

C J Herbal Remedies, Inc.

1776 Legacy Circle Suite 102, Naperville, IL 60563 Phone/Text: 1-630-885-6558 Email: cjchen525@cjherbalremedies.com

CONSULTATION & CONSENT FORMS p. 1 of 4

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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CONSULTATION & CONSENT FORMS p. 2 of 4

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 to 10 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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CONSULTATION & CONSENT FORMS p. 3 of 4

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 _____.