ACUPUNCTURE

Please write your legal name on all paperwork

Name_____ **Date of Birth**_____

Address_____**City**_____**State**_____**Zip Code**_____

Home Phone _____ **Work Phone** _____

Cell Phone _____ **Email**_____

Social Security #_____-_____-_____ **Gender** ☐ **Male** ☐ **Female**

Occupation_____**Employer Name**_____

Martial Status ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Other**

Primary Care Physician_____**Phone number**_____

Who referred you to our office?_____

Welcome to Greenapple Sports & Wellness!

We are glad that you have chosen us to help serve you healthcare needs. For your information, we use disposable sterile acupuncture needles, which are disposed following OSHA guidelines for biomedical waste.

Consent for Treatment

I, the undersigned, freely consent to treatment at Greenapple Sports & Wellness. I understand that treatment may include the use of acupuncture needles, electrical acupuncture, TDP lamps, cupping, and acupressure.

I fully understand that the risk of treatment although very limited could include the following: slight burns from the mineral heat lamp or slight bruising from cupping and needles. If I use a pacemaker, have heart problems, have metal plates or rods in my body, have an infectious disease, am taking herbs or pharmaceuticals, am pregnant or suspect that I might be pregnant, I agree that I will inform the practitioner before beginning treatment.

I accept that Greenapple Sports & Wellness cannot be held liable for any intentional misrepresentations by myself. I state that I have read the “Consent for Treatment” form in its entirety and understand and accept the risks involved in the treatment.

Patient Signature_____ **Date**_____

4805 Park Road Suite 225 Charlotte, NC 28209 Phone 704-527-7246 Fax 704-527-3080 www.drgreenapple.com

GREENAPPLE
Sports & Wellness

Name:_____

Main condition you would like us to help you with?_____

_____

How long have you had this problem?_____ **Caused by**_____

Have you been given a diagnosis for this problem? If so, what is it?_____

What kind of treatments have you tried for the problem?_____

How long?_____

Effectiveness of treatments_____

Past Medical History

Illness_____

Surgeries_____

Significant Trauma(Motor Vehicle accidents, Sports Injuries, etc)_____

_____

Do you have or have you had any infectious disease? Yes/ No If Yes,please describe_____

_____

Medicines (include prescriptions, over the counter drugs, vitamins, herbs, takes within the last 3 months)

_____

_____

_____

Allergies_____

Family Medical History

Are there an hereditary diseases in you family? Yes / No If yes, please describe _____

_____

Patient Signature_____ **Date**_____

PERSONAL MEDICAL HISTORY

Name:_____

Significant Illness

☐ Cancer	☐ Seizures	☐ Diabetes	☐ Rheumatic Fever	☐ High Blood Pressure
☐ Hepatitis	☐ Heart Disease	☐ Thyroid Disease	☐ Stroke	☐ Herpes
☐ HIV (AIDS)	☐ Weight Problem	☐ Venereal Disease	☐ Mental Illness	☐ Other:
☐ Allergies	☐ Tuberculosis	☐ Addictive Disorders	☐ Asthma	

Please check if you have experienced any of the following in the last 3 months

General

☐ Poor Appetite	☐ Localized Weakness	☐ Peculiar Tastes	☐ Sweat Easily	☐ Headaches
☐ Fevers	☐ Insomnia	☐ Bleeding	☐ Change in Appetite	☐ Sudden Energy Drop
☐ Fatigue	☐ Strong Thirst	☐ Weight Loss	☐ Night Sweats	☐ Hearing Loss
☐ Tremors	☐ Poor Balance	☐ Weight Gain	☐ Depression	☐ Bruising Easily
☐ Cravings	☐ Chills	☐ Joint Pain	☐ Emotional Changes	

Skin & Hair

☐ Rashes	☐ Itching	☐ Skin Texture Change	☐ Ulcers	☐ Psoriasis
☐ Eczema	☐ Hair Loss	☐ Dandruff	☐ Acne	☐ Hives
☐ Recent Moles	☐ Hair Texture Change			

ENT + Head & Eyes

☐ Dizziness	☐ Eye Pain	☐ Earaches	☐ Migraine	☐ Sore Throat
☐ Ringing in Ears	☐ Glasses	☐ Glaucoma	☐ Eye Strain	☐ Sores On Lips
☐ Gum Problems	☐ Sinus Problems	☐ Poor Vision	☐ Teeth Grinding	☐ Sores on Lips
☐ Night Blindness	☐ Headaches	☐ Cataracts	☐ Floaters	☐ Mouth of Ulcers
☐ Facial Pain	☐ Blurred Vision	☐ Concussion	☐ Spots in front of eyes	☐ Color Blindness
☐ Jaw Click	☐ Poor Hearing	☐ Nose Bleeds	☐ Toothache	

Respiratory

☐ Coughing	☐ Coughing Blood	☐ Shortness of Breathe	☐ Phlegm	☐ Painful Breathing
☐ Wheezing	☐ Bronchitis			

Cardiovascular

☐ Blood Clots	☐ Fainting	☐ Cold Hands or Feet	☐ Low Blood Pressure	☐ Irregular Heartbeat
☐ Phlebitis	☐ Dizziness	☐ Swelling of Hands	☐ Shortness of Breath	☐ Difficult Breathing
☐ Chest Pain	☐ Swelling of Feet			

Gastrointestinal

☐ Nausea	☐ Bloating	☐ Blood in Stool	☐ Abdominal Pain	☐ Belching
☐ Constipation	☐ Black Stool	☐ Vomiting	☐ Diarrhea	☐ Hemorrhoids
☐ Bad Breath	☐ Gastric Ulcers	☐ Indigestion	☐ Parasites	☐ Intestinal Gas

Genito/Urinary

☐ Painful Urination	☐ Urgent Urination	☐ Scanty Urination	☐ Frequent Urination	☐ Blood in Urine
☐ Impotence	☐ Unable to Hold Urine	☐ Freq. Night Urination	☐ Genital sores	☐ Kidney Stones

Gynecology & Pregnancy (females only)

☐ Irregular Period	☐ Breast Lumps	☐ Clots	☐ Vaginal Sores	# of Pregnancies _____
☐ Light Flow	☐ Heavy Flow	☐ Painful Periods	☐ Vaginal Discharge	# of Births _____
☐ Fertility Problems	Age of 1st Menses_____	Date of Last_____	# of Premature Births____	# of Miscarriages _____
				# of Abortions _____

PERSONAL MEDICAL HISTORY

Name:_____

Neuro-Psychological

☐ Seizures	☐ Areas of Numbness	☐ Concussion	☐ Loss of Balance
☐ Dizziness	☐ Lack of Coordination	☐ Depression	☐ Mood Swings
☐ Stress	☐ Poor Memory	☐ Anxiety	☐ Irritability
☐ Disorientation	☐ Migraines	☐ Easily Angered	☐ Headaches

Have you ever received psychiatric treatments?_____

Have you attempted suicide?_____

Any nervous habits?_____

Any other problems you would like us to be aware of? _____

_____

_____

Musculo-Skeletal

☐ Neck Pain	☐ Back Pain	☐ Joint Pain	☐ Muscle Spasms	☐ Hand/Wrist Pain
☐ Scoliosis	☐ Shoulder Pain	☐ Knee Pain	☐ Muscle Cramping	☐ Hip Pain
☐ Arthritis	☐ Muscle Weakness	☐ Muscle Soreness	☐ Weak Joints	☐ Foot/Ankle Pain
☐ Recent Sprains	☐ Recent Injuries			

Please circle any areas of Pain or Injury