RADIANT POINT ACUPUNCTURE

22 Merrick Ln. Northampton, MA
(413)727-3220

Please take a moment to provide us with information about your current and past health history. All information is considered privileged physician/patient communication and we will hold it in confidence as such. None of your history will be released with out your signed consent. Radiant Point Acupuncture strives to be an inclusive clinic and every effort will be made to provide sensitive care to all. If pages of this paperwork are not relevant or do not represent you, please leave it blank and we can discuss details during our consult.

NAME _____ DATE _____

AGE DOB SEX GENDER IDENTITY _____

ADDRESS _____

_____ CELL NUMBER _____

EMAIL ADDRESS _____

OCCUPATION _____

EMERGENCY CONTACT _____

NAME OF PCP/OBGYN/CNM _____

MEDICAL INSURANCE CARRIER _____

ARE YOU BEING TREATED ELSEWHERE? _____

HOW DID YOU HEAR ABOUT RADIANT POINT ACUPUNCTURE?

_____

MAJOR COMPLAINT/HEALTH PROBLEM YOU WOULD LIKE TO FOCUS ON:

HOW DID THIS CONDITION DEVELOP & HOW LONG HAS IT PERSISTED?

ANY SIGNIFICANT TRAUMA OR INJURIES?

PLEASE LIST ANY SURGERIES AND DATES PERFORMED

ANY RELEVANT FAMILY MEDICAL HISTORY:

CURRENT MEDICATIONS (PRESCRIPTION, HERBAL & SUPPLEMENTARY):

NAME:

please circle any symptoms you currently have or have had in the past 6 months

GENERAL
chills
low energy
dizziness
allergies
fevers
excessive thirst
insomnia
nervousness
numbness
spontaneous sweating
night sweating
lack of sweating
weight loss
weight gain
aversion to heat
aversion to cold

CARDIOVASCULAR
chest pain
palpitations
high/low blood pressure
poor circulation
swelling ankles
varicose veins
hypochondriac pain
anemia

GENITOURINARY
urinary tract infection
blood in urine
cloudy urine
burning with urination
scanty urine
frequent urination
urgency
loss of control

EMOTIONAL
insomnia
irritability, anxiety
frequent anger/frustration
troubling dreams
uncontrollable crying
depression
grief

HEAD & NECK
blurred vision
heavy head
headache
phlegm in throat
double vision
eye pain/strain
nasal obstruction
hearing loss
ringing in ears
sinus problems
hoarseness
loss of sense of smell
sores on lips or tongue
dental problems
loss of sense of taste

MUSCULOSKELETAL
pain,weakness,numbness:
neck & shoulders
arms & hands
rib cage
hips
knees & feet
low back
mid back
all over weakness

SKIN
rashes
hives
acne
psoriasis
eczema
dry skin
brittle nails
hair loss

LIFESTYLE
smoker
drink alcohol
recreational drug use
exercise regularly
exercise excessively

RESPIRATORY
asthma
hay fever
persistent cough
cough w/ blood
shortness of breath
bronchitis
phlegm
difficult in/exhalation
sleep apnea
snoring
re-occurrent sore throat

GASTROINTESTINAL
abdominal pain
bloating, gas
belching
constipation
loose stools
poor appetite
heartburn/acid reflux
black stools
hemorrhoids
indigestion
nausea
vomiting

NEUROLOGIC
fainting
convulsion
handwriting changes
paralysis
stroke
tremor
vertigo

DIET
vegetarian
vegan
eat meat /seafood often
drink coffee/tea
crave sweets
crave salt
often eat fast food
often eat dairy
often eat fried foods

IF YOU ARE MENSTRUATING PLEASE FILL IN THIS PAGE

Age at which menses began
Date of last menstruation
How many days from one period until the next?
Is this regular from month to month?
How many days do you bleed? How heavily?
What color is the blood? Is there clotting?
Do you spot or bleed between periods?
Do your bowel movements become loose prior to your period?
Do you have premenstrual tension? Do you have premenstrual breast tenderness?
Are your periods painful? How many days does the pain last?
Do you have low back pain with your menses?
Do you have skin break outs at certain times of your cycle?
Do you douche or use vaginal lubricants?
Do you feel you are experiencing peri-menopause?
Are using a birth control method?

	NUMBER	YEAR
How many pregnancies have you had?		
How many children do you have?		
How many abortions have you had?		
How many miscarriages have you had?		
How many times has a D&C been performed?		

