Lisa C. Francolini, L.Ac., PC
State License # 0283

RiverWEST ACUPUNCTURE

Sheridan Horning, L.Ac.
State License # 1195

WELCOME TO OUR OFFICE!

Thank you for choosing our office. The purpose of River West Acupuncture clinic is to assist each individual in achieving their optimum health. We look forward to providing for your health needs, emphasizing preventative care and health maintenance. Traditional Chinese Medicine, which primarily includes Acupuncture and Chinese Herbs, offers an approach that may differ from other methods but is very complimentary to other medical approaches. We refer and work closely with physicians, medical specialists, other complimentary practitioners as well as our patients in order to accomplish our stated purpose.

In order to serve you properly we will need the following information. Please print and answer all questions completely. All information will be strictly confidential.

Name:_____ Date:_____

Address:_____ Age:_____ Date of Birth:_____

City/State/Zip:_____

Home Phone:_____ E-Mail:_____

Cell Phone:_____ Marital Status: Single Married Partner Divorced Widowed

Employer: _____ Occupation:_____

Emergency Contact: _____ Relation:_____ Phone: _____

How did you find out about us? _____

I voluntarily consent to be treated with acupuncture by Lisa C. Francolini or Sheridan Horning, Licensed Acupuncturists, at RiverWest Acupuncture, and/or my residence.

I understand that acupuncture is performed by the insertion of needles. This occurs through the skin, and/or by the application of heat to the skin, at certain points on or near the surface of the body. The effect of acupuncture is to treat bodily dysfunctions or diseases, to modify or prevent the perception of pain, and to make normal the body's physiological functions. I have been informed that only disposable needles will be used during each treatment.

I have been made aware that certain adverse side effects may result. These could include, but are not limited to, some local bruising, minor bleeding, fainting, temporary pain or discomfort, and the possible temporary aggravation of symptoms existing prior to acupuncture treatment.

I am also aware that acupuncture is licensed in Oregon and many other states and has been safely practiced for centuries and the FDA classifies the procedure as a medical procedure. I understand that no guarantees concerning its use and effects are given to me, and that I am free to stop acupuncture treatments at any time.

I have carefully read and understand all of the information and I am fully aware of what I am signing.

_____

Signature (Patient/Parent/Guardian) Date

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What are your top three health conditions for which you are seeking treatment?

1)_____2)_____3)_____

If pain is associated with any of these conditions, please rate your current pain level on a scale of 0 to 10 with 0= no pain and 10= extreme pain. Indicate how long you have had each condition.

1) _____Pain___/10 How long? _____ 2) _____ Pain___/10 How long? _____

Check off any of the symptoms you have experienced in the past 6 months:

❍Pregnant (Currently)	❍Upper Back Pain	❍Shoulder Pain	❍Allergies
❍Fatigue/Tired	❍Low Back Pain	❍Knee Pain	❍Tension
❍Headaches	❍Neck Pain	❍Hip Pain	❍ Irritability
❍Digestive Issues	❍Elbow Pain	❍Pain in the Body	❍ Nervousness
❍Numbing/Tingling	❍Ankle/Foot Pain	❍Ringing in Ears	❍ Anxiety
❍Difficulty Sleeping	❍Hand Pain	❍Dizziness	❍Depression

❍Other: _____

Which of the above bothers you the most? _____

How long have you been bothered by this condition? _____

Describe how it feels or affects you when it is at its worst: _____

What is/was the cause of the problem? _____

Have you had acupuncture before? ❍ Yes ❍ Yes, a long time ago ❍Never

Do you have any concerns for your treament? _____

Is there anything else you would like your practitioner to know today?
(fear of needles, high sensitivity, significant trauma, negative past experiences with acupuncture,etc.)

_____

_____

_____

*** Please let us know if you have NOT eaten any food today**