Accidental injuries and dates (include any car accidents):

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Self and Family Medical History (Do you have or have you ever had the following):

Leave blank, if you do not have, and there's no family history…

Condition	X if you have/had	X if family history	Condition	X if you have/had	X if family history
High Blood Pressure			Psoriasis / Eczema/ Rosacea		
Hypo / Hyper Thyroidism			Asthma		
Goiter			Emphysema		
Autoimmune Disease			Pulmonary Embolism		
Diabetes			Pneumonia		
High Cholesterol			COVID-19		
Artherosclerosis			Allergies		
Angina or Heart Attack			Arthritis		
Stroke			Cancer / Leukemia		
Epilepsy/ Seizures			Psychiatric Disease		
Kidney or Gall Stones			Other Chronic Disease		
Hepatitis					

Have you had any DNA testing done? YES NO

If yes, which service?

Have you submitted your DNA to further analysis for health markers?

If yes, do you have a polymorphism for the MTHFR gene?

If yes, do you have hereditary hemochromatosis (which can cause iron overload)?

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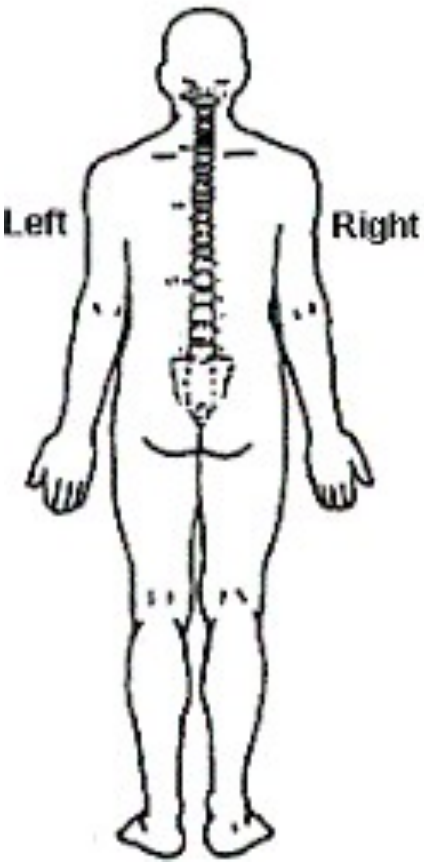
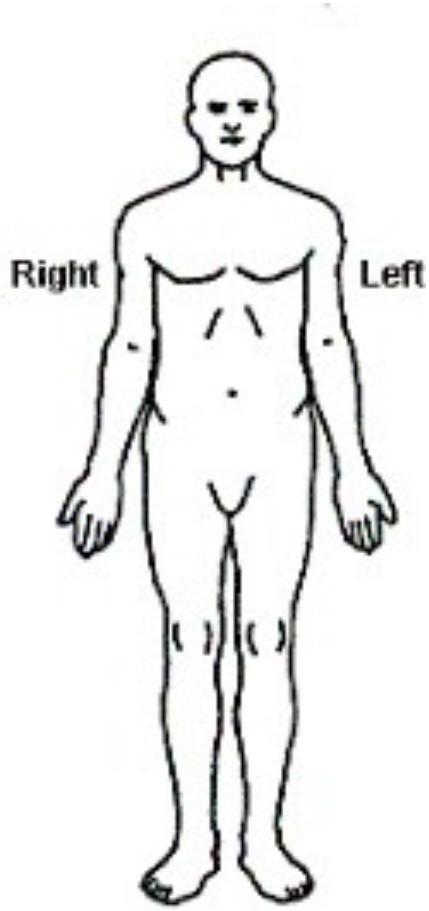
Physical Injuries: please mark areas of pain and describe injuries / symptoms:





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SYSTEMS REVIEW

General: ☐ Recent Weight Gain ☐ Recent Weight Loss ☐ Fatigue ☐ Weakness ☐ Fever ☐ Recent Changes in Appetite	Sweating: ☐ Night sweats ☐ Excess daytime sweat ☐ Rarely sweats Areas of body where you tend to sweat the most:	Circulation: ☐ Often feel cold ☐ Often feel too hot ☐ Cold Hands ☐ Cold Feet ☐ Temperature feels difficult to regulate (feeling hot / cold) ☐ Anemic or History of Anemia
Skin: ☐ Dry / Itchy ☐ Moist / Clammy ☐ Burning Sensations ☐ Frequent Rashes ☐ Excessive Reaction to Bug Bites ☐ Acne ☐ Easily Bruised ☐ Other	Sleep: Average number of hours you sleep each night: _____ ☐ Good sleeper ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Excess dreams / nightmares ☐ Snoring ☐ Sleep Apnea ☐ Wake without feeling rested ☐ Regular Sleep Schedule ☐ Irregular Sleep Schedule	Head: ☐ Chronic Headaches ☐ Migraines ☐ Dizziness / Vertigo ☐ Memory Loss ☐ Trouble Concentrating ☐ High Pitched Ear Ringing ☐ Low Pitched Ear Ringing ☐ Hearing Loss ☐ Tendency for Ear Wax Buildup
Eyes: ☐ Dry Eyes ☐ Itchy Eyes ☐ Blurry Vision ☐ Floaters ☐ Eye Pain ☐ Cataracts ☐ Glaucoma ☐ Watery Eyes	Nose: ☐ Sinus trouble / infections ☐ Frequently “stuffy” ☐ Frequent nose bleeds ☐ Frequent colds ☐ Loss of sense of smell ☐ Deviated Septum	Throat / Mouth: ☐ Sore throat ☐ Hoarseness ☐ Difficulty Swallowing ☐ Feeling like something is stuck in the throat ☐ Teeth / gum problems ☐ Mouth Ulcers ☐ Lumps/Swollen Glands

