CONSULTATION & CONSENT FORMS p. 1 of 5

C J HERBAL REMEDIES, INC.

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_____

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?_____

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 _____

Color: pale red _____ bright red _____ dark red _____

Emotion around period: depression _____ irritability _____ anger _____

crying _____ anxiety _____ others: _____

Emotions occur: before period _____ during period _____ after period _____

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? _____

Liquid Intake: dry mouth _____ thirsty _____ drink a lot of water_____

Not thirsty, but drink a lot of water anyway _____

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_____ drink alcohol _____

eat chocolate _____ eat cinnamon powder_____ eat spicy food_____

Exercise: light_____ medium_____ vigorous_____

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 CONSENT FORM

C J Herbal Remedies Inc.
1776 Legacy Circle, Suite 102
Naperville, IL 60563
(630) 799-9288

ACUPUNCTURE INFORMATION AND INFORMED CONSENT

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) Needle reaction symptoms: pale face, dizziness, palpitation shortness of breath, cold sweat, nausea, even fainting, reactions similar like low blood sugar condition, 2) Minor burning, 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, and 7) Potential side effects of Chinese herbs.

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.

I understand that I am responsible for all consequences should I choose to purchase herbal products from sources other than C J Herbal Remedies.

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 Signature_____ Date _____