RENO ACUPUNCTURE
DR GARY DANCHAK, OMD
16500 Wedge Pkwy, Ste. 400 • Reno, NV 89511
www.reno-acupuncture.com

INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other procedures within Dr Danchak's scope of practice on me (or on the patient named below, for whom I am legally responsible) by Dr Danchak and /or other licensed doctors of acupuncture working or associated with or serving as back-ups for Dr Danchak, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping, electrical stimulation, Chinese herbal medicine and nutritional counseling. I understand that herbal formulas prepared by Dr Danchak may be needed for my treatment and come at an additional cost. Please always feel free to text Dr Danchak if you have questions about your herbs.

I have been informed that acupuncture is a generally safe modality, but that it may have some side effects, including bruising, numbness or tingling near the needle sites (which may last a few days), and dizziness or fainting. Bruising is a common side effect of cupping and usually go away after a few days. Very unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture including lung puncture. Infection is a possible risk, although we use sterile, disposable needles and maintain a clean environment. Other side effects not mentioned here may occur. Herbal formulas from plant, animal and mineral sources are traditional and considered safe in Oriental Medicine, although some may be toxic in large doses. Some herbs may be inappropriate during pregnancy. Possible side effects of taking herbs are nausea, gas, stomach ache, diarrhea, and rashes (we see this in less than 10% of patients and they usually go away in a week or so).

I will notify Dr Danchak if I am or become pregnant.

I don't expect Dr Danchak/staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on Dr Danchak/staff to exercise judgment during the course of treatment which he/they think are in my best interest. I understand that results are not guaranteed.

I understand Dr Danchak/staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I attest that I have read the above consent to treatment, have been made aware of the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature (or patient representative) Date

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Dr Gary Danchak, OMD

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:
X_____ _____
Patient Signature or Legal Representative **Date**

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PERSONAL HISTORY

LAST NAME:_____ FIRST:_____ MIDDLE INITIAL:

TODAY'S DATE:_____ DATE OF BIRTH:_____ AGE:_____

MARRIED:_____ SINGLE:_____ DIVORCED:_____ OTHER:_____

MAILING ADDRESS:_____CITY:_____

STATE:_____ZIP:_____ EMAIL: _____

HOME NUMBER:_____ CELL NUMBER:_____

OCCUPATION:_____WORK NUMBER:_____

REFERRED BY:_____

PRIMARY PHYSICIAN:_____ PHONE:_____

IN CASE OF EMERGENCY~ NAME:_____ PHONE:_____

FATHER: ALIVE DECEASED UNKNOWN

HIS PRESENT HEALTH OR CAUSE OF DEATH:_____

_____

MOTHER: ALIVE DECEASED UNKNOWN

HER PRESENT HEALTH OR CAUSE OF DEATH:_____

_____

(PLEASE MARK ILLNESSES WHICH HAVE OCCURRED IN YOUR BLOOD RELATIVES, INDICATING CORRESPONDENCE TO MOTHER AND / OR FATHERS SIDE)

_____DIABETES	_____ALCOHOLISM	_____OBESITY
_____CANCER	_____MENTAL ILLNESS	_____ANXIETY
_____HEART DISEASE	_____STROKE	_____HIGH BLOOD PRESSURE
_____BLOOD DISORDERS	_____HIGH CHOLESTEROL	_____ORGAN DISORDERS

OTHER _____ _____

DESCRIBE YOUR HEALTH AS A CHILD:_____

(PLEASE CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE OR HAD IN THE PAST)

_____DIABETES	_____ALCOHOLISM	_____OBESITY
_____CANCER	_____MENTAL ILLNESS	_____ANXIETY
_____HEART PROBLEMS	_____STROKE	_____HIGH BLOOD PRESSURE
_____KIDNEY DISEASE	_____TUBERCULOSIS	_____EYE PROBLEMS
_____STD/HIV	_____HIGH FEVERS	_____ASTHMA
_____JAUNDICE	_____ORGAN PROBLEMS	_____PNEUMONIA
_____ALLERGIES	_____HEPATITIS	_____CHRONIC FATIGUE
_____ANTIBIOTIC USE	_____MEASLES	_____CHICKEN POX
_____HIGH CHOLESTEROL	_____SEVERE FATIGUE	_____FIBROMYALGIA