PLEASE CIRCLE & DATE ANY SYNDROMES YOU HAVE/HAD

Abnormal Pap	Abnormal vaginal discharge	Cirrhosis
Venereal disease	Pelvic Inflammatory Disease	Heart disease
Chlamydia	Fibroids	Thyroid disorder
Endometriosis	Polyps	Hepatitis
Yeast infections	Pelvic adhesions	Arthritis
Genital sores	Pelvic abnormalities	UTI
Breast infections or lumps	Autoimmune disease	Blood disorders
Diabetes	PCOS	Stroke history
Epilespy	Mental illness	Cancer

FERTILITY & PREGNANCY PATIENTS PLEASE CONTINUE TO RELEVANT PAGES

ACUPUNCTURE TREATMENT CONSENT

I hereby request and consent to acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by the acupuncturist named below. I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, moxa, massage, cupping, electrical stimulation, Chinese 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. I will immediately notify my acupuncturist 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 and/or numbness or tingling near the needling sites that may last a few days. There have been rare instances reported in which a patient fainted, developed a scar or infections, experienced a spontaneous miscarriage, sustained a pneumothorax (air in the chest cavity that could cause a collapsed lung) or a burn from moxa or cupping. The herbs and nutritional supplements that have been recommended are considered safe in the practice of Chinese medicine. Some herbs may have undesirable effects in larger doses than we recommend. Some possible side effects of taking herbs are nausea, gas, stomachache, diarrhea or rashes. I will notify my acupuncturist if I am pregnant since some herbs can be harmful. I do not expect my acupuncturist to be able to anticipate and explain all possible risks and complications of treatments, and I wish to rely on my acupuncturist to exercise good judgment during the course of treatment. I understand that results are not guaranteed. By voluntarily signing below, 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 form to cover the entire course of treatment for my present condition and for any future condition (s) for which I seek treatment.

FINANCIAL AGREEMENT & CONSENT

Your appointment time is reserved specifically for you. 24hr notice must be given for cancellations or a fee will be charged to your account

EMAIL CONSENT

Clients may want to use email to facilitate communication. Federal regulations impose a "duty to warn" clients of risks associated with unencrypted email. Kathryn Cadwgan must document in the medical record that clients have been advised that email communications could potentially be read by a third party. Upon receipt and documentation of this notification, the client has the right to request communication via email. Kathryn Cadwgan will use reasonable means to protect the security and confidentiality of electronic information sent and received. However, because of the risks outlined above Kate can't guarantee the security and confidentiality of electronic communication unless the email is encrypted through a secure server, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the Federal Health Insurance Portability and Accountability Act) that is not caused by Kathryn Cadwgan's intentional misconduct. I hereby acknowledge that I have read and understand the risks and conditions of communication through electronic transmission. By signing below I am authorizing communication through email.

PATEINT SIGNATURE: _____ *DATE:* _____

IF YOU ARE TRYING TO CONCEIVE PLEASE FILL OUT THIS PAGE

Everyone's journey to parenthood is unique but making paperwork reflect that is challenging. Please fill in what is relevant and comfortable. We will discuss your case in more detail during your consult.

NAME:
How long have you been trying to conceive?_____
Are you seeing a Reproductive Endocrinologist? _____
Have you been given a western medical diagnosis in regards to fertility challenges?____
_____
Have you taken any medications to help you ovulate? _____
Do you know your day 3 FSH level?_____ Estrodial _____ Prolactin _____ AMH _____
Please list any other lab tests performed and the results:
_____
Have you used a BBT graph to chart your body temperature?_____
Have you had an HSG exam?_____Results_____
How is your sexual energy?_____Emotional energy?_____
Describe any family gynecological history that may be relevant: _____
_____
Are you using any lubricants or douches on a regular basis?_____
Did your mother/grandmother take DES when pregnant?_____
Do you have any autoimmune diseases?_____
Are you seeing any alternative health care practitioners?_____
What forms of ART are you or have you tried?
please list procedure, medications & date:
_____
_____
_____
_____
Has your partner had any relevant lab tests performed? please list date and results
_____
Are you using donor sperm? Please specify if known donor or name of bank
_____
Are you using donor eggs? Please specify if known donor, frozen or fresh embryo:
_____

IF YOU ARE PREGNANT PLEASE FILL OUT THIS PAGE

NAME:

What is your estimated due date?
Where your cycles regular prior to conception?_____How many days long?_____
What is your primary health concern?_____
_____
_____

Is this your first pregnancy?_____If no, please describe your previous pregnancy, labor and deliveries including dates:_____
_____
_____
_____
_____

Who is your OBGYN/CNM_____
Where are you planning on delivering?_____
Please briefly describe your diet:_____
_____

What is your exercise routine?_____
How are you feeling emotionally?_____
Have you had any major surgeries or hospitalizations?_____
Please list all medications: please include all prescriptions, herbs, supplements and over the counter aids:_____
_____

Please circle any conditions that are applicable now or have been in the past
Cardiovascular disease, Anemia
Hypertension, Depression
Diabetes, Allergies