Lakeside Park - 591 North Ave., First floor- Door #4
Wakefield, MA 01880-1647 Tel/text: 617-652-1056
Kristina@AcupuncturebyKristina.com

Client Covid-19 Informed Consent

Please answer the following questions:

1. Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the past 14 days? _____yes _____no
2. Have you experienced any of the following symptoms in the last 14 days (fever, shortness of breath, cough, runny nose, nausea, diarrhea, loss of taste or smell)? _____yes _____no
3. Have you had close contact or cared for someone diagnosed with Covid-19, or someone exhibiting any of the above listed symptoms within the past 14 days? _____yes _____ no
4. Have you been tested for Covid-19? _____yes _____ no. If yes, what was the result? _____

Please read and initial the following statements and fill out and sign the bottom part:
_____" I understand that close contact with people increases the risk of infection from Covid-19. By signing this form, I acknowledge that I am aware of the risk involved and give consent to receive a session from this practitioner."

_____" I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner of this facility tests positive for Covid-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department."

_____" I agree that should I be diagnosed with Covid-19 and it be relevant to my visit of today, I will inform this practitioner ASAP."

Name:_____

Date:_____

Cell:_____

E-Mail:_____

Signature:_____

Thank you,
Kristina Langdon LAc

Client History Information

Name:		Contact - Cell:
Street:		Home:
City:		Work:
State:	Zip:	Email:
DOB:	Height:	Occupation:
Age:	Weight:	Physician:
Emergency Contact - Name & Phone Number:		
How did you hear about my practice?		

Main Complaint(s): 1- 2- 3-
How long ago did this begin?
Have you consulted aphysician?
Have you been given a diagnosis, if so, what?
What forms of treatment have you tried?
Have you tried acupuncture or Chinese herbal medicine before?

Past Medical History - Please circle all applicable to you:				
Cancer	Diabetes	Hepatitis A, B, C	High Blood Pressure	Heart Disease
HIV	Seizures	Auto Immune	Thyroid Disease	Pace Maker
Depression	IBS	Hysterectomy	Kidney Disease	Prostate Issues
Significant Trauma, auto accidents,injuries:				
Surgeries and Dates:				
Other Significant Illness(es):				

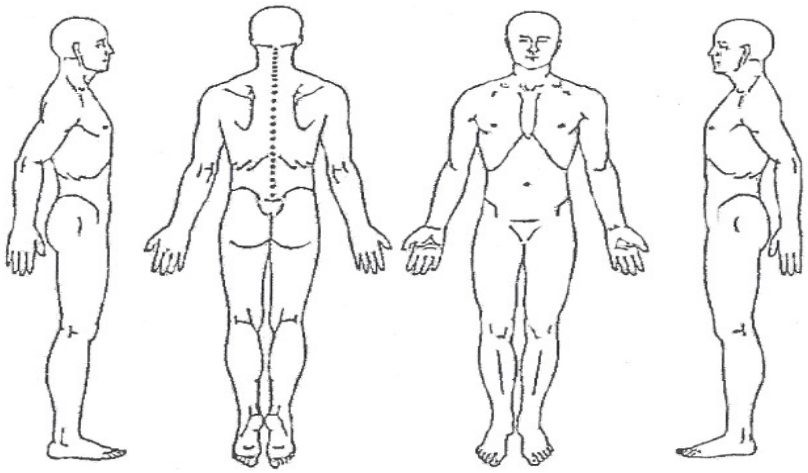
Medications: (include prescription, OTC, vitamins, herbs etc.)	
Do you currently take a multivitamin or antioxidant? Yes No	

Daily Health - Habits

Do you smoke? Yes No - If yes, how much?			
How much soda do you drink in a week?			
Do you drink Diet beverages			
Is more than 25% of your diet frozen, canned, boxed or processed foods? Yes No			
How much water do you drink in a day			
How much coffee do you drink in a day			
How much alcohol do you drink in a week?			
Describe how you feel about your appetite	Too Good	Just Right	Not Good Enough
Average number of hours of sleep per night?			

