Two Trees Acupuncture

1318-A3 Central Ave Charlotte, NC 28205
704-770-1318 (*info@twotreesacupuncture.com)*

All medical information is confidential. We appreciate your thoughtfulness and honesty.

Contact Information:

Name:_____ Date:_____

Address:_____ City/ Zip:_____

Phone: (H)_____ Email:_____

(C)_____ Gender: F M Age_____

Can we leave a message? Y N (prefer: Home/ Cell) Date of Birth:_____

Occupation:_____ Do you enjoy your work?_____

How did you hear about us?_____

Have you had Acupuncture before? _____

Medical Doctor's name & phone number:_____

Emergency Contact Name & Phone number:_____

Emergency Contact's Relationship:_____

Reason for Visit:

Please include how long you have had each condition, when it occurs, and what therapy you have used or currently using for treatment.

I)_____

_____

_____

II)_____

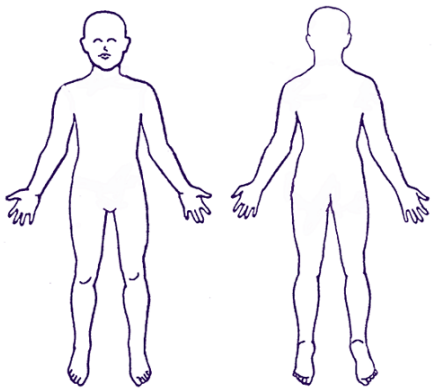
_____

_____

III)_____

Please check any pain or circle areas of discomfort:

- Arthritis
- Joint Pain/ swelling
- Difficult walking
- Leg cramps
- Weakness
- Burning pain
- Numbness/ tingling
- Throbbing pain



Personal Health Information:

Please check any illness below and date when they occurred.

- ○ AIDS/ HIV
- ○ Allergies
- ○ Anemia
- ○ Antibiotic Use
- ○ Asthma
- ○ Bleed Easy
- ○ Cancer
- ○ Chicken Pox
- ○ Diabetes
- ○ Glaucoma
- ○ Heart Disease
- ○ Hepatitis
- ○ High Blood Pressure
- ○ Jaundice
- ○ Kidney disease
- ○ Mental disorder
- ○ Multiple sclerosis
- ○ Night sweats
- ○ Whooping cough
- ○ Pneumonia
- ○ Polio
- ○ Rheumatic fever
- ○ Shingles
- ○ Stroke
- ○ Thyroid disorder
- ○ Tuberculosis
- ○ Ulcers
- ○ Vascular disease
- ○ Other:_____

Do you have a PACEMAKER: Yes No

Have you had any surgeries, major accidents or injuries:

_____

_____

_____

List ALL Allergies to drugs, foods, herbs, and environment:

_____

_____

_____

List ALL Medications you are taking:

_____

_____

_____

List ALL Vitamins/ Supplements/ Herbs you are taking:

_____

_____

_____

Family Health History:

- ○ Alcoholism
- ○ Allergies
- ○ Bleed easy
- ○ Cancer
- ○ Diabetes
- ○ Epilepsy
- ○ Heart disease
- ○ High blood pressure
- ○ Kidney disease
- ○ Mental illness
- ○ Obesity
- ○ Stroke
- ○ Other:_____

Lifestyle:

Check which substance & how often used:

- ○ Caffeine:_____
- ○ Alcohol:_____
- ○ Tobacco:_____
- ○ Marijuana:_____
- ○ Sugar:_____

Check if your work or lifestyle attributes to:

- ○ Stress
- ○ Insufficient sleep
- ○ Working long hours
- ○ Long commute times
- ○ Heavy lifting or hazardous substance

What is your favorite recreational activity? _____

How do you relax? _____

Nutrition:

Please list what you typically eat for the following meals:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks/ Treats:_____

Foods AVOIDS:_____

How many glasses of water per day_____ juice/ other:_____

Exercise & Energy

What type of exercise:_____ How Often:_____

When is your energy the highest: _____am/pm energy lowest:_____

How many hours a night do you sleep?_____ Do you wake up rested?_____

Do you wake up throughout the night: Yes No how often:_____ what time:_____

Do you have night sweats:_____ Do you have dreams? Yes No how often:_____

Female Health:

Please check/ fill in all that applies

Last menstrual period date: _____Days in cycle:_____

- o Currently Pregnant
- o PMS:_____
- o Breast tender/ pain
- o Pelvic pain or infection
- o # of children:_____
- o Irregular cycle
- o Hot flashes
- o Excess discharge
- o Menopause began:____
- o Urinary Frequency
- o Uterine Fibroids
- o Hysterectomy
- o Other:_____

**Please note if you are coming in for female health concerns please fill out the additional form*

Male Health:

Please check/ fill in all that applies

Date of last prostate exam*:*_____

- o Testicular Pain
- o Urinating at night
- o Prostate pain/swelling
- o Urinary Frequency
- o Impotence
- o Discharge from Penis

What are your personal health goals? _____

_____

_____

Patient Signature:_____Date:_____

Check all that apply:

Section I:
- Heart Palpitations
- Rapid/irregular heart beat
- Chest pain
- High/ Low blood pressure
- Insomnia/ Sleep problems
- Early waking
- Difficulty falling asleep
- Vivid dreams
- Nightmares
- Easily startled
- Prone to feel restless
- Low in spirit
- Dark urine
- Red complexion
- Crave Bitter
- Anxiety/ nervous/ restless

