CONTACT INFORMATION

Richard A. Covello, L.Ac.
AcupunctureConnecticut .com

Please complete the following:

SSN #_________________________________

Email Address: ____

Name____ Date_________________________

Home Address____

City__________________________ State_________ Zip________________

Home Phone___________________ Work Phone___________________

Person responsible for your account_____________________ Occupation__________________

Who should we thank for referring you to this office? ____________________________

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Office Use Only

Your CHSLife.com ID _________________________

Your CHSLife.com Password _________________________

PATIENT INFORMATION

☐ Male ☐ Female Height_________ Weight______ Birth Date__________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Approximate date you were last examined by a physician (M.D). ___________

Have you ever had acupuncture therapy before? ☐ Yes ☐ No

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any allergies, food sensitivities or food cravings that you have?

List any accidents; surgeries, or hospitalizations include dates.

Medications and supplements you are currently taking.

Medicine	***Reason***	***Dosage***	***How Long***	***Prescribed by***

Please **check** the box for any illnesses you or a blood relative (Grandparent, parent or sibling) has had:

	YOU	***RELATIVE***	***DATE***	***NOTES***
AIDS	☐	☐		
Cancer	☐	☐		
Diabetes	☐	☐		
Emotional Disorders	☐	☐		
Heart Diseases	☐	☐		
Hepatitis	☐	n/a		
High Blood Pressure	☐	☐		
Infectious Diseases	☐	n/a		
Rheumatic Fever	☐	n/a		
Seizures	☐	☐		
Tuberculosis	☐	n/a		
STD (Syphilis, HPV, Herpes, Gonorrhea Chlamydeous)	☐	☐		
Other	☐	☐		
Other	☐	☐		

Please check use and frequency of the following:

	Yes	***How Much***	***Notes***
Coffee / Black tea	☐		
Non-Medical Drugs	☐		
Tobacco	☐		
Alcohol	☐		
Water Intake	☐		
Soda Pop	☐		

Please indicate as follows (+) frequently experience, (-) sometimes experience.

	Mark		***Mark***		***Mark***
Lack of appetite		Abdominal Pain		Hemorrhoids	
Excessive appetite		Chest pain		Recent use of antibiotics	
Loose stool or diarrhea		Sciatic pain		Eye problems	
Digestive problems, indigestion		Headaches		Jaundice (yellow skin or eyes)	
Vomiting		Pain or coldness in the genital area		Difficulty digestion oily foods	
Belching, burping		Cough		Gall stones	
Heartburn / reflux		Shortness of breath		Light colored stool	
Feeling the retention of food		Decreased sense of smell		Soft or brittle nails	
Tendency to become obsessive in work,		Nasal problems		Easily angered or agitated	

Insomnia, difficulty sleeping		Skin problems		Difficulty making plans or decisions	
Heart palpitations		Feeling of claustrophobia		Spasms or twitching of muscles	
Cold hands and feet		Bronchitis		Low back pain	
Nightmares		Colitis or diverticulitis		Knee problems	
Mentally restless		Constipation		Kidney stones	
Laughing for no apparent reason		Hearing impairment		Decreased sex drive	
Angina pains		Ear ringing		Hair loss	
Urinary problems		Fatigue		Edema	
Blood in stool		Black tarry stool		Easily bruised	
Difficult to stop bleeding		Intolerance to weather changes		Tendency to catch colds easily	
Asthma		Allergies		Hay fever	
Dizziness		Tendency to faint easily		High cholesterol	
Sudden weight loss					

MALE

	Date/ Number	***Notes***
Date of Last Prostate Exam		
PSA Results		
Manual prostate exam results		
Lab Results		
Frequency of Urination Daytime		
Frequency of Urination Nighttime		
Color of Urine		

	Yes		***Yes***	***Notes***
Prostate Problems	☐	Dribbling		
Rectal Dysfunction	☐	Testicular Pain		
Incontinence	☐			
Delayed Stream	☐	Premature Ejaculation	☐	
Increased / Decreased libido	☐	Retention of Urine	☐	
Groin Pain	☐	Impotence	☐	
Testicular Pain	☐	Dribbling	☐	
Incontinence	☐			
Other				

FEMALE

	Yes	*No*		*Yes*	*Notes*
Are you pregnant	□	□	Fibroids	□	
Are you trying to get pregnant	□	□	Fibrocystic Breasts	□	
Number of pregnancies		□	Endometriosis	□	
Number of live births		□	Ovarian Cysts	□	
Number of Miscarriages		□	PID	□	
Number of Abortions		□	Other	□	
Age of first period (menarche)		□	Number of days of flow		
Age of last period (menopause)		□	Number of days between periods		
Color of flow			Clots	□	

	Number	*Date*	*Notes*
Average # of pads used 1st day			
Average # of pads used 2nd day			
Average # of pads used 3rd day			
Average # of pads used 4th			
+ days			
Last Gynecological Exam			
Last Mammogram			
Last Bone Density Exam			
Date of last Pap Smear			

Pain	*Yes*	*Other Symptoms*	*Yes*	*Notes*
Cramping	□	Discharge	□	
Burning	□	Nausea	□	
Dull Pain	□	Swollen breasts	□	
Constant Pain	□	Increased / Decreased Appetite	□	
Bearing Down Sensation	□	Increased / Decreased libido	□	
Stabbing Pain	□	Vaginal dryness	□	
Aching	□	Constipation	□	
Bloating	□	Mood Swings	□	
Intermittent Pain	□	Hot Flashes	□	
Night Sweats	□	Headaches	□	
Insomnia	□	Diarrhea	□	

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Acupuncture by the Licensed Acupuncturist named below and /or other members of the clinical staff. I have discussed the nature and purpose of my treatment with the member of the clinical staff named below.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, cupping, gua sha, electrical stimulation and Tui Na (Chinese Massage). I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping and gua sha. Unusual risks of acupuncture include miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although sterile disposable needles are utilized in a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and hot rock therapy. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (which are from plant, animal and mineral sources), which may be recommended, are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. I understand that some herbs may need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbal teas or products.

I will notify the clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinic staff to be able to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts known to them, is in my best interests.

I understand the clinical and administrative staff may review my medical records. I may be given a web site identifier and password to utilize the www.CHSLife.com web site. Otherwise, all of my records will be kept confidential and will not be released to any party without my written consent.

Although acupuncture and traditional Chinese modalities have much to offer the American health care system it can not replace the resources available to your primary care physician. We request that you inform your medical doctor (M.D.) about all conditions now and in the future for which you are seeking acupuncture treatment.

By voluntarily signing below I show that I have read, or have read to me, this 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.

To be completed by patient (or patient’s representative if the patient is a minor or is physically or legally incapacitated).

Date Consent Completed:______________

Patient Name:____________________________Patient Signature_________________________

Representative Name:_____________________ Representative Signature:__________________

Acupuncturist: Richard A.Covello, L.Ac.