Average Diet		
Morning	Afternoon	Evening

Indicate Areas of Pain



General Client History

	General						
	Fevers			Strange Tastes or Smells			Poor Sleep
	Sweat Easily			Cravings			Fatigue
	Night Sweats			Change in Appetite			Sudden Energy Drop
	Running Warm			Weight Loss			Cold Hands/Feet
	Running Cold			Weight Gain			Strong Thirst

	Skin & Hair						
	Rashes			Ulcerations			Hives
	Itching			Oozing Ulcers			Recent Moles
	Dandruff			Eczema			Discoloration
	Dry Skin			Psoriasis			Infection
	Brittle Nails			Hair Loss			Other:

	Head						
	Dizziness			Poor Vision			Migraines
	Vertigo			Eye Tenderness			Tension Headaches
	Ringing in Ears			Eye Twitching			Sinus Congestion
	Ear Blockage			Eye Tearing			Sore Throats
	Facial Pain			Dry Eyes			Post Nasal Drip
	Teeth Grinding			Spots/Floaters in Vision			Nose Bleeds
	TMJ			Poor Night Vision			Cloudy/Fogginess
	Cankersores-Mouth Ulcer			Cataracts			Concussion

	Cardiovascular/Chest						
	Pain/Tightness			Fainting			Blood Clots
	Irregular Heartbeat			Cold Hands or Feet			Peripheral Artery Desease
	High / Low Blood Pressure			Swelling in Limbs			Varicose Veins

	Respiratory						
	Cough / Coughing			Asthma			Production of Phlegm
	Blood Bronchitis			Difficulty Breathing			Pneumonia
				Wheezing			Short of Breath

	Gastrointestinal						
	Nausea			Gas Belching			Abdominal Pain - Cramps
	Vomiting			Diarrhea			Rectal Pain - Burning
	Indigestion			Constipation			Hemorrhoids
	Acid Reflux			Sluggish Bowel			Blood in Stool Undigested
	Bloating						Food in Stool
	Other:						

	Urinary						
	Frequent Urination			Pain Upon Urination			Inability to Empty Bladder
	Urgency to Urinate			Blood in Urine			Week Stream
	Incontinence			Frequent UTIs			Kidney Stones
	Dark Color to Urin			Strong Odor to Urine			Frequent Night Urination
	Male Health						
	Impotence			Low Sperm Count			Low Libido
	Premature Ejaculation			Low Motility			STDs
	Enlarged Prostate			Testicular Pain			Other:
	Female Health						
	Age of first Period ? & Days between Day 1 of period?						
	Using Birth Control?						
	Are you or is it possible that you're pregnant?						
	# of Live Births ? & # of Miscarriages ?						
	Heavy Period			Uterine Fibroids			Vaginal Discharge
	Light/Scanty Period			Ovarian Cysts			Fequent Yeast Infections
	Painful Period			Endomitriosis			STDs
	Breast Tenderness			Clots in Blood Flow			Infertility Issues
	Period begins w/ spotting			PMS			Spotting During Ovulation
	Musculoskeletal						
	Neck / Shoulder Pain			Hand / Wrist Pain			Overall Muscle Achiness
	Back Pain			Foot / Ankle Pain			Muscle Weakness
	Sciatica			Hip Pain			Herniated Discs
				Knee Pain			Other
	Neurological						
	Seizures / Stroke			Dizziness / Vertigo			Areas of Numbness
	Concussion			Loss of Balance			Tremors
	Other:			Confusion			Neuropathy - Nerve Pain
	Emotions						
	Are you currently being treated for emotional or psychological issues?						
	Have you ever considered or attempted suicide?						
	Depression			Insominia - Mind racing			Panic Attacks -- Cloudy
	Anxiety			Fearful			Foogy Mind Other:
	Anger			Phobias			

CONSENT TO TREATMENT

I, _____, hereby authorize Kristina Langdon to administer treatment of acupuncture, adjunctive techniques and herbal medicine relevant to my diagnosis. I have the right to refuse any form of treatment. I understand that acupuncturists practicing in the state of Massachusetts are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended. Acupuncture treatment may include, but is not limited to the following:

1. Insertion of various styles and sizes of acupuncture needles into my body at various depths and locations.
2. Heat treatments using conventional heat lamp or moxibustion (Artemesia Vulgaris). With any heat treatment exists the risk of burn.
3. Massage technique of "gua sha". This technique may cause redness on the skin at the sight of treatment. Slight bruising and tenderness may persist after the treatment.
4. The placement of suction cups on the skin. These cups may produce a red or purple mark on the skin after the treatment.
5. Electrical stimulation of the needles may be used producing a tapping sensation at the needle location.
6. Herbal medicine, administered in various forms including tablets, capsules, extract powders, aw herbs and liniments. These herbs are taken orally and/or topically. Some patients may experience side effects including but not limited to upset stomach or nausea.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment and have been given the opportunity to ask questions pertaining to the treatment. I also understand there is always a possibility of an unexpected complication and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantee can be made concerning the results of treatment.

Signature of Patient or Legal Guardian:

_____

Printed Name of Patient: _____