Section II:
- Muscles feel weak
- Fatigued/ low energy
- Feel sluggish
- Poor circulation
- Edema in hands/ feet
- Varicose veins
- Easily bruising/bleeding
- Bad breath
- Sweet taste in mouth
- Lack of taste
- Excess appetite
- Excess thirst
- Lack of thirst
- Nausea/ vomiting
- Gas/ belching
- Hemorrhoids
- Organ prolapse
- Chronic loose stools
- Abdominal pain
- Indigestion/ heartburn
- Mouth ulcers
- Gain weight easily
- Hypothyroidism
- Anemia
- Crave sweets
- Overthinking/ worry
- Acid reflux/ heart burn

Section III:
- Bloody cough
- Dry cough
- Chronic cough
- Nasal discharge
- Post nasal drip
- Sinus infection/congestion
- Itchy/red/ painful throat
- Dry skin
- Skin rashes/ hives
- Snoring
- Shortness of breath
- Allergies
- Asthma
- Low immunity
- Catch colds easily
- Bronchitis
- Black or bloody stool
- Constipation
- IBS
- Diarrhea
- Colitis/ spastic colon
- Crave pungent/ spicy

Section IV:
- Osteoporosis
- Dark circles under eyes
- Thyroid problems
- Poor memory
- Cavities
- Impotence
- Premature ejaculation
- Crave salty food
- Feel fearful
- Weak/ pain in low back
- Ear ringing
- Dizzy feeling
- Night sweat
- Hot flashes
- Cold hands
- Cold feet, at night
- Low back pain
- Low libido
- Night urination
- Early morning urination
- Frequent and or profuse urination
- Early morning loose stools
- Profuse vaginal discharge
- Difficulty staying asleep

Section V:
- Prone to depression/ stress
- Headaches/migraines
- Red/ dry/ itchy eyes
- Visual problems
- Blurry vision
- Dizziness
- Gallstones
- Feeling of lump in throat
- Clenching teeth at night
- Difficult to fall asleep
- Vivid/ scary dreams
- Muscles cramping/ twitching
- Neck/ shoulder tension
- Seizures/ tremors
- Poor circulation
- Bitter taste in mouth
- Heartburn
- PMS/ irritable with ovulation
- Breast soreness/ distention
- Menstrual issues
- Tendonitis
- Pain below the ribcage
- Crave sour food
- Feel irritable/ angry
- Poor digestion with stress

Section VI:
- Dry flaky skin
- Chapped lips
- Brittle finger nails
- Losing hair
- Brittle hair
- Diminished night vision
- Lightheaded with period
- Pale lips, tongue, eyelids
- Difficulty falling asleep
- Poor memory

Section VII:
- Tired/sluggish after meals
- Cystic or pustule acne
- Urgent/ foul smell stools
- Body heavy/ joint achy
- Overweight
- Mental sluggish
- Brain fog
- Lump in throat
- Hard to get up in AM

Two Trees Acupuncture

Consent to Treat Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the *Oriental Materia Medica* by a Licensed Acupuncturist at Two Trees Acupuncture. I understand that acupuncturists practicing in the state of North Carolina are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These 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. I understand that a very low risk of pneumothorax, infection and spontaneous miscarriage also exists with the use of certain acupuncture points. I understand that no guarantees concerning acupuncture's use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that if I receive indirect moxibustion as part of therapy, this is a technique that uses heat and anytime this therapy is utilized there is a risk of possible burning, and I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, 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. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Due to the delicate nature of herbal substances, all sales are final. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the clinic or my acupuncturist as soon as possible.*

Acupressure/Tui-Na Massage/ Cupping/ Gua Sha: I understand that I may also be given acupressure, cupping, gua sha, Tui-Na or Shiatsu massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Clinic Fee Schedule (due at time of service):

Initial Private Treatment:	$95.00
Private Follow-up Treatment:	$75.00
Community Acupuncture Sliding Scale:	$20-$45 (+$15 for initial visit)
Tui Na Session:	$40 ($45 for initial visit)
Cupping Session:	$40
Pediatric Visit:	$40 ($45 for initial visit)
Herbal Consultation:	$35.00 (+ cost of herbs)
Arvigo® Maya Abdominal Massage	$125
Facial Rejuvenation Treatment Series	$1200 for 10 treatment series
Treatment Series for Private Follow up:	$210 for 3 Visits/$390 for 6 visits

Please note- Treatment Series are non-refundable and non-transferrable

For Community treatments cash/check is preferred, a 3% fee applies for credit card processing.

Cancellation Policy:

At Two Trees Acupuncture, our time is dedicated to you, our patients. As such, our cancellation policy reflects this. If you are going to have to cancel your appointment, we require 24 hour notice before your scheduled visit. We understand that life happens, and we are willing to be flexible with you, however we ask for a phone call if there are any extenuating circumstances which may require you to miss your appoint that day. A no-call/no-shows will incur a charge of $25 to your credit card on file. We thank you for your understanding in advance and for your helpful communication regarding timely cancellations.

I understand that there may be other treatment alternatives, including treatment offered by another licensed medical professional. I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____