Name_____

Jessica I. Yunker, M.S., L.Ac.

Traditional Chinese Medicine

Personal Information and Health History

ALL INFORMATION IS CONFIDENTIAL

Identification and Contact Information: Please print.

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

_____ Age: _____

Home Phone: _____ Gender Identity: _____

Cell Phone: _____ Preferred Pronouns: _____

Work Phone: _____ Ethnic Background: _____

E-mail: _____

How did you hear about this Chinese medicine practice? _____

Emergency Contact (name, relationship, phone) _____

Hospitalizations: Please include hospitalizations for serious medical illness or surgery. Please do not list normal pregnancies / deliveries.

Year	Reason	Hospital Name	City & State

Medications and Allergies:

Please list the names of any medications you are currently taking:

Please list any medication allergies you have:

Please list anything else that you are allergic to:

Name_____

Family History: Please check any disorders or organ systems that apply to your family history.

	Father	Mother	Spouse	Sibling	Sibling	Sibling	Child	Child
Allergies								
Blood / Anemia								
Diabetes								
Cancer / Tumors								
Seizures								
High Cholesterol								
High Blood Pressure								
Kidney / Bladder								
Stomach / Intestines								
Drug Abuse								
Tuberculosis								
Heart Disorder								
Stroke								
Mental Health								
Other (please list)								
Age at Death								

Is there anything else that you think is important about your family history?

Habits and Lifestyle: Please answer each of the following. All information is confidential.

Do you smoke cigarettes / cigars?

□ No, never
□ No, but I have smoked in the past (when did you quit? _____)
□ Yes, occasionally / socially
□ Yes, _____ packs / day

Do you drink alcohol?

□ No, never
□ Yes, I drink about _____ drinks per week.

Do you drink caffeine? (check all that apply)

□ No, never
□ Yes, I drink about _____ sodas per day
□ Yes, I drink about _____ teas per day (caffeinated)
□ Yes, I drink about _____ coffees per day (caffeinated)

Do you use any street drugs (such as marijuana, cocaine, crack, heroin, LSD, mushrooms, etc)?

□ No, I have no history of drug use
□ No, but I have in the past (when did you stop? _____)
□ Yes, occasionally / socially

Name_____

□ Yes, I use medical marijuana
□ Yes, I use other drugs (please list) _____

General Information:

What is the highest level of education you completed?
□ Did not complete high school
□ High school / GED
□ College graduate
□ Graduate school / post-graduate work

Are you currently employed or in school? Please check all that apply.
□ Employed (__ full time OR __ part time)
□ Student (__ full time OR __ part time)
□ Not currently employed OR in school

What is your current occupation and / or course of study? _____

About how many hours per week do you work or attend school? _____

Are you currently on any special diets, or do you have any dietary restrictions? Please list here.
(For example: vegetarian, vegan, kosher, low-carb, low-fat, etc.)

Do you exercise?
□ Yes
□ Occasionally
□ No

If yes or occasionally, what kind(s) of exercise do you do, and how often?

_____

Personal Health Goals: Please list any areas of your health and wellness that you are interested in exploring with traditional Chinese medicine. These may include the reason you are here today, or something you would like to address in the future.

Name_____

Pregnancy History: Please complete each of the following.

Are you currently pregnant? □ Yes □ No

Are you currently trying to become pregnant? □ Yes □ No

How many times have you been pregnant? _____

____# living ____# miscarriages ____# induced abortions ____# ectopic

Current Health Conditions: Please indicate any conditions that you currently experience or have had chronically in the past.

Skin
__ Hives
__ Rashes
__ Eczema
__ Night sweats
__ Excessive sweating
__ Dry skin
__ Bruising easily
__ Changes in moles / lumps
__ Other _____

Head and Neck
__ Dizziness
__ Fainting
__ Stiff neck
__ Stiff shoulders
__ Enlarged lymph nodes
__ Migraines
__ Frequent headaches
__ Other _____

Eyes and Ears
__ Blurry vision
__ Visual disturbance
__ Poor night vision
__ Spots / floaters in vision
__ Red / itchy / teary eyes
__ Ear infection
__ Ringing in ears
__ Poor hearing
__ Other _____

Cardiovascular
__ Palpitations
__ Chest pain / tightness
__ Rapid heart beat
__ Poor circulation
__ Swollen ankles
__ Phlebitis
__ Other _____

Gastronintestinal
__ Nausea
__ Indigestion
__ Acid reflux / GERD
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting blood
__ Bloody / black stools
__ Hemorrhoids
__ Gallbladder disease
__ Recent change in weight
__ Food cravings
__ Other _____

Male Reproductive System

Muscles and Joints
__ Joint disease / arthritis
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Spinal curvature
__ Lower back pain
__ Middle back pain
__ Upper back pain
__ Other _____

Neurological
__ Seizures
__ Tremors
__ Numbess / tingling
__ Pain: where?_____
__ Paralysis
__ Other _____

General
__ Insomnia
__ Frequent dreams / nightmares
__ Fatigue
__ Agitation / anxiety
__ Depression
__ Irritability
__ History of psychiatric treatment
__ Aversion to heat
__ Aversion to cold

Name_____

Nose, Mouth, and Throat
__ Bleeding
__ Sinus infection
__ Hay fever / allergies
__ Sore throat
__ Hoarseness
__ Difficulty swallowing
__ Taste in the mouth
__ Changes in smell
__ Oral ulcers / mouth sores
__ Other _____