OTHER:_____

LIST ANY ILLNESSES REQUIRING SURGERY OR HOSPITALIZATION_____

_____

_____

LIST ANY TRAUMA:_____

_____

LIST ANY KNOWN ALLERGIES:_____

_____

(PLEASE LIST THE RESULTS AND DATES OF THE FOLLOWING EXAMS THAT PERTAIN TO YOUR GENDER)

PHYSICAL:_____

PROSTATE:_____

CHOLESTEROL:_____

PAP SMEAR:_____

ARE YOU CURRENTLY PREGNANT: YES NO DUE DATE:_____

MAMMOGRAM:_____

BLOOD TESTS:_____

THE PURPOSE OF YOUR VISIT:_____

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Please check all symptoms that apply to you:

Qi
- ☐ general weakness
- ☐ fatigue/lethargy
- ☐ spontaneous daytime sweating
- ☐ organ prolapse
- ☐ sinking feeling in abdomen
- ☐ lowered immunity
- ☐ breathlessness/trouble breathing
- ☐ hemorrhoids
- ☐ low voice
- ☐ hiccups, belching, vomiting

Xue
- ☐ pale complexion
- ☐ fatigue
- ☐ dry skin
- ☐ dry eyes/floaters
- ☐ tremors
- ☐ tingling limbs/numbness
- ☐ difficulty FALLING asleep
- ☐ red spots/purple blotches on skin
- ☐ pale or small amount of blood with period

Yin
- ☐ night sweats
- ☐ cheeks flush in afternoon
- ☐ evening restlessness
- ☐ difficulty STAYING asleep
- ☐ dry mouth
- ☐ sores on tongue
- ☐ irritability
- ☐ ringing in ear(s)
- ☐ constipation
- ☐ dizziness
- ☐ hands/feet warm or hot
- ☐ desire for cold drinks

Yang
- ☐ cold limbs/hands/feet/nose/buttocks
- ☐ aversion to cold
- ☐ desire for warm food/drinks/clothes
- ☐ diarrhea

Dampness
- ☐ water retention under skin (edema)
- ☐ fatigue
- ☐ no desire to drink water
- ☐ loose stools/diarrhea
- ☐ absence of taste
- ☐ craving for sweets
- ☐ heaviness of body or limbs
- ☐ cloudy urine
- ☐ reduced appetite
- ☐ nausea/vomiting
- ☐ phlegm/mucus
- ☐ runny nose
- ☐ vaginal discharge
- ☐ foggy thinking
- ☐ headache that feels like a band around the head

Wind
- ☐ trembling/shaking
- ☐ pain that moves from joint to joint
- ☐ fever/chills
- ☐ aversion to wind
- ☐ skin rashes

Xin—fire
- ▢ any awareness of your heart beating
- ▢ palpitations
- ▢ chest pain/pressure
- ▢ swelling of face/hands
- ▢ depression
- ▢ poor memory
- ▢ anxiety
- ▢ restlessness
- ▢ dream-disturbed sleep
- ▢ insomnia
- ▢ night sweats
- ▢ heat in palms or soles of feet
- ▢ agitated feeling
- ▢ impulsiveness
- ▢ excessive multi-tasking
- ▢ irritable and angry
- ▢ flushed face
- ▢ preference for cold drinks
- ▢ mouth or tongue ulcers
- ▢ bluish lips and nails
- ▢ laughing/crying w/o reason
- ▢ inability to find the right words

