Michelle Racine, LAc, LMT, MAOM

Acupuncture, Massage Therapy, and Chinese Herbal Medicine | 16 Franklin Street, Suite D, Exeter, NH

INFORMED CONSENT TO TREAT

By signing below I consent to Acupuncture, Massage Therapy and/or Chinese Herbal Medicine and other procedures within the scope of the practice of Acupuncture and Massage on me (or on the patient named below for whom I am legally responsible) by NH and MA Licensed Acupuncturist and Chinese Herbalist and NH Licensed Massage Therapist Michelle Racine, LAc, LMT, MAOM. Methods of treatment may include Acupuncture, moxibustion, cupping, guasha, nutritional counseling and/or massage techniques such as acupressure, facia release, shiatsu and tuina.

I understand that Acupuncture is a generally safe method of treatment, but that it may occasionally have some side effects, including bruising, numbness, tingling or pain near the needling site that may last a few days, and in rare cases, dizziness or fainting. Marks on the skin that appear like bruising are a common side effect of cupping and guasha. Herbal consultations are based on the concepts of Traditional Chinese Medicine. I understand that these services are not a replacement for diagnostic medical procedures. An Acupuncturist, Herbalist or Massage Therapist does not diagnose according to standard medical practice, nor should a “Chinese Diagnosis” be considered a replacement for standard medical evaluation or testing. If you have any concerns about what may be causing your symptoms, you must see a medical doctor.

OFFICE POLICIES

Payment: Payment is expected at the time of service by cash, check, or credit card. Returned checks will incur a $35.00 processing fee.
Insurance: Some health insurance covers acupuncture services, please complete the online form available on my website to pre-verify coverage. I can provide a detailed receipt to submit to your insurance company, as requested.
Missed Appointments: If you need to change or cancel your appointment, please give 24 hours notice. With the exception of emergencies, failure to do so will result in being charged the full fee for your appointment.

PRIVACY

Your client records and information will be kept confidential and shared only when necessary to provide care and services, or by your authorization, or when required or permitted by law.

Your email privacy is important to us. If you received a mailing from us, your email address is either listed with us as 1) someone who has expressly shared this address for the purpose of receiving information in the future (“opt-in”), or 2) you have registered or purchased or otherwise have an existing relationship with us. We respect your time and attention by controlling the frequency of our mailings. If you have received unwanted, unsolicited email sent via this system or purporting to be sent via this system, please forward a copy of that email with your comments to michelle4acu@gmail.com.

Print Name _____

Signature _____

Date _____

Michelle Racine, LAc, LMT, MAOM

Name	DOB	Age
Address	City	State/Zip

Phone	Email	Have you had acupuncture before? Y / N
Is it okay to text you with appointment reminders or changes? Y or N	Is it okay to email with appointment reminders or changes? Y or N	Occupation

How did you hear about me?

Main Health Issues: Please write in your top two health issues/concerns in order of importance. Please rate severity on a scale of 1-10, 1 being no symptoms, 10 cannot imagine it being worse.

Health Concern 1: Main Symptoms: When did this start? Severity Scale (1-10) _____	Health Concern 2: Main Symptoms: When did this start? Severity Scale (1-10) _____

Please indicate if you have been diagnosed with any of the following health conditions:

☐ AIDS/HIV	☐ Cancer, type:	☐ Kidney Disease
☐ Alcoholism	☐ Depression	☐ Mental Illness
☐ Allergies, food	☐ Diabetes, type:	☐ Osteoporosis
☐ Allergies, seasonal	☐ Dizziness/Vertigo	☐ Pacemaker
☐ Allergies, other	☐ Heart disease	☐ Seizures
☐ Anemia	☐ Hepatitis	☐ STD
☐ Anxiety	☐ Herpes	☐ Stroke
☐ Asthma	☐ High Blood Pressure	
☐ Bleed or bruise easily	☐ Low Blood Pressure	

Habits Please indicate amount per week. If you have quit, list the year	**Exercise** Do you exercise regularly? Y / N If so what and how often?	**Diet** Do you have a special diet, now or in the past? Please describe.	**Medication** Please note what medications, herbs or supplements you take regularly.	**Injuries/ Surgeries** Please note what happened to what body area and when it occurred.
Coffee/tea _____ Soda _____ Tobacco _____ Alcohol _____ Drugs _____				

Please indicate any symptoms experienced in the past few months.