Respiratory
__ Chronic cough
__ Coughing up blood
__ Excessive phlegm / sputum
__ Difficulty breathing
__ Asthma / wheezing
__ Frequent colds
__ Environmental Allergies
__ Other _____

__ Pain / itching of genitalia
__ Genital lesions / discharge
__ Impotence
__ Weak urinary system
__ Frequent urination
__ Lumps in testicles
__ Other _____

Female Reproductive System
__ Abnormal PAP smear
__ Frequent urinary tract infection
__ Frequent vaginal infections
__ Pain / itching of genitalia
__ Genital lesions / discharge
__ Pelvic inflammatory disease
__ Irregular periods
__ Painful periods
__ PMS
__ Bleeding between periods
__ Menopausal symptoms
__ Uterine fibroids
__ Breast lumps
__ Ovarian cysts
__ Other _____

__ Excessive thirst
__ Frequent urination
__ Other _____

Medical History
__ Diabetes (Type __)
__ Tuberculosis
__ Chronic bronchitis
__ Organ Transplant
__ Cancer / history of cancer
__ Stroke
__ Thyroid disorder
__ High blood pressure
__ Other _____
__ Other _____
__ Other _____

Jessica I. Yunker, M.S., L.Ac.
Traditional Chinese Medical Practice
Advisory to Consult a Physician

Jessica I. Yunker, M.S., L.Ac., is committed to your health and well-being. While traditional Chinese medicine modalities, such as acupuncture and herbal medicine, have a great deal to offer as a health care system, it cannot entirely replace the services available from biomedical practitioners. Therefore, it is recommended that you consult a physician regarding any condition(s) for which you are seeking acupuncture or herbal treatment.

Please read and sign the following statement:

I, _____ (print name here)**, do affirm that I have been advised by Jessica I. Yunker, M.S., L.Ac., to consult a physician regarding the condition(s) for which I seek acupuncture treatment.**

_____ _____
(signature of patient or representative) (date)

_____ _____
(signature of licensed acupuncturist) (date)

Name_____

Jessica I. Yunker, M.S., L.Ac.
Traditional Chinese Medical Practice
Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and other procedures within the scope of the practice of acupuncture by **Jessica I. Yunker, M.S., L.Ac.**, a licensed acupuncturist in New Jersey. I also consent to treatment by other licensed acupuncturists who now or in the future may treat me while employed by, or working with, Jessica I. Yunker, M.S., L.Ac. Traditional Chinese medical treatment may include, but is not limited to, the following:

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin, and is generally a safe method of treatment. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, or organ puncture (including lung puncture). I understand that Jessica I. Yunker, M.S., L.Ac., like other traditional Chinese medicine practitioners, has been trained to help prevent any of these adverse events from occurring. I understand that there is a risk of infection from acupuncture, although Jessica I. Yunker, M.S., L.Ac., uses only sterile, disposable needles and maintains a safe and clean environment. Moxibustion involves the burning of plant substances on or near the skin, and there is a risk of burning or scarring the skin, although precautions will be taken to prevent this.

Chinese Herbs: I understand that substances from the Chinese Materia Medica may be recommended to me to treat illness or dysfunction. I understand that these substances are traditionally considered safe in the practice of Chinese medicine, although some may be toxic in large doses. I understand that I should alert Jessica I. Yunker, M.S., L.Ac., to any allergies or dietary restrictions that may affect the herbal prescription given to me. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, nausea, gas, abdominal pain, abdominal discomfort, vomiting, rashes or hives. Should I experience any problems which I associate with these substances, I will stop taking them and call Jessica I. Yunker, M.S., L.Ac., as soon as possible. I understand that

Name_____

some substances may be inappropriate during pregnancy, and I will notify Jessica I. Yunker, M.S., L.Ac., if I am pregnant or if I become pregnant.

I understand that there may be other treatment modalities or methods that, in the opinion of Jessica I. Yunker, M.S., L.Ac., would be beneficial to me, and that these will be explained in full. I understand that I always have the right to ask questions or to refuse any treatment. I understand that it is not possible to anticipate all possible risks or complications of treatment, and I wish to rely on Jessica I. Yunker, M.S., L.Ac., to exercise judgment during the course of treatment that is in my best interest, based on the facts that are known.

I understand that there may be other treatment alternatives for the conditions I wish to treat, including treatment offered by a licensed physician.

I understand that the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released to any other party without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, this Consent to Treatment, I have been told about the risks and benefits of acupuncture and other procedures, and I 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 may seek treatment.

_____ _____
(signature of patient or representative) (date)

_____ _____
(signature of licensed acupuncturist) (date)

OFFICE CANCELLATION POLICY

Jessica I. Yunker, M.S., L.Ac. is a member of a collective of independent practitioners in a shared office space. In order to provide all of the practitioners and all of their patients access to appointments, we ask that you please respect our office's Cancellation Policy. This allows all of the practitioners to provide care to any patient who needs treatment.

We request that you give at least 24 hours notice if you cannot come to your scheduled appointment. Please understand that if you do not provide adequate notice, you may be charged in full for the missed appointment.

I have read the above statement, and agree to provide at least 24 hours notice if I cannot come to my appointment.

_____ _____
Signature Date

Name____