Pi--earth
- ▢ low appetite
- ▢ fatigue after eating
- ▢ anemia
- ▢ loose stools with undigested food
- ▢ chronic sinus discharge
- ▢ hemorrhoids
- ▢ bruises of unknown origin
- ▢ purple blotches on skin
- ▢ chronic uterine bleeding
- ▢ varicose veins/spider veins
- ▢ excessive nose bleeding
- ▢ abdominal distention
- ▢ stickiness in eyes
- ▢ foggy/cloudy thinking
- ▢ jaundice/yellow complexion
- ▢ bleed easily

Wei--earth
- ▢ stomach pain
- ▢ dark black or tarry stools
- ▢ stomach pain worse after eating
- ▢ vomiting of blood
- ▢ eating small amount and feeling full
- ▢ heat sensation in stomach
- ▢ sipping water throughout the day
- ▢ excess thirst
- ▢ constant hunger
- ▢ bleeding, swollen, painful gums
- ▢ dry mouth
- ▢ bad breath
- ▢ heartburn/acid regurgitation
- ▢ belching
- ▢ stomach distention
- ▢ nausea/vomiting
- ▢ mouth sores
- ▢ toothache

Da Cheng--metal
- ▢ constipation/diarrhea
- ▢ abdominal pain
- ▢ burning anus
- ▢ blood or pus in stools
- ▢ dark urine
- ▢ hard and dry stools
- ▢ urgent need to defecate which continues after defecation

Fei--metal
- ▢ short of breath
- ▢ weak/shallow breathing
- ▢ weak voice
- ▢ lowered immunity
- ▢ dry cough
- ▢ cough w/ sputum (color?_____,
- ▢ dry throat
- ▢ asthma
- ▢ wheezing
- ▢ difficulty breathing while lying down
- ▢ frequent yawning

Shen—water
- ☐ premature gray hair
- ☐ low back pain
- ☐ knee or ankle pain
- ☐ deafness/loss of hearing
- ☐ ringing in ears (low-pitched)
- ☐ loose teeth/many cavities
- ☐ early morning diarrhea
- ☐ hot or sore feeling in bones
- ☐ swelling/edema in lower body
- ☐ infertility
- ☐ leaking urine with coughing/sneezing
- ☐ incontinence
- ☐ dribbling after urination
- ☐ nocturnal emission
- ☐ reduced sex drive
- ☐ excess libido not satisfied by Intercourse
- ☐ vaginal discharge
  - ☐ color_____
  - ☐ odor? Yes / No

UB—water
- ☐ frequent urination
- ☐ difficult to initiate flow
- ☐ flow stops and starts
- ☐ urgent urination
- ☐ cloudy urine
- ☐ blood in urine
- ☐ painful or burning urination
- ☐ feeling of coldness in abdomen
- ☐ kidney stones

Gan—wood
- ☐ irritable
- ☐ anger easily
- ☐ moodiness
- ☐ depression
- ☐ muscle spasms/cramps
- ☐ muscle /tendon stiffness
- ☐ trembling, twitches
- ☐ feel like something is stuck in throat
- ☐ distention/tenderness around ribcage
- ☐ dry, red, itchy eyes
- ☐ night blindness
- ☐ vision problems/blurred vision
- ☐ brittle nails
- ☐ headache
- ☐ gallstones
- ☐ yellow colored stools
- ☐ ringing in ears (high-pitched)
- ☐ bitter taste in mouth
- ☐ frequent sighing
- ☐ tenderness/oppression in center of chest

Menstrual Cycle
- ☐ heavy bleeding (color of blood_____
- ☐ clots? Yes / No
- ☐ uterine fibroids
- ☐ PMS
- ☐ irregular menstruation
- ☐ no period
- ☐ distention/soreness of breasts/lower abdomen

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POLICY STATEMENT FOR APPOINTMENTS

Canceling an appointment requires 24 hours' notice, otherwise the patient is responsible for paying the full one-hour fee of $130.

I agree to these terms (please sign and date):

Signature: _____

Date: _____