Skin:
- ☐ Cold hands or feet
- ☐ Chills
- ☐ Cold 'in the bones'
- ☐ Areas of numbness
- ☐ Hot hands, feet, chest
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Unusual daytime sweating
- ☐ Dry skin
- ☐ Rashes, area:
- ☐ Itching, area:
- ☐ Dandruff
- ☐ Oily skin
- ☐ Oily hair

Moisture:
- ☐ Dry hair
- ☐ Dry eyes
- ☐ Dry or brittle nails
- ☐ Dry mouth
- ☐ Dry lips
- ☐ Dry throat
- ☐ Dry nose
- ☐ Edema/swelling:
- ☐ Excessive thirst
- ☐ Thirst for hot or cold drinks
- ☐ Absence of thirst

Digestion:
Bowel movements, how often?
_____x/every ____days
- ☐ Stools keep shape Y / N
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stools difficult to pass
- ☐ Foul smelling stools
- ☐ Gas and/or bloating
- ☐ Belching
- ☐ Poor appetite
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Bad breath
- ☐ Excessive hunger

Energy:
- ☐ Hard to get going in morning
- ☐ Sudden energy drop
- ☐ Low energy after eating
- ☐ Fatigue
- ☐ Caffeine/stimulant dependency
- ☐ Wired/ungrounded feeling
- ☐ Body/limbs feel heavy
- ☐ Body/limbs feel weak
- ☐ Hard to concentrate

Sleep:
Number of hours/night: _____
- ☐ Difficulty falling asleep
- ☐ Waking ___x/night
- ☐ Wake to urinate ___x/night
- ☐ Disturbing dreams
- ☐ Restless sleep
- ☐ Not rested on waking

Chest:
- ☐ Shortness of breath
- ☐ Chest tightness
- ☐ Heart palpitations

Emotions:
- ☐ Anger
- ☐ Irritable
- ☐ Anxious
- ☐ Worry
- ☐ Obsessive thinking
- ☐ Sad
- ☐ Grieving
- ☐ Depressed
- ☐ Joyful
- ☐ Fearful
- ☐ Timid/shy
- ☐ Indecisive

Head/Ears/Eyes/Nose/Throat:
- ☐ Dizzy/lightheaded
- ☐ Headaches: # per week _____
- ☐ Poor vision
- ☐ Night blindness
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in front of eyes
- ☐ Nasal discharge
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Excess ear wax
- ☐ Sore throat
- ☐ Dental problems
- ☐ Mouth sores
- ☐ Cough
- ☐ Phlegm, color: _____

Genito/Urinary:
- ☐ Excess urination
- ☐ Decreased flow
- ☐ Dribbling
- ☐ Difficulty start/stop flow
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Urinary urgency
- ☐ Urinary frequency
- ☐ Pain on urination
- ☐ Burning sensation
- ☐ Cloudy urine
- ☐ Blood in urine
- ☐ Sores on genitals
- ☐ Prostate disease
- ☐ Genital pain
- ☐ Hernia

Reproductive Health:
- ☐ Change in sexual drive
- ☐ Erectile dysfunction
- ☐ Vasectomy
- ☐ Birth control pill
- ☐ IUD
- ☐ Age at first menses _____
- ☐ Menstrual cycle length _____
- ☐ Date of last menses _____
- ☐ #pregnancies _____
- ☐ #live births _____
- ☐ #abortions _____
- ☐ #miscarriages _____
- ☐ Painful periods
- ☐ Irregular periods
- ☐ PMS
- ☐ Menstrual cramps
- ☐ Breast tenderness
- ☐ Midcycle spotting
- ☐ Menopause, age _____