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Chest / Lungs:	Blood Pressure:	Bowels / Digestion:
☐ Wheezing ☐ Short of Breath ☐ Trouble breathing at night ☐ Persistent Cough ☐ Mucus rattles when breathing ☐ Pain / Pressure in Chest	☐ High ☐ Low ☐ Changes rapidly ☐ Controlled by medication ☐ On meds, but BP still high Cardiac: ☐ Swelling of Feet ☐ Chest Pain ☐ Coughing Phlegm ☐ Heart Palpitations ☐ Heart beats too quickly	☐ Diarrhea / Chronic Loose Stool ☐ Chronic Constipation ☐ Alternating Diarrhea / Constipation ☐ Difficult Bowel Movements ☐ Bowel Movements feel Incomplete ☐ Rectal Bleeding ☐ Gas and bloating ☐ Foul Odor ☐ Hemorrhoids ☐ Blood in Stools ☐ Trouble Swallowing ☐ Nausea / Vomitting

Urine:	Musculoskeletal:	Neurological / Emotional:
☐ Frequent UTIs ☐ Dark Color ☐ Difficult / Weak Stream ☐ Burning / Painful ☐ Frequent Urination (Day) ☐ Frequent Urination (Night) ☐ Blood in Urine ☐ Strong Odor	Pain in: ☐ Neck ☐ shoulder ☐ Jaw ☐ Upper back ☐ mid back ☐ low back ☐ arms/ hands ☐ fingers ☐ loss of grip ☐ feet/ toes ☐ knees ☐ tingling in feet / legs ☐ leg cramps at night ☐ weak legs ☐ weak ankles ☐ all over stiffness ☐ migrating inflammation / pain ☐ other:	☐ Depressed ☐ Anxious ☐ Nervous ☐ Easily Irritated or Angry ☐ Frequent Crying ☐ Excessive Worrying ☐ Mood Swings ☐ Memory Issues/ Confusion ☐ Suicidal ☐ Tremors ☐ Numbness / Tingling Limbs ☐ Poor coordination ☐ Muscle Weakness ☐ Seizures ☐ Shingles ☐ Feel Weak / Shaky ☐ Post Traumatic Stress Disorder ☐ Eating Disorder ☐ Family Stress ☐ Phobias

Vaccinations:
Have you received any of the following vaccines:

COVID-19: YES NO
Type of COVID vaccine (if known):_____ How many doses:_____
Date(s):_____

Hepatitis A? YES NO
Hepatitis B? YES NO
Shingles Vaccine? YES NO

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MEN:

☐ Low / no libido	☐ Discharge	Other:
☐ Erectile Dysfunction	☐ Pain / Burning while Urinating	
☐ Premature Ejaculation	☐ Weak Urine Stream	
☐ Hormone Therapy	☐ Prostate Trouble	
☐ Mood Swings	☐ Prostate Cancer	

WOMEN:

Pregnant? ☐ YES ☐ NO If yes, how many weeks?	Birth Control Method, if any:
Start date of last monthly period:	Age of Menarche:
Date of last PAP test:	Age of Menopause:
Operations: ☐ Cervix ☐ Uterus ☐ Ovaries	Hormone therapy? ☐ YES ☐ NO

Menstrual Patterns and Symptoms:
Average Length of Menstrual Cycle (e.g. 28 days): _____ Average Length of Menstrual Bleed (e.g. 5 days): _____
☐ Irregular Cycles ☐ Cycle Is Changing ☐ Heavy Bleeding ☐ Light Bleeding ☐ Bleeding In Between Periods ☐ Clots
☐ Missed Periods ☐ Dark Blood ☐ Light Colored ☐ Blood Bright Red Blood ☐ Cramping ☐ Mood Changes
☐ Symptoms Happen Before Period ☐ During Period ☐ After Period ☐ Hot Flashes ☐ Night Sweats ☐ Low / No Libido

Pregnancies:
Number of Pregnancies: _____ Number of Deliveries:_____ Number of Miscarriages:_____ Number of Cesareans:_____ Number of Abortions:_____ Number of Ectopic Pregnancies: _____
Have you had gestational diabetes? YES NO. Do you have a history of Infertility? YES NO

HORMONES FOR GENDER/SEX TRANSITIONING

Are you currently taking, or have you taken, hormones for sex or gender transitioning purposes? YES. NO

If yes, list hormones and how long you have been taking them:

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DIET / EXERCISE / LIFESTYLE

APPETITE: ☐ Good ☐ Excessive ☐ Low ☐ Grumpy / weak if a meal is missed ☐ Excess Thirst ☐ Lack of Thirst CRAVINGS FOR:_____ FOOD ALLERGIES (please list): FOOD SENSITIVITIES (please list):	DIET: ☐ Omnivore (I eat meat): ☐ Fish ☐ Chicken ☐ Beef ☐ Lamb ☐ Pork ☐ Vegetarian ☐ Vegan ☐ Pescatarian ☐ Paleo Diet ☐ Other diet: ☐ Eat breakfast daily ☐ Tend to eat with emotional upset ☐ I feel happy with my current dietary habits ☐ I wish to make dietary changes
Exercise: Type and Frequency of your Exercise Habits: ☐ I feel happy with my exercise habits ☐ I wish to make changes in my exercise habits	**Substance Use:** Number of alcoholic drinks consumed per week:_____ Type of alcohol consumed regularly:_____ Cigarettes per day:_____ Number of years smoking:_____ Marijuana frequency and type (smoked / edible): Other recreational substances used: ☐ I feel comfortable with my current use habits ☐ I wish to make changes in my use of substances

Any additional comments: