C J Herbal Remedies, Inc.
1776 Legacy Circle Suite 102, Naperville, IL 60563 / 111 N. Wabash Ave. Suite 1219, Chicago, IL 60602
Naperville Phone: (630) 885-6558 Chicago Phone: 630-885-6558

_____
List your full name, age, sex, and today's date

_____List your complete address

_____
List your home phone, work phone, and cell phone numbers

_____
List your E-mail address

_____
Occupation

_____
Referred by whom

WHAT ARE YOUR COMPLAINTS?

#1_____How long? _____

#2_____How long? _____

#3_____How long? _____

#4_____How long? _____

#5_____How long? _____

#6_____How long? _____

#7_____How long? _____

#8_____How long? _____

#9_____How long? _____

#10_____How long? _____

#11_____How long? _____

#12_____How long? _____

#13_____How long? _____

#14_____How long? _____

#15_____How long? _____

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Please check the appropriate descriptions and fill in the necessary information:

Emotions: depress ____ sad ____ panic attack ____ anger ____ anxiety ____

Energy: low ____ exhausted ____ hyperactive ____

Sleep Pattern: have difficulty falling asleep _____ wake up _____times per night

wake up too early ____ cannot go back to sleep after waking up _____

Menstrual Cycle: Average days from the last cycle _____

Days of menstruation period _____

clots _____ menstrual pain _____ (scale of 1 to10 extremely painful) days of pain _____

Color: pale red _____ bright red _____ dark red _____

Date of first menstruation flow: _____

Date of ending flow: _____

Temperature: fever ____ cold hands ____ cold feet ____ hot flash ____

Sweating: too little ____ too much ____ night sweats ____

Sensitivity and Allergy: cold ____ hot ____ dampness ____ food _____

dust ____ hay ____ pollen ____ others _____

Appetite and Digestion: poor appetite ____ rapid hungering ____ craving ____

nausea ____ bloating ____ gas ____

Bowel Movement: constipation ____ diarrhea ____ loose ____ watery ____

incomplete ____ hard and dry ____ strong smell ____ with mucous ____

with blood ____ Time of day when BM occurs: _____

Body Weight: Overweight ____ Underweight ____

How many pounds would you like to gain or lose? _____

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Liquid Intake: dry mouth ____ thirsty ____ Quantity _____ oz/day

Temperature of water: warm _____ room temperature _____ cold _____ with ice _____

Urination: frequent ____ urgent ____ burning ____ painful ____ cloudy ____

dark color ____ foul smell ____ retention ____ bloody ____

Number of times per day: _____ Number of times per night: _____

Pain - Degree of Pain: _____ (0 - 10) Location of Pain: _____

Chronic _____ , Acute _____ ; How long _____

Dull _____ , Sharp _____ , Burning _____, Spasm _____ , Ache _____

Palm Moisture: Right _____ Left _____

Habits: smoking_____ drink coffee_____ cups /day

drink alcohol _____oz./week beer_____ red wine_____ white alcohol _____

eat chocolate _____ eat cinnamon powder_____ eat spicy food_____

Blood pressure _____ Blood sugar _____

Medication: Antacids _____ Antibiotics_____ Blood pressure_____

Blood thinning_____ Hormones_____ Insulin_____ Laxatives_____

Sleeping Pills_____ Thyroid Medications_____

Family History (F=father, M=mother; circle your answers):

Asthma (F) (M); Arthritis (F) (M); Allergies (F) (M)

Anemia (F) (M); Cancer (F) (M); Colitis (F) (M)

Diabetes (F) (M); Epilepsy (F) (M); Goiter (F) (M)

Hypertension (F) (M); Heart Disease (F) (M); Migraine (F) (M)

Overweight (F) (M); Stroke (Clots) (F) (M); Stroke (Bleeding) (F) (M)

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ACUPUNCTURE INFORMATION AND INFORMED CONSENT FORMS p. 4 of 4

Acupuncture is performed by the insertion of PRE-STERILIZED, DISPOSABLE acupuncture needles through the skin, and / or the application of heat stimulation to skin, or both, at certain points on the body. The benefits and risks of receiving acupuncture procedures and Chinese herbal consultation have been explained to me. Although rare, certain side effects may result from Acupuncture, I understand that each procedure has specific risks and benefits. I understand that the practice of Acupuncture and Herbal consultation is not an exact science, and I acknowledge that no guarantees have been made to me. I understand that licensed Acupuncturists perform these procedures.

I have been informed of the risk and benefits of the procedures and products listed below that apply to my case:
Acupuncture needles to stimulate points and meridians, including the specific risks of needling certain points, and the use of mechanical stimulation of acupuncture points or acupressure.

I have been informed and understand the risks and side effects listed below:
1) Minor burning, 2) Needle sickness, 3) Broken needles, 4) Some pain at the site of needle insertion, 5) Infection, 6) The risks from needling in the vicinity of an infection, 7) Potential side effects of Chinese herbs, and 8) if I discontinue the herbal consultation, I will discontinue taking any herbal product recommended by the acupuncturist/herbalist. After the consultation service is terminated, the acupuncturist/herbalist is not liable for any herbal products that I use/purchase from any other sources.

I understand that when I have needle reaction symptoms, and emergency care is necessary, I authorize CJ Herbal Remedies Inc. to call 911. I am responsible for payment of the full amount of emergency care cost. I have been advised to visit medical doctor regularly, and in emergency situations, I have to seek emergency medical service immediately.

I understand that C J Herbal Remedies Inc. may record information concerning my case in electronic and in other physical form. Such information may be released by C J Herbal Remedies Inc. for the purposes authorized on this form. I understand that portions
of my records may be disclosed to other personnel for the purpose of management, financial audits, and licensure and program evaluation without my express consent.

RECORDS RELEASE AUTHORIZATION
I understand that I am responsible for my bill. I authorize payment directly to C J Herbal Remedies Inc. I authorize the use of this form for all of my insurance submissions. I authorize release of information to all my insurance companies.
I permit a copy of this authorization to be used in place of the original.
I authorize C J Herbal Remedies Inc. to make another copy of my previous medical information which I have provided.
I authorize the use of my previous medical information to be the basis of acupuncture procedures and herbal consultation.
This authorization is not intended to allow the release of records regarding my case for services requiring a restricted release under State of Federal Law.

Client's Name (print) _____

Client's Signature _____ Date _____.

NOTICE OF PRIVACY PRACTICES
I have received a copy of C J Herbal Remedies Inc. Notice of Privacy Practices. I understand this information defines my rights under 45 CFR 164.528 of the federal regulations and is intended to comply with federal patient privacy rights.

Client's Signature _____ Date: _____.

CONSENT FOR A MINOR CLIENT
I authorize C J Herbal Remedies Inc. and whomever it designates as assistants to administer Acupuncture procedures and

Chinese herbal consultation as deemed necessary to my _____(relationship).

Minor Client's Name_____.

Custodian's Signature_____ Date _____